Submission to the Ministry of Finance Fraud and Abuse Consultation

July 12, 2021

The Coalition of Health Professions in Auto Insurance (the "Coalition") is pleased to have the opportunity to provide a submission to the Ministry of Finance and Financial Services Regulatory Authority (FSRA) proposed Fraud and Abuse Strategy for the Auto Insurance Sector.

The Coalition was formed in 1990 and currently has eight regulated health professional associations[1] as members that represent over 40,000 regulated, front line health professionals involved in the assessment and treatment of Ontarians. The health professions we represent are key stakeholders in the auto insurance system and advocate for timely access to assessment and care for claimants.

We support a comprehensive, fair, and transparent approach to preventing, detecting, and deterring fraud and abuse. We also support access to the information concerning fraudulent and abusive activities among all stakeholders in Ontario's motor vehicle accident (MVA) sector. In a similar vein, we believe that a comprehensive fraud and abuse strategy must recognize that all parties to a transaction can be involved in fraud and abuse, including, but not limited to, claimants, regulated and non-regulated service providers/vendors, insurers, brokers, and legal representatives.

Central to our comments on the proposed strategy is our belief that:

- Strong anti-fraud measures must be adapted to fit the unique requirements of the diverse service providers and stakeholders that comprise Ontario's auto insurance sector;
- Education on fraud prevention and remediation must be incorporated at all levels;
- Robust safeguards must be put in place to protect the rights and interests of both injured claimants and consumers;
- To address concerns regarding health professional behaviour, existing organizations such as the health professional colleges and the FSRA licensing system should be utilized; and
- Any new measures should compliment FSRA's proposed Unfair or Deceptive Acts or Practices UDAP rule which is intended to " promote safety, fairness and [fair] choice for insurance customers" (FSRA, 2020. p. 1).

[1] The 8 Health Professional Associations that comprise the Coalition are the Ontario Association of Social Workers (OASW), the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA), Ontario Chiropractic Association (OCA), the Ontario Dental Association (ODA), the Ontario Physiotherapy Association (OPA), the Ontario Psychological Association (OPA), the Registered Massage Therapist's Association of Ontario (RMTAO), and Ontario Society of Occupational Therapists (OSOT).

We underscore the fact that multifaceted and stringent protections are already in place to regulate and deter fraud among regulated health service providers (HSPs). Specifically, regulated health professionals working in the auto insurance sector in Ontario are subject to two different forms of regulation: 1) professional regulation through regulatory colleges, and 2) licensing through FSRA.

Regulatory colleges have a duty to protect the public and ensure that health professionals practice in a safe, ethical and competent manner. These entities set regulations that protect the public and address issues such as registration, misconduct, business practices and quality assurance as well as professional codes of ethics and standards of practice.

In parallel, FSRA licenses "suitable [HSPs] … to receive direct payment from insurers for benefits claimed under the Statutory Accident Benefits Schedule (SABS)" (FSRA, 2020, para 1). FSRA-licensed HSPs must adhere to prescribed standards regarding their business systems and practices, and appropriately manage their practices within the context of the Health Claims for Auto Insurance (HCAI) system.

The Coalition believes it is critical that the proposed fraud and abuse strategy align and optimize the existing protections (including standards and penalties) afforded by both Colleges and FSRA to prevent, detect and deter fraudulent behaviour. The professional regulatory Colleges are required to investigate every complaint they receive, and each has specific standards regarding fraudulent behaviour and billing practices. To this end, **we recommend that any identification of fraud by insurers should be properly investigated by HSP's respective regulatory colleges, FSRA, or law enforcement (where appropriate).** Furthermore, we recommend that the proposed fraud and abuse strategy focus on those parties involved in the auto insurance sector where such oversight is absent or lacking, and where real vulnerabilities exist.

Outlined below is our feedback to each of the four themes outlined in the proposed strategy: Definitions, Data, Management Tools; and Regulator Tools.

A. Insurance 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?

- The Coalition recommends that the proposed fraud and abuse strategy should provide separate definitions of fraud and abuse.
- The definition of **fraud** should be written in plain language and be applicable to all parties in the auto insurance sector (e.g., service providers/vendors and consumers and claimants). This basic definition should:
    - State that the central feature of fraud is **intent** to receive improper payment or personal gain from an insurer or any third party.
    - Distinguish between wrongful, or criminal deception intended to result in financial or personal gain *versus* unintended actions precipitated by administrative error, misunderstanding, miscommunication, or misrepresentation.
    - Define the various types of fraud including organized, premeditated, and opportunistic fraud as well as identity theft (e.g., HSP and claimant identity theft).
    - Clarify that insurance fraud may vary in severity.
    - Describe the serious consequences and penalties associated with insurance fraud.

- Companion, sector-specific definitions of fraud that incorporate specific examples/scenarios should also be developed with the sector and included in educational materials.

- The definition of **abuse** should include an interpretation of the term "reasonable" to ensure clarity for claimants and service providers and minimize the impact of power imbalance from insurers being the sole interpreters of what is reasonable. Some recent examples of abusive acts or practices by insurers towards claimants include:
    1) Unreasonable claim denials for necessary goods, services, care and treatment, or blanket denials as experienced with virtual care at the beginning of the pandemic that could be interpreted as an abuse of power (towards either claimants and/or HSPs).
    2) Unreasonable and unnecessarily burdensome administrative requirements such as:
        i) attendant care: minute by minute logging of care services; and
        ii) requiring completion of Statutory Declarations to include information that is already available to the insurer and/or included in the FSRA AIR.
- The definition of abuse should be linked to Unfair and Deceptive Acts and Practices and should include anything that requires claimants and/or providers to adhere to an "unreasonable" standard (i.e., improper use of power, untimely response to a benefit, etc.).
- Differences of opinion between the injured person's treating health professional and the insurer regarding injury, causality, diagnosis, impairment, disability, or the reasonableness and necessity of goods and services are inevitable and should not be described as indicators of fraud or abuse in the system. There are appropriate resolution processes for this including the LAT and an independent assessment process.

- Fraud must not solely be defined by, or encompassed within, internal insurer policies and rules. Rather, the definition of fraud should be included in governing regulations that are specific to the automobile insurance sector and be open and transparent to all stakeholders who will be held to account.

2. Will a definition require multiple parts to account for different types of auto insurance fraud and abuse that can be committed?

- Yes. (See feedback to Question A. 1.)
- The basic definition of fraud should rely on general concepts with sector-specific definitions including regulated health service providers and all other non-regulated service providers such as towing, storage, body repair, brokers, etc.

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

- The Australian government defines fraud as "dishonestly obtaining a benefit, or causing a loss, by deception or other means" (Commonwealth Fraud Control Guidelines, 2011, as cited in Flynn 2016). For fraud to occur, there must 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, as cited in Flynn, 2016).

- **Abuse** is commonly **defined** as any action that intentionally harms or injures another person. In short, someone who purposefully harms another in any way is committing **abuse**. However, one must be cautious about abuse since it is open to interpretation.

B. Fraud and Abuse Data

Overall comment:

- Currently, the majority of data and statistics on Ontario auto insurance health claims is held by the Insurance Bureau of Canada (IBC) (and in some cases aggregated under HCAI). In order to have a neutral system that looks for fraud (and abuse) across all stakeholders (including insurers), this data should be under the custodial care of a neutral third party. Given its mandate, FSRA is well-positioned to act as a neutral third party for, in this case, two of their licensees. Furthermore, FSRA is best positioned to provide impartial data analysis and appropriate access to data for all stakeholders.
- Claimants should have access to their own health and non-health data.
- HSPs should be permitted real time access to view charges for services billed in their name.
- As a central part of its regulatory mandate, FSRA should, at a minimum, be monitoring key metrics to identify fraud and (when necessary) trigger appropriate investigations (i.e., scanning billing data from outliers). Insurer cooperation in such investigations should be mandated.

Specific Consultation Questions:

1. 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?

- Data points to measure and manage fraud could include the following:
    - Information regarding the behaviour of insurers (individually and across the system) including:
        i) Number of OCF-18 denials by insurers;
        ii) Number of Insurer Examinations, outcomes, and costs; and
        iii) Number of requests of Statutory Declarations by insurers.
    - Continue using CIHI codes (intervention codes), ICD10 (injury codes), and HCAI data, to identify possible outliers that may signify potential risk of patterns of fraud and/or abuse by individuals or organizations for further investigation.
    - The Coalition submits that this data should be available to each FSRA-licensed facility (either sole practitioner or multiple providers), the professional health care associations and the Coalition. This would include access to standard reports; the ability to request specific reports; and access to the data should we wish to conduct further analyses.
    - Certain systemic and arbitrary denials based solely on HCAI codes that are consistently denied (e,g., 7. SF.12; 7. SF.15).
    - Metrics regarding claimant and HSP complaints to the regulator.
    - Number of individuals/facilities who have lost their FSRA license to practice in the sector due to alleged fraud/abuse.
    - A multistakeholder group (i.e., such as FSRA Technical Advisory Committees) should be responsible for achieving consensus on those data points and metrics that must be collected. These decisions will also be informed by the definition of fraud and abuse. (Note: HSPs have only a limited sightline on what data is collected by IBC).

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?**

   - Yes, metrics should be able to identify insurer-specific approaches (i.e., policies) that may not be consistent with FSRA guidance.

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 noncompliance, should be put in place if government or FSRA plays a role in removing those barriers?**

   - The current proprietary approach to data management inhibits quality improvement. Indeed, the system has no focus on education or remediation and thus little to no real ability to undertake quality improvement. This leads to an unfortunate and unsustainable situation where, for instance, a newly graduated HSP starting their career may be left with little recourse but to exit the system, if they make an unintentional mistake (due to misinformation) that results in a finding of fraud by an insurer.
   - Opportunity for the multi-stakeholder groups, such as the recently formed Technical Advisory Committees (TACs), to review the data together such that the data is not misconstrued or misinterpreted. Those improvements can be made in processes, education, and regulation to address fraud and avoid unintentional issues.
   - FSRA oversight of the data, along with a collaborative approach to determine which data points would render useful information, would point the process in the right direction.

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?**

   - Personal information of the claimant must be protected.
   - The HSP company name should remain anonymized until further investigations have been completed by FSRA and/or the relevant College and there is a finding against the HSP.

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?**

   - Consumers should be made aware that, through data collection, their personal health information could be used to detect fraud and abuse, and have the opportunity to provide or retract their consent. Consumers should also be told how their information will be protected.

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

   - FSRA should take a lead role and house a centralized fraud reporting repository and continue to be informed by the MOF and industry stakeholders on this issue.

C. Fraud Management Tools

Overall comment:

- Currently, FSRA possesses many tools to manage HSPs such as FSRA licensing (including the HSP Annual Information Return (AIR); access to health professions regulatory colleges; the Professional Service Guidelines (PSG); the SABS; the HCAI system (which permits only a licensed HSP with pre-approval to bill the insurance system, and includes the automated diagnosis matching service).
- Within the parameters of the SABS, consumer and HSP fraud is further curtailed by regulations including the prior approval mechanism, the OCF Forms (including patient and HSP signatures) and insurer examinations.
- We recommend that use of the Credential Tracker be resumed. This tool permits HSPs to see which health care facilities have registered their credentials to bill insurers in the HCAI system. The HSP is then able to report any concerning activity to HCAI. This process should be further developed to allow the health professional to check all applications and invoicing done in their name in real time.
- FSRA should adopt a risk-based approach and target individuals/organizations whose data indicates potential fraud or abuse for investigation via audit and whose billings cross a specific threshold.

I. Mandated Insured's Cooperation with Insurer F&A

Specific Consultation Questions:

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

- The proposed tool may undermine the protection of claimant interests in several ways. First, vulnerable claimants (such as those who are not proficient in English or from racialized or educationally disadvantaged communities) may be susceptible to misinformation. They may also have no access to appropriate legal guidance or representation.
- The threshold of reasonable cooperation is too vaguely defined.

2. What are some concerns and mitigations to protect consumers from being unfairly targeted by insurers?

- Limits on the insurer's ability to cancel a policy due to a claimant's failure to cooperate during an investigation of insurance fraud undertaken by another party (i.e., the HSP) should be maintained.
- Special care should be taken to ensure that any reforms do not create a disproportionate power imbalance between the insurer and claimant (this is especially a concern for claimants who are from vulnerable or racialized communities).

3. What is considered an adequate level of cooperation?

- If a third party such as FSRA (not the insurer) requests the claimant's cooperation, the claimant can volunteer information if they're comfortable doing so.

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

Overall Comments on PPNs:

- While PPNs are often used to reduce administrative costs, there is no guarantee that such savings are passed on to consumers in the form of lower insurance premiums. PPNs may be appropriate for some specialty health and translation services.
- PPNs may create a conflict of interest that favours the *consumer* (i.e., potential for reduced premium) over the interests of the *claimant* (who may receive reduced care at the time of the accident.
- Claimant is not truly able to provide informed consent/choice at the time of purchase since they do not know the terms of the contract between the insurer and the PPN (such as limitations, volume incentives, etc.).
- Claimant may not fully understand which clinics/HSPs are included within the PPN; and once injured, these same PPNs may no longer be within the insurer's network of providers.
- In contrast to Ontario's medical system, which permits patient choice in the selection of a care provider, PPNs may:
    - restrict access to a HSP that the claimant might have used previously and in whom they trust.
    - undermine provision of integrated and patient-centred care (by circumventing the patient's regular circle of care).
    - Prevent access to a HSP who shares the claimant's culture/language or who is located within the claimant's local community (i.e., transportation and/or the claimant's ability to tolerate distance travel may be an issue).
- The PPN model precludes participation in the system by sole providers and small clinics because they would not meet the expectation of broad provincial coverage. From the provider's perspective, the administrative requirements to be part of a PPN would not be worthwhile if only a small portion of their caseload involves MVAs.
- Provider's contractual arrangement with the insurer (to be a part of the PPN) may be perceived by the patient to create a conflict of interest with their health care needs. This may generate patient distrust with their HSP which is essential for their successful treatment and rehabilitation.

Specific Consultation Questions:

1. **Would this tool [PPNs] help insurers manage fraud and abuse in a way that protects and advances consumer interests?**
    - Insurers have advocated for PPNs as a cost control measure; however, these arrangements have the potential to erode claimant's trust that the health care being delivered is in their best interest. PPNs may restrict the claimant's choice of provider and there are concerns with the overall transparency of the process and contractual agreements entered between the PPN and the insurer.
    - The Coalition has no comment around other PPNs that provide towing, storage, car rental or car body repair services.

2. **Do PPNs help insurers manage fraud and abuse in a way that protects and advances consumers' interests?**
    - As stated above, PPNs may lead to a conflict of interest. By reducing a claimant's choice of provider and muddying the relationship between the claimant and the health service provider, these arrangements may undermine optimal rehabilitative patient outcomes.

- The Coalition submits that the consumer's best interests with respect to health care are protected by giving the claimant his/her choice of treatment provider as recommended by the claimant's own primary care provider and/or treatment team.
- The Coalition cannot comment as to whether other PPNs that provide towing, storage, car rental or car body repair help insurers to manage fraud and abuse.

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?

- (See Response to Question 4 below)

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

- As noted above, the Coalition has concerns with the use of PPNs in health care, however, should this practice continue, we feel the following enhancements would be required to protect injured consumers:

    a. At the point of purchase, the insurer must disclose which clinics and/or HSPs are part of their PPN, and the contracts with the PPNs.

    b. If at any point a clinic or HSP is removed from the insurer's PPN, all insureds must be notified and given the opportunity to alter their policy.

    c. If the claimant selected the PPN option at the point of purchase, and after starting treatment , finds the PPN no longer suits their treatment needs (e.g., due to referral by their primary health provider to a health professional not within the Insurer's PPN; complexity of treatment needs; change in geographical location; language/culture, etc.), the claimant should have the option to switch out of the PPN program to find a suitable treatment provider without any penalty.

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?

- Consumers should be permitted personal choice in selecting a HSP provider over a health care PPN program. The option to utilize the insurer's PPN should be limited to fully informed, voluntary participation at the point of the need for the service.

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

- We refer you the FSCO guidelines for best practices for PPNs and s.46 of the SABS (excerpted below):

Conflict of interest re referrals by insurer

46. (1) This section applies if an insurer intends to refer an insured person to a person with whom the insurer has a potential conflict of interest and the referral is for the purpose of,

(a) the insured person obtaining any goods or services referred to in section 15 or 16 from the person recommended by the insurer; or

(b) the insured person being examined or assessed, other than under section 44, by the person recommended by the insurer. O. Reg. 34/10, s. 46 (1).

(2) The insurer shall not refer the insured person to the person unless the insurer has first given the insured person a notice that satisfies the following and the insured person gives a written consent to obtain the goods or services from or be examined or assessed by the person:

1. The notice must specify the nature of the relationship between the insurer and the person, including the terms of remuneration of the person.

2. The notice must specify the nature, amount and duration, if applicable, of the goods or services or the assessment or examination.

3. The notice must inform the insured person that he or she is free to decline the proposed referral, or to revoke any consent given at any time, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits.

4. The notice must inform the insured person that he or she is free to choose from whom the insured person prefers to receive the goods and services, or by whom the insured person prefers to be assessed or examined, in accordance with this Regulation, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits under this Regulation.

5. The notice must inform the insured person of his or her rights and responsibilities with respect to the goods, services, assessments and examinations. O. Reg. 34/10, s. 46 (2).

(3) In this section, an insurer is deemed to have a potential conflict of interest with a person if,

(a) the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of goods or services by, on behalf of, or under the authority or supervision of the person; or

(b) goods or services will be provided by, on behalf of, or under the authority or supervision of the person,

(i) pursuant to a subsisting arrangement with the insurer under which goods or services referred to in this Regulation are or will be provided at the insurer's expense, or

(ii) as a result of the insurer's referral, recommendation or suggestion of the person to the insured person. O. Reg. 34/10, s. 46 (3).

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

- We emphasize that FSRA has an equal fiduciary responsibility to claimants, insurers, and HSPs.
- Insurers should never be permitted sole authority to exclude a HSP without an obligation to formally report such a decision to both FSRA and the HSP's regulatory college. A decentralized approach that gives sole authority to insurers is not sustainable from the point of view of HSPs, who are almost never able to fully gauge an insurer's internal rules (due to lack of open and transparent rule-setting processes).

- Exclusion of an individual provider must not be performed solely at the discretion of the insurer.
- Insurers should not have the authority to supersede FSRA's or the Regulatory College's authority with respect to a claimant's access to a treatment provider.

Specific Consultation Questions:

1. **Would this tool help insurers manage fraud and abuse in a way that protects and advances consumer interests?**
   - No. With respect to the delivery of health care, individual insurers should not be able to unilaterally exclude coverage for HSP services.

2. **What criteria is appropriate for excluding service providers?**
   - A revocation or suspension of an HSP's license to practice from their respective regulatory body or from FSRA's investigation.

3. **What methods/avenues could service providers and auto insurers use to resolve their disputes?**
   - The insurer currently could lodge a complaint or report about a HSP with the HSP's regulatory body. If there is a recurring complaint to the Market Conduct Branch from an HSP about an insurer or vice versa, FSRA could provide a virtual meeting to discuss the dispute and help to resolve it.

4. **How can this program benefit consumers without reducing consumer choice?**
   - From a health service provision standpoint, giving insurance companies the unilateral ability to exclude certain vendors on their own accord reduces consumer choice and could possibly lead to a shortage of health care vendors, particularly in rural areas as well as those with specific specialties (i.e., types of injuries), matching for factors such as language/culture, limitations in local communities, etc.

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?**
   - This tool would be contrary to improving consumer outcomes. Any concerns regarding HSPs are appropriately addressed by the regulatory bodies and the FSRA licensing system.

D. Regulator Tools

Overall comment:

- The proposed strategy does not acknowledge the continuum of regulatory tools FSRA currently possesses with respect to HSPs including FSRA licensing (including AIR); the Provider Service Guidelines (and prior approval); the SABS, Insurer examinations; HCAI system (which permits only a licensed health service provider with preapproval to bill the system, and includes an automated diagnosis matching service); and patient informed consent.
- We recommend that the Credential Tracker and FSRA audits be resumed.
- FSRA should adopt a risk-based approach (e.g., targeting high billers).

I. Set up a whistle-blower program and/or protection(s)

- The Coalition is supportive if a whistleblower's identity is protected.
- HSPs have a reporting obligation that already exists if they become aware of any misinformation provided on an OCF form.

As per the Insurance Act, Ont. Reg.90/14, s.9*,* SERVICE PROVIDERS - STANDARDS FOR BUSINESS SYSTEMS AND PRACTICES AND OTHER PRESCRIBED CONDITIONS

9. (1) A licensed service provider shall not submit to an insurer any form, plan, invoice or other type of document or information authorized or required under the Statutory Accident Benefits Schedule that relates to a claim for statutory accident benefits or to a listed expense if either of the following circumstances exists:

1. The service provider has reasonable grounds to believe that the form, invoice, document or information contains inaccurate, false, misleading or deceptive information.

2. The service provider has reasonable grounds to believe that the individual to whom the claim relates,

i. was not involved in an accident in respect of which the claim for statutory accident benefits is made or the assessment , examination, report, form, plan, good or service is requested or provided; or

ii. did not sustain an impairment in respect of which the claim for statutory accident benefits is made or the assessment , examination, report, form, plan, good or service is requested or provided.

(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.

II. Establish expectations for fraud and abuse management plans.

Overall comment:

- When there is a finding of fraud and abuse, this is reported to police to prevent fraudulent actors from simply moving on and conducting fraudulent practices in other jurisdictions. Or at a minimum, as part of the criteria in investigation, there is a decision point required on whether or not to engage.

III. Review and update / Introduce FSRA investigation and enforcement tools.

Overall comment:

- Coalition suggests that there may be a place for FSRA to provide oversight for non-licenced service providers (e.g., tow truck drivers, storage providers)
- The proposed FRAUD AND ABUSE strategy should allocate resources and energy to focus on those sectors where an existing regulatory system is not in place.
- Example of existing regulatory sanctions for fraud and abuse under the Workplace Safety and Insurance Act via WSIB:
    i. People convicted under the Workplace Safety and Insurance Act can be subject to a fine of up to $100,000 and/or six months in jail for each offence. People who commit fraud exceeding $5,000 can be sentenced to imprisonment for up to 10 years. Penalties may also include fines, probation, and/or an order to pay full restitution.
    ii. Corporations convicted under the Act can be fined up to $500,000 for each offence.
    iii. The court may also order restitution of the full amount of money received in the commission of the offence.
    iv. Facilitate FSRA's ability to share FRAUD AND ABUSE information with other regulators.
        - Coalition supports such reforms for non licensed providers.
        - The proposed FRAUD AND ABUSE strategy should allocate resources and energy to focus on those sectors where an existing regulatory system is not in place.

Specific Consultation Questions:

1. **Other provinces have provided enhanced investigation powers, such as the British Columbia Financial Services Authority (BCFSA). Should FSRA have similar powers?**

   We are not able to comment about this at this time. We will need more information about these specific 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?**

   Yes; all providers of goods and services in the auto sector

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

RHPs – respective Colleges have the to impose penalties, fines, license suspension or removal

FSRA licensing body – also imposes monetary penalties, suspension and removal of the license

Fraud/illegal behaviour – police and legal authorities, i.e. criminal charges

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