Unica Insurance

October 15, 2024

Financial Services Regulatory Authority of Ontario (FSRA)
25 Sheppard Avenue West
Suite 100
Toronto, ON M2N 6S6

Re: Fraud Reporting Services Proposed Rule and Guidance Consultation

Unica Insurance Inc. acknowledges FSRA as the first provincial insurance regulator to create a Fraud Reporting Service (FRS). We support FSRA's efforts to combat automobile insurance fraud which impacts honest hardworking Canadians

The recommendations within this submission support consistent reporting of fraud and compliance with the FRS for the benefit of all automobile insurance stakeholders. The below proposed suggestions have been carefully considered to enrich the outcomes of the FRS's important Phase I purposes and also provide insurers with the tools needed to reduce fraud

RECOMMENDATION: Consumer support and insurer compliance with the Fraud Reporting Service can be enhanced through partnership with Équité Association.

Unica Insurance Inc. is supportive of FSRA for its initiative to combat fraud as the first insurance regulator to develop a Fraud Reporting Service ("FRS") and we appreciate FSRA's commitment to privacy principles. We understand that the Rule requires insurers to de-identify data that is not necessary for the purposes of the Rule. The Guidance identifies that for Phase I, FSRA will interpret the statutory purposes to include:

1. Quantifying the prevalence of automobile insurance fraud in Ontario;
2. Creating a baseline for fraud detection; and
3. Identifying trends throughout the industry

It is also noted that FSRA will work with insurers to create unique identifiers for each instance of reporting to allow insurers to update the information in Phase II and to identify information that requires correction or removal from the FRS during both phases. We fully support managing personal information in compliance with applicable privacy principles; however, we believe that operational efficiencies for both FSRA and insurers could be realized through leveraging Équité Association's expertise in data privacy, security, and regulatory compliance.

Équité Association holds robust and certified cybersecurity controls and exceeds all privacy requirements. Équité's membership already includes the vast majority of the automobile insurance industry market share. Équité

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Association's operations would eliminate the additional steps of insurers de-identifying data, creating new unique identifiers, and removing the unique identifiers during Phase II. Instead, insurers would be able to provide their data directly to Équité who would then aggregate the data to provide FSRA with the information that satisfies all three purposes of Phase I. This recommendation would also positively impact the advancement of Phase II by eliminating the need for data to be re-identified.

We believe that this recommendation honours privacy requirements but also benefits FSRA's implementation of the Rule, consumers through the expediting of fraud detection and reduction, and insurers who would require fewer resources to comply.

RECOMMENDATION: Phase II Initiatives to reduce fraud can be streamlined through a minor amendment to section 101.3(2) of the *Insurance Act*.

Consumers depend on the industry's active engagement in fraud reduction. It is anticipated that consumer protections will be enhanced by active measures to prevent and suppress insurance fraud under Phase II of the FRS.

Section 101.3(2) identifies that the information collected, used, and disclosed through the FRS will be done for the purpose of assessing and detecting automobile insurance fraud. We recognize that assessing and detecting automobile insurance fraud is an important purpose and critical to Phase I of the FRS; however, we recommend that the purpose also reflect the prevention and suppression of fraud that will be a required purpose for Phase II. We recommend that FSRA engage the legislature to make a minor addition to the current amendment as below:

> *(2) The Chief Executive Officer and any agency designated by the Chief Executive Officer are authorized to directly or indirectly collect, use and disclose personal information about identifiable individuals if the collection, use or disclosure of the information is for the purpose of preventing, supressing, assessing and detecting automobile insurance fraud under subsection (1).*

This minor addition will provide FSRA with significant flexibility to implement Phase II measures at the earliest opportunity. This will also result in operational efficiencies as the purposes will fulfill FSRAs complete objectives from the outset of the initiative. We believe this is preferable to re-engaging the legislative process at a future date for further amendment. All stakeholders, including consumers, FSRA, and insurers, have a vested interest in reducing fraud at the earliest possible opportunities. Our proposed amendment would further that objective.

RECOMMENDATION: Support for industry collaboration in the fight against automobile insurance fraud can be enhanced through identification of Phase II uses for data collection.

We anticipate that the FRS will generate informative insights into the fraud industry. We note that eradicating automobile insurance fraud is a multi-faceted and complex problem that requires collaborative action and resourcing from multiple stakeholders: regulatory bodies such as FSRA and professional colleges, law enforcement, insurers, consumers, and industry whistleblowers to name a few.

Consumers, insurers, and other industry stakeholders would benefit from a greater understanding how the data will ultimately be used to reduce fraud and the tools that may become available for a collaborative approach to this problem. We recommend that FSRA include the potential future uses of the data within the proposed Guidance, specifically identifying that insurers will be able to access information about specific bad actors to conduct further investigation within their own organizations.

We also suggest that FSRA consider ways in which the information could be used as a means of intelligence to promote deterrence, prevention and suppression of automobile insurance fraud by coordinating efforts with stakeholders such as insurers, law enforcement, FINTRAC, RIBO, professional colleges and the Director of Towing and Vehicle Storage Standards.

RECOMMENDATION: Support the reduction of fraud by complementing the existing Take-All-Comers Rule with an Adverse Contractual Actions Regulation.

Locking fraud out of the system is the most effective way to combat it and protect honest hardworking Canadians. Consumer confidence in automobile insurance can be enhanced by ensuring that premiums are used to fund the legitimate claims that automobile insurance was designed for.

We align with FSRA in the need to combat fraud as a crucial consumer protection. Identification and quantification of fraud is an important first step. Unfortunately, fraud will persist if insurers are unable to take action against confirmed fraud. While regulatory, criminal, and civil remedies may be available to insurers, they are often not timely or cost-efficient solutions to the problem of fraud.

We ask FSRA to consider the adoption of an Adverse Contractual Action Regulation ("ACAR") to complement FSRA's existing Take-All-Comers rule. We propose that TAC continue to be maintained and enforced as intended, while also enhancing consumer protection by empowering insurers with ACAR exceptions strictly for limited cases of fraud. Such exceptions would permit insurers to cancel a contract or refuse to issue / renew a contract in limited fraudulent cases. Examples of fraudulent activity that may allow in insurer to apply an adverse contractual action are:

- providing false information on the approved application form
- making any misrepresentation in the information provided for the purposes of obtaining, updating, or renewing an automobile insurance policy, including on the application form;
- a history of fraudulent activity in relation to an automobile insurance policy and the most recent instance of such an activity occurred less than 7 years before the day of the request to obtain, update or renew an automobile insurance policy.

TAC would continue to protect the rights and interests of automobile insurance consumers and contribute to public confidence while ACAR would also deter deceptive or fraudulent conduct. This would allow insurers to impact

automobile insurance fraud at the organizational level and enhance consumer confidence in the industry by ensuring premiums are being used for the funding of legitimate claims.

FRAUD EVENT DEFINITION

RECOMMENDATION: Amend the definition of a "Fraud Event" to create greater clarity and agility.

We agree with and support FSRA's definition of a "fraud event" in its inclusivity of all types of insurance fraud. The interpretation of a fraud event empowers insurers to identify activities that meet this definition which consists of a wide range of deceptive practices aimed at those manipulating the automobile insurance system for financial gain, other advantages, or benefits.

The Guidance identifies that the definition is non-exhaustive and not prescriptive as the Rule is "constantly evolving". We agree that the definition of a "fraud event" requires agility to meet the ever-changing landscape of automobile insurance fraud. However, for greater clarity we recommend the following underlined amendment:

> ***"fraud event"*** *means a deceptive act or omission, or series of deceptive acts or omissions intentionally committed by a person(s) to obtain advantage, financial gain, or benefits beyond that to which one is entitled to with regard to any policy, claim, provision of goods or services or other occurrence related to automobile insurance, and for greater clarity includes <u>but is not limited to</u> instances of:*
>
> - *Obtaining an automobile insurance policy through fraudulent means, including underwriting fraud;*
> - *Obtaining a benefit under a contract of insurance through fraudulent claims;*
> - *Providing goods or services to a beneficiary under a contract of insurance; through fraudulent means or in a fraudulent manner;*
> - *Fraudulent activity in the selling or distribution of insurance products; and*
> - *Fraudulent activity committed by internal employees of an insurer.*

The proposed amendment would provide greater clarity for the purposes of statutory interpretation while empowering insurers to identify new and emerging fraud within the industry.

PRESCRIBED INFORMATION

RECOMMENATION: Amend the definition of "Prescribed Information" to include the term "relevant" and to include information encompassing all fraud scenarios

We support the reporting of prescribed information in section 3(1). We recommend an amendment to better align the proposed Rule to the proposed Guidance. The Rule provides that Insurers are required to provide "all information, including personal information, in the insurer's possession, control or power…." whereas the Guidance identifies that "all information" will be interpreted to mean "all *relevant* information". Such interpretation in the Guidance would be unnecessary if the Rule were amended as below:

> *3(1) Prescribed information includes all relevant information, including personal information, in the insurer's possession, control or power related to any policy, claim, provision of goods or services or any other occurrence or event where the information provides reasonable grounds for the insurer to believe that a fraud event has occurred or is likely to occur.*

The Guidance is unclear as to whether the term "relevant" will be applicable during subsequent phases. Drafting the word "relevant" into the Rule rather than the Guidance would create greater clarity and certainty as the FRS moves from Phase I to Phase II.

Additionally, we support FSRA's consideration of data points prior to implementation as the addition of new data points in the future may present operational challenges for both the designed system and for insurers who may not be collecting such information. For example, the proposed data set could include digital data points such as Device ID to capture the digital footprint of devices used to perpetuate fraudulent activity. . It is suggested that FSRA collaborate with industry stakeholders to identify fraud information that are being increasingly prevalent and to encompass all fraud scenarios.

RECOMMENDATION: Amend the Guidance to create greater clarity regarding the requirement to de-identify data and the addition of limited liability provisions.

We agree with and support FSRA's commitment to applying privacy principles to the Fraud Reporting Service. To enhance the protections contemplated by FSRA, we recommend a minor amendment to the Guidance.

Appendix B of the Guidance provides a non-exhaustive list of data elements and states,

> *To the extent that the following list includes personal information that is not necessary for the purposes of assessing and detecting fraud, an insurer should not report the personal information during phase one of the FRS*.

We recommend that the words "*during phase one of the FRS"* be removed from the Guidance to ensure that the privacy principles of de-identification will persist throughout the phases of the FRS

Additionally, we recommend that FSRA consider limited liability protections for FSRA and insurers for the purposes of protecting against privacy compliance complaints with respect to disclosure of identified individuals that has been made in good-faith compliance with the Rule.

WHEN TO REPORT INFORMATION ON FRAUD EVENTS

RECOMMENDATION: Enhance consistency in reporting by employing an industry standard to RGB and by adding qualifiers to "Actions" / "Decisions"

We align with FSRA's desire to balance the triggering event for fraud reporting between "suspicion" and "conclusion" of fraud. We appreciate FSRAs consideration for two necessary thresholds which must both be met before the reporting requirement is triggered:

1. The information must be the RGB threshold; and
2. The insurer must take action or make a decision based on the information.

To enhance the consistency of reporting we propose that FSRA consider a modest amendment to the definition of "Reasonable Grounds to Believe" that is similar to the standard applied by FINTRAC.[1] We recommend,

> *Reasonable grounds to believe means that there are verified facts that support the probability that a fraud offence has occurred…and there is enough evidence to support a reasonable and trained person to believe, not just suspect, that a fraud offence has occurred.*

This subtle enhancement to the well-written Guidance on RBG would create an industry standard for of reporting among insurers who may otherwise not be aligned on their internal definition of "a high degree of certainty" that is currently written into the Guidance.

The Guidance provides that "Actions" may include:

- Escalating a file for further investigation to SIU;
- Denying a claim; and
- Voiding or otherwise terminating an insurance policy.

"Decisions" include:

- Paying or processing a claim despite having information that provides RGB; and
- Closing a claim made under a policy that has been abandoned by the claimant.

[1] FINTRAC's Compliance Guidance, August 19, 2024

[1] See sections 38(8), 42(3) and (13), 45(3) and (5) of O. Reg. 34/10: *Statutory Accident Benefits Schedule – Effective September 1, 2010*

To enhance consistency of reporting among insurers, we also recommend that qualifiers be added to the Guidance for "Actions" and "Decisions" that will present clear triggers for reporting.

For example, under the current actions, escalating a claim for further investigation to SIU would trigger a reporting requirement if the RGB for the information is met. Each organization will have different standards for referral to SIU which may create inconsistent reporting among insurers. We also note that the *SABS* includes several provisions that provide only two adjusting decision options: approve or deny a claim for a benefit within 10 days of receipt of the claim or an insurer's examination.[2] In practice, this means that an insurer may not reach a "high degree of certainty" with respect to the suspicion of fraud, and yet must take an "Action" by statutory requirement in order to further pursue investigation into the suspected fraud. Additionally, each organization will have different schedules and triggering events to close a claim for abandonment resulting in reporting that would be applied differently between various organizations. These examples could have the effect of skewing the results of the presence of fraud within the industry as the triggering event to report will in some cases be very early in the claim (i.e., referral to SIU stage) while others will be very late in the claim (i.e., closure after a period of inactivity / abandonment).

We recommend that FSRA consider actions and decisions that will generate greater consistency and timeliness in reporting such as:

- Claims that are referred to SIU and remain open after 45 days;
- Denial of a claim on the basis of RGB with notice to the insured; and
- Closure of a claim as abandoned on the basis of RGB with notice to the insured.

We also recommend consideration of actions and decisions that may be implemented in response to underwriting fraud and selling/distribution of insurance products fraud, such as:

- Notifying an individual of the non-existence of a policy purchased in good faith from a Ghost Broker.
- Notifying an insured of material misrepresentation on policy application or renewal applications

HOW OFTEN INSURERS WILL NEED TO REPORT INFORMATION ABOUT FRAUD EVENTS TO FSRA

RECOMMENDATION: Support an industry standard in compliance by amending Section 4(3) to allow insurers to determine that the information fails to meet the threshold and providing insurers with five business days to report the determination.

We agree with FSRA's proposal for regular and ongoing reporting of fraud event data and recommend additional clarity and guidance to assist insurers in understanding and complying with reporting requirements.

For example, section 4(3) of the proposed Rule mandates that an insurer "immediately" give notice and recommend the Chief Executive Officer to withdraw information that includes deficiencies that cannot be remedied or that fails to meet the threshold of the reporting requirement. We propose that the Rule be amended with consideration given to operational constraints within organizations: the persons who may discover that a claim no longer meets the reporting threshold may not be the same persons responsible for compliance with the Rule. Moreover, insurers are required to consider the totality of information before them in adjusting claims; as a result, there may be no clear single point in time in which an insurer "discovers" that a claim no longer supports the RGB threshold. This creates significant uncertainty for insurers with respect to FSRA's supervisory and enforcement role in upholding this section.

We recommend that FSRA amend section 4(3) to the following:

4(3) If an insurer provides information to the Chief Executive Officer and subsequently determines that the information either:

(a) includes deficiencies that cannot be remedied as required by subsection 5(2)(b) of this Rule; or

(b) fails to meet the threshold of the reporting requirement outlined in subsection 3(1) of this Rule,

then the insurer must give notice within five business days and recommend the Chief Executive Officer to withdraw the information provided.

The proposed amendments recognize that RGB is a determination of insurers rather than a discovery and provides operational flexibility to allow insurers to seek withdrawal of the information.

Respectfully Submitted

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