ONTARIO PSYCHOLOGICAL ASSOCIATION

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Fraud and Abuse Consultation
Financial Institutions Policy Branch Ministry of Finance
Delivered to: AutoInsurance@ontario.ca

**INTRODUCTION**

The OPA is pleased to respond to the Ministry of Finance Fraud and Abuse Consultation Paper. The Ontario Psychological Association (OPA) is the professional organization representing psychology in Ontario. On behalf of over 2400 members, the OPA provides leadership to promote the mental health and well being of Ontarians, and to inspire excellence in the profession of psychology through research, education, clinical treatment and rehabilitation, and advocacy. The OPA strives for a healthcare system in which psychological services are accessible to all Ontarians, where psychologists can practice to their full potential, and the value of the professional healthcare services psychologists provide is widely and properly recognized. As part of the OPA's Planning and Policy Development Committee, the OPA has an Auto Insurance Subcommittee comprised of psychologists and psychological associates who work with Ontarians involved in vehicle accidents and are thus impacted by various elements of auto insurance.

The OPA is pleased to see that the Ministry and the regulator are working to define fraud and abuse in auto insurance and determine the scope of the problem. However, the OPA is concerned that some of the "anticipated outcomes" listed ahead of the definition or scope being developed could lead to unintended consequences. While the OPA recognizes that fraud and abuse exist in the auto insurance system and has worked cooperatively with the Insurance Bureau of Canada to address aspects of it, any solutions to address fraud and abuse in the system should put drivers first by not only reducing costs for consumers, but also ensuring that consumers receive the coverage they paid for if they are injured.

The OPA is most concerned with the proposals to allow "enhanced" use of insurer preferred provider networks (PPNs) for health care services and granting them the authority to de-list health service providers. These proposals are at odds with the government's stated commitments to put drivers first and give consumers choice. Firstly, there are inherent conflicts of interest and consumer protection issues with locking in the use of PPNs at the time of purchase. This would also limit claimants' choice of health care providers when injured in a way that could be detrimental to their recovery and rehabilitation. Health care services are not commodities that are interchangeable. There needs to be a level of trust between the patient and practitioner. Fundamentally, insurers should not be allowed to supersede the authority of the Financial Services Regulatory Authority and the regulatory bodies of health professionals.

The Ministry call to action asserts that "there are limited tools and resources that are made available to FSRA, regulated entities, and the public to tackle fraud and abuse, when it is suspected or proven" and the call to action mentions the need to "prevent bad actors from entering the system." Although tools have not been available to address fraud in the towing, storage, and auto collision repair sectors and are only now being developed; many tools are available to address suspected fraud by health professionals. In fact, tools have been developed with significant investment of time and costs. These include:

- SABS requirements and Health Claims for Auto Insurance (HCAI) system
- FSRA Professional Fee Guidelines
- FSRA licensing process
- Health professional regulatory colleges
- Insurance Act, Ontario Regulation 7/00 Unfair of Deceptive Acts or Practices (UDAPs)

If there is concern about the efficiency of the existing regulatory and licensing processes related to health service providers, FSRA can address any need for improvements to their own licensing system and they can work with the health professional colleges to better coordinate about health professionals working in the auto sector.

**INSURANCE FRAUD AND ABUSE DEFINITION**

Establishing accurate and shared definitions is the necessary first step prior to moving forward with potential solutions. The consultation paper correctly states that a definition "could also include involvement from a number of parties, (who may engage in fraud or abuse), such as consumers, service providers, agents or insurers". Currently the terms fraud and abuse are often used to describe very different activities without consensus on what is included. This inconsistency contributes to broad differences in estimates of the magnitude of the problems and the costs.

The definition of fraud should outline distinctions between behaviours that are considered criminal fraud and other behaviours that are considered instances of abuse of benefits. Terms often used to describe types of fraud such as "organized", "premeditated", and "opportunistic" fraud should be clearly defined.

"Abuse" should not be considered as the equivalent of fraud. What is considered "abuse" of benefits is often subjective. Many examples of this so-called abuse are in fact just differing opinions regarding what is reasonable and necessary for the claimant. This includes both the insurers' descriptions of unnecessary health services as well as health service providers' views of insurer unreasonable denials of necessary services. These differences of opinion about "reasonable and necessary" need to be determined in the individual case. The definition of abuse should be distinct and cover both abuse of benefits and abuse towards claimants by insurers.

In addition, FSRA's consultation paper on Unfair or Deceptive Acts and Practices earlier this year listed deterring "deceptive or abusive conduct, practices and activities by the regulated sectors". Therefore, the distinction between behaviours that are considered Unfair or Deceptive Acts and Practices and behaviours that are considered fraudulent or abusive, need to be addressed in the definition to prevent confusion or redundancy.

OPA response to questions regarding fraud and abuse definition:

1. Based on the anticipated outcomes described in the ministry's F&A Strategy, what are important aspects of fraud and abuse that the definition should capture?
2. Will a definition require multiple parts to account for different types of auto insurance fraud and abuse that can be committed?

OPA notes that the proposed Fraud Management Tools included in the paper focus on consumers and health service providers and do not include tools to address fraud and abuse by tow truck drivers, storage facilities, auto body repair services, insurance brokers, adjusters, or insurance companies.

It is essential that definitions include fraud and abuse by all parties, including insurers. In *Putting Drivers First: A Blueprint for Ontario's Auto Insurance System*, Ontario's 2019 budget acknowledges that "during those unfortunate times when drivers do need to make an insurance claim, they are left at the mercy of a system that often seems to cater to lawyers or insurance companies, rather than to the victims it is

supposed to help." In addition, the government's own auto insurance survey found that of the over 51,000 responses, "53% said it takes too long to receive benefits after being injured in an accident." Auto accidents can be traumatic experiences to begin with. Then, some bad actors in the industry abuse their claimants using malicious tactics, denying claims, delaying timely access to treatment, without any clinical evidence. This forces them through long, expensive processes including multiple invasive and inconvenient assessments when it would have cost less to approve the initial claim, allowing the claimant to get the treatment they needed. Some insurer practices include arbitrary denials of necessary services, unreasonable and systemic requests for duplicative paperwork, and demands for additional unnecessary medical records prior to considering an application for services. These are all examples of abusive insurer behaviours that create delays and barriers for access to services for accident victims.

In addition, any definition will need to reflect new and evolving types of fraud due to advances in technology for things like ride sharing and delivering services virtually.

3. Do you have a suggestion for a proposed definition of insurance fraud and abuse?

The OPA is not in a position to develop a legal definition. However, the definition should include fraud and abuse by all parties and distinguish between fraud and abuse. The OPA would welcome an opportunity to participate in a multi-stakeholder process, with legal guidance, to develop the comprehensive and nuanced definition required.

An example of a reasonable starting place may be the definition used by the Australian government which defines fraud as "dishonestly obtaining a benefit, or causing a loss, by deception or other means" (Commonwealth Fraud Control Guidelines, 2011: 4). For fraud to occur there has to be a proven intention to defraud. For it to be judged a criminal offence the behavior in question must demonstrate intention to defraud, recklessness or negligence (Commonwealth Fraud Control Guidelines, 2011:16).

**FRAUD AND ABUSE DATA**

In *Putting Drivers First: A Blueprint for Ontario's Auto Insurance System*, Ontario's 2019 budget says:

> *The government will work with FSRA and the newly established Serious Fraud Office to develop a fraud reduction strategy and modernize the systems that improve the delivery of health care benefits, including:*
>
> - *Strong anti-fraud measures, such as enhanced data analytics to detect fraud, and new rules on unfair or deceptive acts or practices; and*
> - *A modern online claims process that lets consumers see how their auto accident benefits are being used, to make the claims process more convenient and help detect and discourage fraud.*

The OPA agrees that enhanced data analytics are needed. The consultation paper correctly states, "insurance crimes range in severity, from slightly exaggerating claims to deliberately causing accidents or damage". Fraud can range from organized major crime rings to some individuals who may attribute some minor previous vehicle damage to the collision. Without comprehensive, accurate, timely, and accessible data regarding the extent and costs of various types of fraud and abuse, policies developed may not address the most significant problems and costs for the system. Solutions which are not based on accurate information could lead to unintended consequences that actually add costs if they are targeted at rare events and/or instances that add little overall cost to the system.

The OPA supports a modern online claims process that lets all parties, insurers, health professionals and consumers view billings in real time. Insurers' ability to view all services billed and costs in real time would allow the insurer to identify and investigate any situations that appear to be problematic in a timely manner.

If consumers can see how their auto accident benefits are being used, it will make the claims process more convenient and help detect and discourage fraud. Information technology is used effectively to provide access to information about services provided or goods purchased and costs in real time in multiple spheres but is not yet utilized in the auto insurance system. For example, the ability to view charges made to credit cards makes it possible to inform the payer companies of any that appear to be suspicious for further investigation and action. Similarly, the payer company identifies any billings that seem out of the ordinary for confirmation with the customer. Consumer access to a modern online claims process could provide the same deterrence and detection for auto insurance claims by giving them a way to ensure that services that are billed for them were received.

Health providers' ability to view all services and costs billed in their name would allow them to effectively monitor for professional identity theft and fraudulent billing in their name. The "Professional Identity Tracker" was previously tested by the IBC with several health professional colleges. The test provided "proof of concept" and the usefulness of this tool to identify misuse of health professional's credentials. Psychologists and other health professionals indicated a desire for this tool to be able to monitor billings made in their name. The functionality of the tool should be enhanced to allow the health professional to be aware of the dates and amounts of invoices in addition to which facilities are billing in their name.

OPA Response to questions regarding Fraud and Abuse Data:

1. <u>What aspects of data do you think are important to collect and use when measuring and managing fraud and abuse? What information do you, or your organization, currently collect?</u>

The administrative burden and cost for much of the data entry for the auto insurance system is borne by health care professionals like the Ontario Psychological Association's members. Health professionals are required to input extensive amounts of data including, patient information, injury types and severity, goods and services, associated costs, and more into the Health Claims for Auto Insurance (HCAI) system. This data is required to apply for approval of services and billing for approved services that are provided. Health professionals are also required to enter extensive data into the FSRA licensing system. This data includes personal and professional information, services provided by their facility, other health professionals providing services in the facility, practice arrangements, numbers of claimants seen, billing practices, compliance, and more.

This data is not shared or used as effectively as it should be. In addition, data regarding the utilization of the health professional regulatory colleges and the FSRA licensing process, as well as the utilization of the UDAP regulations to address suspected fraud or abuse, frequency, patterns, outcome, etc. is needed.

In contrast to the HCAI requirements for regulated health professionals, there is currently no equivalent requirement for applications and invoices for other services provided by unregulated businesses including towing, storage, auto body, repair or for benefits like income replacement. In addition, there is no data captured related to behaviour by insurers, such as tracking denials of applications and the costs, frequency, and outcomes of required insurer examinations. These data inputs are necessary for a comprehensive database to allow for accurate identification of trends, outliers and increasing costs

throughout the auto insurance system.

2. Do metrics need to distinguish between standardized approaches and insurer-specific approaches to fraud management? If so, how can the distinction be made while allowing for meaningful measurement and oversight?

Understanding, measuring, and managing fraud and abuse needs to be addressed with a standardized approach. Claimants and service providers of all types interact with multiple insurers. It is not reasonable or effective if each insurance company has different requirements for data gathering and applies different interpretations of fraud and abuse. Standardized approaches are necessary to identify, measure and respond to fraud and abuse on a system level and to examine if insurer-specific practices contribute to an increase or reduction of fraud and abuse occurrences within an insurance company.

3. What are high impact / high priority opportunities that the industry will benefit from improved sharing and/or use of data? What barriers are preventing action on those opportunities? What would you recommend the government or FSRA do to help to remove these barriers and what governance or oversight measures, including consequences for non-compliance, should be put in place if government or FSRA plays a role in removing those barriers?

One barrier identified by health professionals is that each practitioner is limited to knowledge of the patterns of abusive insurer behaviours seen in their individual practices. These observations are shared anecdotally within and across professions, but there is no framework for systematic aggregating and reporting. Therefore, we are limited to bringing forward only single case specific examples rather than what appear to be systemic practices to the attention of market conduct at FSRA.

There have been some episodic reports in the media of investigations of criminal fraud rings and “sting” operations on health professionals engaging in apparently problematic behaviours. Further information sharing and transparency regarding the findings of the investigations would be helpful. This could allow education regarding implications to help consumers and health professionals be aware of situations where this may be occurring. Ongoing education regarding how to best notify the appropriate body for further action is needed.

In the absence of system data, solutions are too often misdirected, add unnecessary barriers to patient access, administrative burden and costs, and fail to actually achieve a reduction in fraud or abuse. Consideration needs to be given to how FSRA can provide a centralized repository for instances of apparently problematic behaviour identified by individual health professionals or insurance companies for further investigation and action while maintaining privacy of consumer information.

4. What are some concerns and controls to protect data privacy and data security related to data sharing? Are there leading examples of these controls?

Opportunities for data sharing and aggregation must protect the privacy of individual information, particularly health information. These data systems must also be constructed and stored in a way that provides all parties with confidence in the security of the data.

FSRA, as the regulator, must provide active direction and oversight of the process to ensure that there is no violation of privacy or lapse in data security. The regulator must also maintain oversight to ensure the accuracy of the data analysis, interpretation, and reporting. There must also be a process for interested

parties to access anonymized data for research and analysis without compromising privacy or security.

The OPA believes it is the responsibility of the regulator to protect data privacy and security and it should not be the direction of the insurance industry. FSRA should engage experts in maintenance of privacy and data security and seek the advice of the Ontario Privacy Commissioner. These experts should provide guidance regarding the necessary requirements and processes. FSRA should be responsible for the direction, implementation, and monitoring of the processes. Reports regarding the measures taken must be available to all parties.

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

All parties, including consumers, must be able to have confidence in the privacy protection and security of information sharing process. All parties should be informed and consent to what information may be shared; what circumstances would lead to sharing their information; how it will be shared; when and how they will be informed if their information is shared; and what process is available to correct or refute the information that is shared.

6. What role, if any, should MOF, FSRA and industry play in the establishment of a centralized fraud reporting repository?

FSRA should lead the establishment of a centralized fraud reporting repository. FSRA must provide direction, control, and management of the centralized fraud reporting repository to ensure its neutrality and independence and to ensure privacy, security and due process are followed.

**INSURER FRAUD MANAGEMENT TOOLS**

The OPA believes it is dangerous to place the responsibility of fraud management with insurers without adequate direction and oversight from the regulator. As noted in our responses regarding the definition of fraud and abuse and the data needed to identify it, insurers contribute to the problem and their employees can limit the effectiveness of fraud detection and prevention. While little research has examined the roles that employees of insurance companies play in fraud detection and investigation, or factors that might limit the effectiveness of fraud prevention practices, there is some research on how some insurer claims management practices can increase instances of fraud and abuse. This needs to be explored further rather than granting insurers more powers.

OPA response to insurer fraud management tools:

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

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

The OPA finds the notion of giving insurers increased authority to cancel policies to be highly concerning, especially before having adequate data to provide a clear sense of the problem. Anecdotally, we know that insurance fraud can often start at the scene of a collision where a vulnerable accident victim has their vehicle towed away by the first tow truck driver on scene who has a network intent on capitalizing on

fraudulent claims including a storage facility, rental car company, medical/rehabilitation provider, trial lawyer, etc. Accident victims can get unknowingly wrapped up in these schemes. The OPA acknowledges and appreciates the government's efforts towards regulating the towing industry aimed in part at preventing these types of scenarios, but that regime is not yet in place. Giving insurers the ability to cancel policies when it is possible that the insured truthfully cannot provide further information for investigations is unfair.

2. What are some concerns and mitigations to protect consumers from being unfairly targeted by insurers?
3. What is considered an adequate level of cooperation?

To protect consumer interests, FSRA must provide clear guidance and provide oversight through an approval process for these cancellation requests.

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

The OPA understands the government's desire to give drivers choices to lower their premiums.

Use of Preferred Provider Networks that are restricted by a decision made at time of purchase of policy (Locked-in PPNs) and removal of health professionals by the insurer (De-Listing), have been proposed by some insurers as a response to undefined and unquantified assumptions of fraud and abuse by health professionals. Locked-in PPNs and De-listing would give insurers inappropriate and harmful power to direct health care of injured claimants. Locked-in PPNs and De-listing are cost control mechanisms used in the United States in a profit driven, private insurance health system. They are inconsistent with the Canadian and, in particular, the Ontario model of health care which, especially most recently, emphasizes the direction of health care by the patient's primary health provider and patient choice to optimize health care and recovery.

Giving drivers the choice to commit to using preferred provider health care services at the time when they purchase their policy (described as Locked-In PPNs through out the remainder of this submission), rather than offering their use as a voluntary option when they make a claim would have the effect of greatly reducing or eliminating consumer choice and is inconsistent with protecting the interests of injured consumers.

Consumer protection requires that the terms used to describe the insurance product are clear and do not create confusion or misunderstanding of what is being offered. The term "Preferred Provider Network" (PPN) is misleading, and comes from US style, private, for profit managed health care. "Preferred" implies that what is being offered somehow superior however, there is no basis to assert that the health professionals on the insurer's roster will provide better care for the injured person. The use of the term "preferred" may suggest that the consumer would get to see the health professional that they prefer. "PPN" fails to communicate that the injured person is restricted to those health professionals chosen by the insurer. Since the choice of health professionals is limited to a restricted list selected by the insurer, the roster would be more accurately described as an "Insurer Restricted Provider Network" (IRPN).

A Lock-In PPN system does not "enhance" provision of care. Being Locked-In to a restricted provider network by a decision made at the time of purchase does not improve the health care options or quality of care available to the consumer if they are injured. Rather it diminishes their choices for their health care.

Although some argue use of a PPN may provide cost savings, if any initial cost savings were achieved, it would be by reducing consumer protection and interfering with access to the care by the insured patient's chosen provider. If this restriction delays and/or hinders recovery it would actually add to costs.

Protecting consumer interest requires ensuring the consumer can make informed decisions and this would not be possible with regards to agreeing to a "Locked-In PPN". At the time of purchase, most consumers do not believe they will be injured in an auto accident. Many Ontarians also incorrectly assume that if they are injured, all needed health care will be available through OHIP and other public systems. There is little public awareness of the frequency and types of auto accident injuries, the treatments needed, and the health professionals required to provide care. Therefore, accident benefits for health care and the need to protect access to the health care professionals of their choice is not an important consideration for many at time of purchase. This lack of information to accurately evaluate risk and future needs creates an unfair opportunity to be swayed by the incentive of a reduced premium in exchange for limiting choice of health care professionals if injured.

It is also impossible for the customer to evaluate the health professionals who will be available at time of injury within the insurer's selected roster. Even if the insurer's current roster is made available, it is not reasonable to assume that the same selected health professionals will continue to be available if the customer is injured and requires care.

It is also not reasonable for the choice of health professional(s) available to uninsured passengers and pedestrians, to be limited by the choices made by the insured driver of the vehicle. Neither injured passengers nor pedestrians are provided an opportunity to consent to be limited to the restricted list of insurer preferred providers.

PPNs create a conflict of interest for the insurer. There may be a real or perceived conflict of interest for the health service providers on the insurer's selected list.

Concern about conflict of interest undermines the injured person's ability to trust the treating health professional's diagnosis and treatment recommendations as being in their best interest. The injured person may assume that the health professionals on the insurer's selected list have a personal business interest in maintaining their status as a provider preferred by the insurer. In a Locked-In PPN situation, the health professional's continued inclusion by the insurer on their PPN is required to receive referrals and to be paid for services. The injured person may assume that the health professional's need to maintain their relationship with the insurer will directly or indirectly undermine the primacy of treatment provider's accountability to their patient. The injured person may be concerned that the health professional's need to maintain their relationship with the insurer limits their ability to advocate for the patient's best interest in health care or other benefits. These concerns undermine the injured person's trust in the patient-treating health professional relationship. This trust, that the health professional is working in their best interest, is an essential component for successful treatment and recovery.

The SABS requires applications for insurer prior approval of treatment and other benefits be submitted by the treating health professional. The insurer may deny these applications and may obtain an opinion from an Insurer Examiner (IE) about the injured person's diagnosis, severity, impairment, treatment or other benefits. Individual insurance companies have rosters of their preferred providers to conduct these examinations. Maintaining consumer protection precludes allowing the insurer to also limit to the insurer's selected list, the injured person's ability to choose the health professional to prepare the applications on their behalf.

Limiting choice of treating health professionals to the insured selected list would give the insurer the ability to determine both the list of health professionals who can propose applications as well as who can review the applications. This effectively limits both the application and review to health professionals selected by the individual insurer. This blurs the distinction and creates confusion for the injured person between their treating health professional(s) who applies on their behalf and Insurer Examiner who reviews the application for the insurer. The distinction between the patient's treating health professional and the insurer's examiner is essential to provide some checks and balances in the system to ensure some protection of the interest of the injured consumer.

Protecting injured consumer interests requires ensuring access to a diversity of health professionals available to provide care and this would not be possible with Locked-In PPNs. Individuals injured in auto accidents present with a wide diversity of treatment needs. Some of these needs include: experience and expertise in treating more unusual and/or complex injuries; geographic location in remote and under-serviced areas; ability to communicate in the native language of the injured person; cultural knowledge; hours of operation; ability to accommodate for to special needs; etc. At the present time there are many sole providers and small groups of single discipline health professionals who provide care to individuals injured in auto accidents. FSRA licensing has been designed to allow registration of a sole provider as a "facility". The costs and administrative burden of licensing are proportionate to make FSRA licensing accessible to the sole provider or small group. Many of these practices provide care to only a very few patients who are injured in auto accidents along with other patients whose services are not funded by the auto insurer. The participation of these sole and small clinics, of which each may only see a small number of auto accident patients, provides necessary diversity and distribution of health professionals to meet the range of specific needs of individual patients.

In contrast, Locked-In PPNs would reduce consumer protection by virtually eliminating access to many of these health professionals. This would negatively impact the ability of the injured person to choose to receive services from the most appropriate health professional for their needs. Inclusion on the insurer's restricted Locked-In PPN roster would require being selected by the insurer.

Current experience with PPNs used in auto insurance for some health services, including Insurer Examinations (IE), provide real world information of anticipated hazards to protecting the interest of the injured consumer. They illustrate how Locked-In PPNs would interfere with injured consumer's reasonable and timely access to the most appropriate health care professionals.

PPNs are limited to very large companies. The insurer's selection processes for the PPN's generally involve Request For Proposals (RFPs) or similar processes. The criteria for PPNs often have requirements that cannot be met by sole or small providers including: province wide coverage; multi-disciplinary services; and time frames for provision of services. The PPNs may also be expected to offer discounted pricing in exchange for anticipation of volume of referrals. The PPNs additional administrative burden (beyond the FSRA licensing and regulatory college requirements) and the requirements preclude participation by sole providers or small clinics seeing a limited number of patients injured in auto accidents.

This concentration of PPNs in large companies has led to significant challenges in the delivery of services. It is unreasonable, but not uncommon, for an injured person to need to wait over 12 weeks for an examination to be conducted by a member of the PPN. There is a further, often extended, wait time for the report and insurer decision. This delay interferes with effective treatment even if it is approved. It is also not uncommon for the injured person with a vehicle phobia and/or body pain due to their motor vehicle

accident to be required to travel a significant distance to attend an examination conducted by the PPN, resulting in significant physical and/or emotional distress on the part of the injured person. These delays, travel requirements, and concerns reported about the quality of the services provided through the PPNs are not consistent with delivery of services in a way that protects the interest of the injured person.

A large PPN company may attempt to ameliorate some of the issues of access to services by subcontracting to local, sole practice, or small groups of health professionals. However, there is little incentive for most local, sole practice, or small groups of health professionals to agree to the PPN arrangements. The fees paid to the subcontracted health professionals are reduced by the PPN company who takes a portion of the fee paid by the insurer. In addition, there are often additional administrative requirements and unattractive service expectations.

A Locked-In PPN with service delivery organized through large companies undermines the direct relationship between the patient and their chosen health professionals. The primary contract for care and accountability should be between the health professional and the patient. There are many inherent and regulatory mechanisms for accountability and consumer protection in this model. In contrast, in a Locked-In PPN model the insurer contracts with their selected large company. The large company then contracts with service providers. The injured person's control over their own health care is reduced by this highly problematic shift in the contracting and accountability. This shift is contrary to protecting the interest of the injured consumer.

Additional Problems with Locked-In PPN's for injured consumers with Psychological Disorders

Of particular concern to the OPA, Locked-In PPNs pose an even greater hazard for injured individuals with psychological disorders including brain injuries. There is continuing stigma which often makes it difficult for individuals with psychological injuries to acknowledge their problems and seek treatment. Any obstacles to engaging in timely care are contrary to protecting the injured consumer's interest. Individuals with psychological injuries often have experienced the motor vehicle accident as a traumatic event. The trauma of the event may result in perceived loss of control and feelings of victimization. The ability to seek care from the practitioner recommended by a trusted source, such as the primary care practitioner, is often critical in being able to take this step and begin to regain a sense of control. In contrast, a Locked-In PPN in which access to care is limited to the insurer's selected list of service providers, would often have the negative effect of increasing the sense of loss of control and victimization. This would interfere with the injured person's ability to obtain timely treatment.

Obtaining care from the right practitioner is often critical to recovery from psychological injuries. There are multiple evidence informed treatments for most psychological disorders. However, psychological practitioners are not simple technicians who follow rigid protocols and can be interchanged. A key component of psychological treatment is the establishment of a therapeutic relationship. Psychological treatment requires a high level of trust by the injured person in their practitioner to be able to disclose very personal information and tolerate challenging their beliefs and behaviour.

There is extensive research over many decades that has examined different predictors of outcome in psychological treatment. Hundreds of researchers have examined patient related variables (e.g., personality characteristics, type of psychological disorder, etc); therapist-related variables (e.g., therapist skill level, therapist's theoretical orientation); therapy-related variables (e.g., what type of therapy and does one type of therapy such as cognitive-behavioural therapy fare better than other types of therapies?) and relationship-related variables (e.g., the quality of the interpersonal relationship between the therapist

and patient). The evidence-based literature has demonstrated one particularly robust finding: that the therapeutic alliance – that is, the degree to which the client experiences the therapist as a collaborator and partner who is "on my side in my recovery" – is one of the strongest predictors of outcome in psychotherapy across different therapeutic orientations, treatment approaches, patient characteristics, face-to-face and internet mediated therapies, and countries. Indeed, meta-analytic studies, which systematically analyze the results of large numbers of research studies collectively, have consistently demonstrated the strong importance of the therapeutic alliance (*see Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. Psychotherapy, 55(4), 316-340. http://dx.doi.org/10.1037/pst0000172 for one example of a meta-analytic study).*

Patient choice of treating psychological practitioner is essential to creation of the therapeutic alliance. If the choice is limited to the insurer's selected list of providers, the injured consumer may perceive the health professional as "working for the insurer" with a need to maintain their contractual relationship with the insurer, and experience this as conflict of interest.

Therefore, the injured person's ability to choose their treating practitioner is essential to consumer protection. To make a meaningful choice there must be sufficient number and diversity of appropriate practitioners accessible to the injured person.

The problems associated with Locked-in PPNs noted above demonstrate that, any use of Locked-in PPNs for health care would be completely inappropriate. Any use of Insurer Restricted Provider Network should be limited to voluntary participation at the time of the claim. The inherent conflict of interest and risks of so-called Preferred Provider Networks, especially for health care, have been previously acknowledged and addressed in the SABS in Section 46 and by FSCO. In response, guidance was developed for best practices. The risks identified for use of PPNs have not been reduced and the solutions mandated continue to be required.

Allowing the use of Locked-In PPNs and De-listing of medical and rehabilitation providers would also be redundant and unfair given that the entire purpose of the FSRA licensing system is to have an approved (licensed) roster of regulated providers to address fraud and abuse and remove health professionals whose behaviour fails to meet standards of professional and/or business practices. Proof of this includes FSRA's recently released *Health Service Provider 2020 2021 Market Conduct Compliance Annual Report*. In FSRA's own words:

> *FSRA found that 88% of service providers resolved compliance issues from past reviews and closed their cases. FSRA took action on service providers who remained non-compliant or whose billing rosters included practitioners with suspended or revoked licences by their regulatory colleges. These actions included escalating for enforcement, issuing letters of warning or licence surrenders.*

Specifically regarding De-listing health professionals, out of 5000 licensed Service Providers, FSRA found 24 with a college sanctioned practitioner listed on their HCAI roster, of these only 2 licensed Service Providers appeared to have billed using the credentials of a sanctioned practitioner and were referred for enforcement action.

Outsourcing this regulation to insurers is a conflict of interest and would diminish the credibility of the well-established and effective tool the regulator already has in place.

The OPA proposes making greater use of the FSRA licensing process as an alternative to insurer Locked-

PPNs and De-listing. All health professionals providing services under auto insurance should be required to be licensed with FSRA. The FSRA licensing data base could be used to create a FSRA Network of Health Service Providers for Auto Insurance, (Auto Health Provider Network). The FSRA licensing process has a data base of health professional providers/facilities whose professional credentials and backgrounds have been verified. The health professionals' facilities in the FSRA data base also must adhere to the business practices required by the SABS and the Health Claims for Auto Insurance (HCAI). As noted above, the licensing process has mechanisms for ongoing monitoring, auditing, and addressing any instances of problematic or noncompliant behaviour.

The Workplace Safety and Insurance Board (WSIB) provides an example of the use of this type of network. The Community Mental Health Program (CMHP) requires that any psychological practitioner who wishes to provide services to injured workers in the CMHP be registered in the CMHP Network. To participate in the CMHP Network the psychological practitioner must be in good standing with the regulatory college and must agree to adhere to the standards and requirements of the CMHP Program. The WSIB can remove a practitioner from the Network if they lose their standing with the regulatory college or fail to comply with the program requirements. An injured worker may choose to receive their approved services from any practitioner in the CMHP network. To assist in this process the WSIB has created a listing and map which can be used to find the practitioners in a given locale. FSRA could enhance this concept to include additional information including, for example, languages spoken, and hours of operation.

Consistent with a focus on consumer protection, the OPA supports the recent steps taken by the government to reduce fraud and abuse and growing costs of towing, storage, and auto body repair. Health professionals have often stressed the problem of a lack of oversight in these areas. This is in stark contrast to health professionals, who have always been subject to regulation by health professional colleges and licensing by FSRA. Information about the extent of fraud identified in towing, storage and auto body repair, the effectiveness of recent initiative, and projected cost savings is needed. This may help identify further interventions to control the rapid growth of costs associated with vehicle damage. <u>If a need is identified, enhancing the use of PPNs for towing, storage and auto body repair could be explored by FSRA as an interim measure until a more comprehensive regulatory regime is in place.</u>

In the Blueprint, it says "the government is putting drivers first by focusing on care for people injured in collisions and making sure that they can access treatment faster." Providing consumer protection includes providing injured claimants with reasonable access to the benefits for their treatment and rehabilitation that are promised when they purchased their insurance. The ability to choose their treating health care professionals is essential to trust in the health care professional-patient relationship, which is a major determinant of successful treatment and rehabilitation. <u>Addressing costs, including any costs that are related to abuse and fraud in the system, must and can be achieved without interference with providing consumer protection, including patient choice of their treating health professional(s)</u>.

OPA response to questions regarding enhanced use of preferred provider networks

1. <u>Would this tool help insurers manage fraud and abuse in a way that protects and advances consumer interests?</u>
2. <u>Do PPNs help insurers manage fraud and abuse in a way that protects and advances consumers' interests?</u>

No, the inherent conflicts of interest in Locked-in PPNs make this approach incompatible with consumer protection in health care. Effective health care requires the patient's active participation, choice,

informed consent, and ability to trust that their health professional is acting in their best interest. Sound health care must always be individualized to meet the needs, context, and choices of the patient. Multiple evidence informed and effective approaches to treat most conditions within the same discipline exist. Patient choice of treatment approach and provider is an essential component health care. Ontario citizens expect that their health care will be directed, with their informed consent, by their chosen health care professionals and not directed by a private, for profit, insurer.

FSRA may explore the potential of use of locked-in PPNs for the towing, storage and auto body repair as an interim measure. Services and costs in these spheres are not currently subject to the same controls over service provision and costs that are in place for health professional providers. FSRA may explore whether issues of consumer choice in this area are as salient in this area as in health care. It may be that towing, storage and auto body repair are more readily subject to verification, through photos and vehicle-based IT systems for example. Costs of towing, storage, parts, services may also be more readily subject to standardization. We would note that with the government's announced Tow Zone Pilot, we are pleased to see the government taking responsibility for having a "preferred" vendor for towing services on 400 series highways.

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

Any use of PPNs in health care should continue to be subject to the requirements in the previously published FSCO guidance. Restricting health care to Locked-in PPNs is clearly contrary to these requirements. Compliance with these guidelines must be monitored and enforced by FSRA.

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

There should not be Locked-in PPNs for health care services.

Regarding other disputes between the health professionals and auto insurers, FSRA, the regulator, needs to provide a neutral complaint and dispute resolution process. These disputes should not be left to processes within the insurer as the dispute may be due to a difference of opinion between the health professional and the insurer. As they are both parties to the dispute it must be addressed by FSRA, the regulator. There should not be obstacles for the health professional to bring forward the dispute and it should not require the involvement of the insured claimants.

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

No, exclusive use of Locked-In PPNs should not be used for medical and rehabilitation services. As discussed above, there is inherent conflict of interest and interference with consumer choice which is essential to effective health care.

6. Should other enhancements to the use of PPNs be considered?

Consideration could be given to the use of PPNs for towing, storage, and autobody repair as an interim

measure until a regulatory regime is in place for these sectors.

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

De-listing of health care service providers would give insurers inappropriate and harmful powers to direct the health care of injured persons. All the concerns noted above regarding Locked- In PPNs would be even more problematic if individual insurers were given the power to De-List health professionals who have good standing with their regulatory bodies and FSRA license.

The power to De-List would allow the insurer to limit all their injured insureds to use of the insurer's de-facto list of selected providers. Giving this power to insurers may also create a perception of a conflict of interest in the minds of injured persons who might think that their health care providers would become overly concerned with maintaining their standing with the payer insurance company.

An insurer's reasons for wanting to De-list a health professional may just be a matter of difference of opinion between the insurer and the health professional regarding what are "reasonable and necessary" services or benefits. This dispute needs to be addressed by the regulator and not by the insurer who is a party to the dispute.

Giving the insurer the power to De-List a health professional who is in good standing with their regulatory body and FSRA license is incompatible with protecting consumer interest. It would allow the insurer to inappropriately limit the health care professionals available to provide services to the insurer's injured customers.

An insurer's ability to De-List and eliminate the injured person's ability to choose specific health professionals would not be known to the customer at time of purchase of their policy. Without information knowing which specific health professionals are excluded from coverage, the customer cannot make an informed decision regarding whether to purchase a policy from a specific company.

OPA Response to questions to "Allow insurers to exclude coverage for services provided by certain vendors":

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

No, giving insurers this power regarding health care providers is entirely contrary to protection of consumer interests.

2. What criteria is appropriate for excluding service providers?

Questions regarding status of a health professional and their professional and business practices should be addressed by the relevant health professional regulatory body and the FSRA licensing process, not by the insurer. If there is a finding by the FSRA licensing body or the regulatory college, these bodies have existing authorities to impose appropriate sanctions including removal of ability to continue to bill auto insurers and removal of ability to practice the profession.

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

This power should not be given to the insurer at all. The health professional regulators and the FSRA licensing process are the appropriate authorities with power to remove the ability to practice and/or bill auto insurers.

4. How can this program benefit consumers without reducing consumer choice?

Consumers are protected by the regulatory college and FSRA licensing processes. The insurers should not be permitted to make decisions that limit the injured person's choice of treating health professional.

5. What consumer outcomes should the use of this tool target, and what mechanisms (e.g. disclosure, transparency, regulatory oversight) should be in place to facilitate achievement of those outcomes?

FSRA should explore how use of this tool for towing, storage, and auto body repair services could have the intended outcome of the Blueprint, which was for it to be a tool for consumers to lower their premiums.

**REGULATOR FRAUD MANAGEMENT TOOLS**

*Set up a whistleblower program and / or protection(s)*

1. Is there any existing case law that the ministry should consider where whistleblower protections either worked well or not?

Health professionals already have an obligation to report inaccurate, false or deceptive forms, etc. in OReg 90/14, Section 9:

> *(2) If a service provider believes on reasonable grounds that a form, plan, invoice or other document or information that the service provider, or any person authorized by the service provider, has submitted to an insurer contains inaccurate, false, misleading or deceptive information, the service provider shall, at the earliest opportunity and in any event within two business days after forming the belief,*
> *(a) advise the insurer of the belief; and*
> *(b) provide the insurer with the correct information.*

2. What are the key types of whistleblower protections that should be considered?

Claimants should be able to safely come forward to identify fraudulent claims made on their behalf by service providers without fear of their policy being cancelled or other consequences.

*Establish expectations for fraud and abuse management plans*

1. What best practices currently exist that could be used as a reference or model?
2. How can an insurer's plan be monitored and continuously improved, and what role can data and metrics (see above) play in that process?
3. Should management plans be proportionate with the size / profile of an insurer's business? Should there be consequences for insurers that do not or cannot establish and carry out a reasonable and proportionate fraud management plan?

4. How can approach to fraud management plans best reflect the competitive nature of the auto insurance industry?
5. What barriers or gaps currently exist that prevent insurers from effectively implementing fraud and abuse management plans?

The OPA is concerned that it is proposed that insurers have the primary responsibility to manage fraud and abuse when the definition of fraud and abuse should include that carried out by insurers and their agents. FSRA regulates this industry and has primary responsibility to manage fraud and abuse by all parties. Certainly, as part of carrying out that responsibility, it would be appropriate for FSRA to set expectations for insurers for certain aspects of fraud and abuse, but it is dangerous and unfair to leave this in the hands of insurers. FSRA, not the insurers, should be accountable for providing and enforcing guidance to insurers to ensure consistent and fair measurements of effectiveness, resourcing, protocols, and procedures. This will also ensure that smaller insurers with less resources are not unfairly burdened by the requirements.

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

1. Other provinces have provided enhanced investigation powers, such as the British Columbia Financial Services Authority (BCFSA). Should FSRA have similar powers?
2. Should FSRA have the tools and mandate to investigate and sanction fraud and abuse within the auto insurance sector by non-licensees? If so, which non-licensees? If not, who should?

The OPA believes FSRA, not the insurers, should be primarily responsible for managing fraud and abuse. As such, FSRA should have enhanced investigation and enforcement powers.

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

More data is needed to determine which powers would be most effective.

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

The OPA would strongly support enhanced cooperation and collaboration between FSRA and other regulators, including FSRA having the ability to share data with regulators and potential partners, such as OHIP and WSIB.

The OPA would also support FSRA making more effective use of the FSRA licensing body data and processes and working more closely with regulatory colleges.

1. What are some concerns and mitigations to protect privacy and data security related to data sharing?

The OPA believes it is the responsibility of the regulator to protect data privacy and security. FSRA should engage experts in maintenance of privacy and data security and seek the advice of the Ontario Privacy Commissioner. These experts should provide guidance regarding the necessary requirements and processes.

**CONCLUSION**

The OPA is grateful for the opportunity to respond to the Fraud and Abuse Strategy Discussion Paper. We agree that a clear and consistent definition of fraud and abuse is needed to better understand and quantify the problem and we are glad to see this work being done.

The OPA also agrees that to provide an accurate picture of the extent and scale of fraud and abuse in the auto insurance system, a modern and accessible database with data regarding behaviour of insurers, brokers, claimants, health service providers, tow truck services, storage services, and auto body services is required. Data regarding income replacement and other costs is also needed to identify and manage fraud and abuse. We are encouraged that this consultation will help in improving the accuracy and accessibility of data. The OPA suggests a good starting point would be the "Professional Identity Tracker" that was previously tested and proven by the IBC with several health professional colleges.

The OPA is concerned by the insurer fraud management tools proposed. Locked-In PPNs and De-listing powers with regards to health professional service providers would run contrary to consumer protection and interfere with injured claimants' recoveries. They would also provide inappropriate power to insurers that have vested interests and would be an outsourcing of the regulator's responsibilities.

The OPA is encouraged by the government's recent initiative towards regulating the towing sector. In the meantime, the OPA suggests that if there is data to support PPNs being effective a reducing fraud in the currently unregulated towing, storage and auto body repair sectors, this tool could be used for those services as an interim measure.

The OPA supports increasing the tools available to the FSRA to be able to identify and address fraud and abuse. We believe that the regulator has existing tools such as the licensing system that could be modernized and strengthened to be more effective.

The OPA looks forward to continuing dialogue with the government on the Fraud and Abuse Strategy. We look forward to receiving information about next steps, including any multi-stakeholder or bilateral consultations that will be taking place.