Submission regarding the Fraud and Abuse Strategy for the Auto Insurance Sector

Presented to the Ministry of Finance and Financial Services Regulatory Authority of Ontario

Canadian Life and Health Insurance Association
July 12, 2021

OVERVIEW

The Canadian Life and Health Insurance Association (CLHIA) is pleased to provide its comments to the Ministry of Finance (MoF) and Financial Services Regulatory Authority of Ontario (FSRA) in response to its consultation on a Fraud and Abuse (F&A) Strategy for the auto insurance sector.

The CLHIA is a voluntary association with member companies that account for 99 per cent of Canada's life and health insurance business. The life and health insurance industry is a significant economic and social contributor in Ontario, and a large majority of life and health insurance providers in Canada have licenses to operate in Ontario, with seventy headquartered in the province.

$2.8 billion in provincial tax contributions

$210 million in corporate income tax

$351 million in payroll and other taxes

$592 million in premium tax

$1.64 billion in retail sales tax collected

Investing in Ontario

$337 billion in total invested assets

98% held in long-term investments

Protecting 11 million Ontarians

10.2 million with drug, dental and other health benefits

8.4 million with life insurance averaging $234,000 per insured

4.9 million with disability income protection

$46.8 billion in payments to Ontarians

$25.7 billion in annuities

$16 billion in health and disability claims

$5.1 billion in life insurance policies

While this consultation is focused on auto insurance, development of the F&A Strategy is of importance to life and health insurers—particularly any changes directly related to health care practitioners as they also provide services to Ontarians with private health insurance coverage.

Auto fraud incidents have direct impacts on L&H insurers

Life and health (L&H) and property and casualty (P&C) insurers experience similar issues when it comes to fraud and the same criminal networks impact both industries.

It is important to note that, unless an injury is work related, employer health plans are first payer in Ontario for any supplementary health and disability benefits. This means that if an individual has an automobile accident, has a workplace plan and is referred for treatment at a health clinic providing services outside of the public health system, the costs of treatment will be incurred by the employer until (if) the employer coverage reaches its maximum limit. Only

at that point, does the auto insurer assume any of the liability. In addition, if the individual is not able to return to work, the employer, through group benefit plans pay health and disability claims that are connected to auto fraud incidents and in some cases would bear a significant portion of the financial loss. The money gained from committing all types of insurance fraud is used to fund other criminal activity.

L&H fraud is itself a significant challenge

Group benefits fraud negatively impacts businesses and consumers (plan members) in Ontario, much like how auto insurance fraud contributes to higher premiums. Group benefit plans are purchased by employers for their employees. Benefits fraud and abuse increases costs to the plan resulting in some plan sponsors (employers) either passing those costs onto their employees or making difficult decisions to reduce the health benefits they offer.

Claims related fraud is a large and growing concern for life and health insurers and both insurers and the industry have invested significantly in people, processes, and technology to fight benefits fraud. As well through the CLHIA, the industry has, and continues to look for, opportunities to work together on development of industry-level initiatives. For example, in the last three years the industry has developed and launched an annual consumer education campaign "Fraud is Fraud" and in 2020 expanded this to include health care provider education under the tagline "Protect your patients and your practice". A further expansion of this campaign is underway. We would be happy to meet with you at your convenience to provide more detail on this program and how it can be leveraged more broadly as you continue to develop the strategy.

Ontario's anti-fraud strategy should cover all insurance markets

Our industry supports MoF and FSRA efforts on creating a fraud and abuse reduction strategy because it will enhance consumer protection and promote plan sustainability. However, as this evolves, we encourage the Ontario government to recognize the severity of fraud and abuse throughout the broader insurance industry.

We would caution that focusing specifically on auto insurance may have unintended consequences on the life and health insurance industry. It is also important to look at this issue more broadly so that we don't unintentionally put measures in place with one industry, simply to push the issue to another. In particular, health care practitioners also provide care to Ontarians with private extended health benefits (employer plans). We know from experience that fraud will always seek out the weakest link in the regulatory chain. It would appear to be fairly straight forward for an organized crime syndicate to establish clinics that submit claims solely to employer plans and thereby avoid all of the suggested enhanced regulatory and oversight rules. We should expect that sophisticated fraudsters will shift their activities in response to regulatory action.

With this in mind, the following are the industry's responses to questions included in the consultation.

DEFINE FRAUD AND ABUSE

We fully agree with gaining clarity and determining a consistent definition of fraud and abuse, not just within P&C insurance, but across all types of insurance. Regardless of the insurance type in question, insurance crimes range in severity, from slightly exaggerating claims to

deliberately submitting false claims for the sole purpose of financial gain. We also agree that fraud and abuse could include involvement from a number of parties, such as consumers, service providers, agents or insurers.

Life and health insurers define benefits fraud as a situation where ***someone intentionally submits false or misleading information to an insurance provider for the purpose of financial gain.*** Examples include:

- Knowingly presenting a false insurance claim;
- Counseling to present a false insurance claim;
- Conspiring to present a false insurance claim;
- Knowingly profiting from an insurance claim;
- Making a false declaration;
- Altering or forging a document;
- Presenting an altered or forged document for an insurance claim;
- Rate evasion; and
- Providing false information for an insurance claim.

We share this for consideration as a starting point for development of a definition as you continue your work. We would suggest that as you continue your work, any definition should be applicable to all forms of insurance to assist with consistent messaging for consumers.

As the MoF/FSRA point out, abuse is also a major factor to consider as it also has often unintended consequences on the cost and sustainability of insurance products. We would suggest language which includes, ***abuse occurs when the insurance benefits are being exploited, and to obtain services which are not medically necessary*.**

The definition could also be enhanced to assist with consumer education by providing a selection of examples. We would also encourage this be updated over time as fraud crimes are continually evolving. As mentioned above, the L&H industry has invested considerable time and resources in creating an education campaign. The “Fraud is Fraud” campaign began in 2018 with a focus on educating Canadian consumers on what benefits fraud is and highlighting that becoming involved in benefits fraud is a real crime with real consequences. Once this campaign launched, we heard from numerous health care provider associations that there was a need to also educate providers. We would invite you to visit our ”Fraud is Fraud” website and leverage any materials on the site in your strategy.

IMPROVE USE OF DATA IN THE INDUSTRY’S FRAUD AND ABUSE MANAGEMENT ACTIVITIES BY ENABLING BETTER COLLECTION, ANALYSIS AND REPORTING OF RELEVANT DATA/INFORMATION

A key consideration with regard to data collection should be improving the ability to share information across all industries and stakeholders including regulatory bodies. When fraud and abuse occurs, it is not happening within just one sector but across many industries. We would hope to see the creation of clear pathways that will enable the insurance industry to collaborate and share information with government for the limited purposes of preventing, detecting and suppressing fraud.

By working together and pooling resources, the government and private insurers (L&H and P&C) can make a bigger impact in the fight against fraud, protect Ontarians, and save taxpayer dollars that are lost due to fraud.

In addition to facilitating better reporting and information sharing to promote deterrence, this can also help alleviate the burden on regulatory colleges that may not have the capacity to investigate every report they receive.

As an example, health providers treat consumers insured by P&C insurers, health insurers, the Ontario Health Insurance Plan (OHIP), and the Workplace Safety and Insurance Board (WSIB). Through effective collection and sharing of information, stronger cases could be built and shared with regulators and law enforcement to mitigate fraud. Fraud is inherently about deception, so it is difficult to quantify on a broad level the cost of fraud. As an industry it is estimated that hundreds of millions of health care dollars are lost to fraud which results in higher costs for everyone. Once a consistent definition of fraud and abuse is agreed upon, beginning the process of centralizing the collection of relevant data may provide an opportunity to start working on quantifying the true economic impact of fraud.

ALLOW INSURERS TO EXCLUDE COVERAGE FOR SERVICES PROVIDED BY CERTAIN VENDORS, BASED ON INVESTIGATIONS AND REASONED DECISIONS, AND REVIEW/UPDATE PROCESSES FOR POTENTIAL DISAGREEMENTS

As you may be aware, life and health insurers have engaged in the practice of delisting certain providers when there is evidence of fraud and abuse. In our view, this does not limit consumer choice. The consumer still has the option of receiving the service from that provider. However, if the provider is delisted, the individual will need to pay for the service on their own as it will not be covered by the benefit plan. It also assists in protecting consumers from those providers not abiding by the standards set out by their regulators and those not cooperating with insurers during claims verification and audit processes. This is not an action entered into lightly and each insurer has their robust processes in place for managing delisting. In many cases, they also have a process in place to review the cases when an appeal is sought.

SET UP A WHISTLEBLOWER PROGRAM AND/OR PROTECTION(S)

Our industry supports the concept of a whistleblower program, but it will be important that these work hand in hand with existing confidential tip lines already established with each insurer. We look forward to further discussion on this.

REVIEW AND UPDATE/INTRODUCE FSRA INVESTIGATION AND ENFORCEMENT TOOLS

The CLHIA and its members support FSRA having adequate authority to enforce its legislative mandate, including matters related to F&A. There should be an enhanced focus on consumer protection in legislative authority to promote compliance and investigate F&A activities.

FACILITATE FSRA'S ABILITY TO SHARE F&A INFORMATION WITH OTHER REGULATORS

The CLHIA and our members support FSRA having the ability to share F&A information with other regulators. Broader collaboration will strengthen the ability to mitigate F&A. It will be important that all stakeholders are engaged in any planned work in this regard for awareness and agreement on the level of information that may be shared.

CONCLUSION

Thank you again for the opportunity to provide you with this feedback. We encourage the MoF and FSRA to continue your work to develop a robust anti-fraud regime. However, we believe it is critical that any regime cover the entire insurance industry. Focusing on one area to the exclusion of others, will simply result in a shift in fraud in the system, and may not result in a reduction in fraud in total.

We would be pleased to respond to any questions or provide further information as needed. We look forward to continued collaboration and engagement on your fraud and abuse strategy. Please contact Shannon DeLenardo, Director Anti-Fraud and Electronic Claims at sdelenardo@clhia.ca or 416-302-6399.

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