



**INSURANCE BUREAU OF CANADA**

**AUTO INSURANCE FRAUD IN ONTARIO**

**KPMG FORENSIC REPORT DATED JUNE 13, 2012**





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## 1 EXECUTIVE SUMMARY

KPMG Forensic was retained by Insurance Bureau of Canada (“IBC”) to undertake an examination of the extent of auto insurance fraud in Ontario. Our work centred on a broad review of available information and documentation addressing auto insurance fraud in Ontario and other jurisdictions.<sup>1</sup>

### 1.1 Estimate of Extent of Insurance Fraud in Ontario

Based upon our review, it is clear that auto insurance fraud in Ontario is a significant problem. The situation in Ontario is similar to that in other countries and there are indications of consistencies in the nature, prevalence and extent of insurance fraud in various jurisdictions. However, there is insufficient information to provide a precise and statistically based estimate of auto insurance fraud in Ontario. While some recent and available analyses provide an indication of the potential extent of organized auto insurance fraud<sup>2</sup> in Ontario, there is no study or analysis that provides a complete picture of the current insurance fraud situation in Ontario.

Given this, in order to provide an estimate of the potential extent of auto insurance fraud in Ontario, we have referenced available information from various studies. Our approach provides a broad estimate of auto insurance fraud which is based upon information from various sources. This is not a statistical analysis<sup>3</sup> but, in our view, it provides an indication of the seriousness of and potential extent of auto insurance fraud in Ontario.

Based upon our review of the available information and as further explained below, we estimate that auto insurance fraud in Ontario ranges between \$770 million and \$1.6 billion per year. This amounts to between 9% and 18% of total auto insurance premiums.

On an overall basis, the extent of fraud, and crime generally, is not something that is prone to measurement. Those who perpetrate fraud are focused on remaining undetected. As a result, it is generally not possible to directly measure the extent and cost of fraud. As described in this report, we have reviewed extensive research, studies, articles, and other literature dealing with insurance fraud in general and auto insurance fraud in particular. We also conducted interviews with representatives of ten Ontario auto insurers and a number of organizations involved with combating insurance fraud in other jurisdictions.

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<sup>1</sup> KPMG Forensic was not retained to perform its own analysis of insurance claims that are potentially fraudulent. Our work relied upon studies and analysis performed by others.

<sup>2</sup> Organized insurance fraud is undertaken by a group of individuals working in concert. By working in together, the group takes advantage of the insurance system in various and often multiple ways.

<sup>3</sup> Such a statistical analysis is not possible given the available data.



There are no recent (since 2001) and larger studies in Canada that consider the full extent of auto insurance fraud in Canada (or Ontario). As a result, in order to provide an assessment of the total extent of auto insurance fraud in Ontario, it is necessary to consider other fraud-related reports and sources. Our approach to estimating the extent auto insurance fraud in Ontario uses information derived from: a) recent Ontario-based “proofs of concept” (“POCs”) that used data analytics (as described in this report); and b) information from certain closed claims studies (also as described in this report). Specifically our approach is as follows:

- Use information from two POCs to estimate an extent of organized auto insurance fraud in Ontario.<sup>4</sup> The POCs were not undertaken for the purpose of estimating the extent of auto insurance fraud in Ontario. Rather, they were intended to assess the viability of using data analytics and data from multiple insurers to assist with the identification of suspicious claims. The focus of the POCs was fraud committed by organized groups rather than opportunistic insurance fraud (e.g., padding a legitimate claim). That said, the results of the POCs provide information that assists with understanding and assessing organized auto insurance fraud in Ontario (albeit for various reasons the resulting estimate is likely understated).
- Use information from closed claim studies to estimate an extent of opportunistic auto insurance fraud in Ontario. We reviewed five closed claim studies (two in Canada and three in the US). One Canadian closed claim study and two US closed claims studies provided an estimate of opportunistic fraud that we have referred to.

As discussed in this report, there are various issues related to the available information and analysis relied upon by us that suggest that our estimate may be understated. However, given the available information, we are unable to indicate the potential extent of any understatement.

## **1.2 Identification of Auto Insurance Fraud in Ontario**

We were also requested to provide our comments on the identification of auto insurance fraud in Ontario. Based upon our review, the following summarizes our relevant observations:

- Data analytics provides a robust and effective approach to identify suspicious insurance claims. The POCs discussed in this report confirmed the successful use of data analytic approaches to identify suspicious claims and each POC was considered to be a success.

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<sup>4</sup> A third POC was not used in our estimate of the extent of insurance fraud in Ontario as explained in Section 7 below.



- The benefits and strengths of data analytics to detect suspicious claims increases significantly and incrementally with the ability to access claims data for multiple insurers, multiple lines of business and multiple years. Overall, larger pools of claims and policy information permits data analysis tools to increase the ability to connect related parties and identify common claims patterns which are key attributes of organized fraud groups.
- A critical issue connected to the use of data analytics by multiple insurers that needs to be addressed and resolved relates to privacy matters connected with the sharing of cross-insurer data.
- The utility of data analytics was confirmed in our interviews. We also note that data analytics has been used extensively for a number of years in the US and in the UK both by individual insurance companies and more broadly by the industry working in concert in some fashion.

## 2 INTRODUCTION AND BACKGROUND

*“Fraud and deceit abound these days more than in former times.”*

Sir Edward Coke (1552-1634)

Insurance fraud has been a part of insurance since arrangements were first made to protect property and life from unexpected events. The lure of cash payments following a seemingly simple claim of damage or loss is too much for some to ignore. Whether or not there has actually been such damage or loss is irrelevant for some who make such claims. For others, the misfortune of suffering a claimable event can be too good to ignore if some additional, albeit unjustified benefit can be obtained.

Insurance fraud is often seen as a “victimless” crime<sup>5</sup>. In addition, insurance fraud is a non-violent crime that can be viewed by those committing it to be a “low risk” endeavour whereby the chances of detection are small and the penalties for being caught minimal.<sup>6</sup> These perceptions do not discourage those with the opportunity, need and personality to take illicit advantage of the insurance system.<sup>7</sup>

Insurance companies are certainly not blind to the existence of claims fraud. Extensive resources are expended to protect companies and their stakeholders (including policyholders) from losses due to fraud. Special investigation units (“SIUs”) are established to investigate fraud both within individual insurance companies and within the P&C insurance industry generally. Insurance company employees are trained to recognize and report suspected fraud. Public relations efforts tell consumers of the damage and cost of insurance fraud.

However, for those intent on taking advantage of the insurance system for personal and unwarranted gain, insurance fraud is a target often too tempting to ignore. This makes insurance fraud a problem that is not easily discouraged.

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<sup>5</sup> *In series – fraud: insurance fraud – a victimless crime?*, Earp, James and Gibson, Angela, 2011.

<sup>6</sup> Compared to violent crimes, insurance fraud is viewed as low risk, high gain for perpetrators, and it is seen as low priority for prosecutors. Little media attention is generally attracted (unless the fraud is larger and noteworthy), and law enforcement agencies usually do not have resources to help detect and prosecute fraud (*Insurance Fraud Prevention and Control Property and Casualty Insurance*, Ontario Insurance Commission, 1993).

<sup>7</sup> A 2010 survey of 1,013 US adults found that the most likely reasons for people to commit insurance fraud were as follows: they believe they can get away with it (68%); they need the money (60%); they believe they are paying too much for insurance (42%); they want to make up for the deductible they would have to pay (33%); their family, friends, insurance agent, doctor or lawyer influence them (19%). (*Improve Customer Service Detection to Deliver High Performance Through Claims Insurance Consumer Fraud Survey 2010*, Accenture, 2010)



This project and report is focused on examining the extent of insurance fraud as it relates to auto insurance in Ontario. The impetus for this review is the perceived growth of auto insurance fraud in Ontario in the past few years. Auto insurance fraud as an issue worthy of focused review has been recognized by the Ontario government which formed its “Automobile Insurance Anti-Fraud Task Force” (the “Task Force”) in July 2011.

The extent of fraud, and crime generally, is not something that is prone to measurement. For obvious reasons, those who perpetrate fraud are focused on remaining undetected and approaches are used to conceal and camouflage such activities. As a result, it is generally not possible to directly measure the extent and cost of fraud. Other methods are required to assess the possible extent of insurance fraud, as discussed in this report.

## **2.1 KPMG Forensic’s Mandate**

KPMG Forensic was retained by Insurance Bureau of Canada (“IBC”) in October 2011 to undertake an examination of the extent of auto insurance fraud in Ontario. It was agreed that KPMG Forensic’s work would focus on available studies addressing this topic in Ontario and other jurisdictions.

Important sources of information for our work are three “proof of concepts” (“POC”) initiated in Ontario by three separate groups. The POCs were each started to examine the feasibility and usefulness of applying electronic data analysis tools to auto insurance claims data for the purpose of identifying claims that were suspicious or potentially fraudulent.

In addition, we conducted interviews with individuals within the insurance sector in Ontario and elsewhere with direct and relevant knowledge of insurance fraud. We also reviewed other research studies, surveys, articles, books and other printed sources related to the topic of insurance fraud and its extent.

KPMG Forensic was not retained to perform its own analysis of insurance claims to identify those that provide indications of fraud.

## **2.2 Overview of Insurance Fraud**

### ***2.2.1 Prevalence of Insurance Fraud***

Insurance fraud is perhaps among the most common criminal acts. For example, a 2003 survey conducted by the Insurance Research Council consisting of 1,008 US adults, found that one-third of respondents agreed that it is acceptable to increase the amount of an insurance claim by a small amount to make up for the deductible that would have otherwise



been paid.<sup>8</sup> In the UK, surveys also indicate that a significant minority of individuals view insurance fraud as potentially acceptable<sup>9</sup>:

<b>Dishonest Act</b>	<b>Percentage who would not rule out committing it in the future</b>	<b>Percentage who think it acceptable or borderline</b>	<b>Percentage who admit having done it in the past</b>
Exaggerating an insurance claim	47%	40%	6%
Making up an insurance claim	37%	29%	2%

In Ontario, IBC recently commissioned Pollara Inc. to conduct a survey of 1,000 individuals to determine their perceptions of insurance fraud and other industry-related issues. The survey found that 83% of the respondents believe insurance fraud occurs frequently or occasionally in the province. Very few (14%) see it as a rare occurrence. Close to everyone (96%) sees the link between insurance fraud and higher premiums for drivers.<sup>10</sup>

In the same survey, respondents were asked how frequently different types of insurance fraud are committed in Ontario:

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<sup>8</sup> *Insurance Fraud: A Public View*, Insurance Research Council, June 2003. This survey also found that 22% of those Americans surveyed said that it was acceptable to slightly increase claim to make up for insurance premiums paid when no claims were made.

<sup>9</sup> *What is Dishonest?*, Association of British Insurers, Facts on Fraud No. 1, February 2003.

<sup>10</sup> *Ontarians' Beliefs about Auto Insurance Fraud*, Insurance Bureau of Canada, February 2012.

Types of Insurance Fraud	Respondent's Belief that the Indicated Activity Occurs "Frequently" or "Occasionally"
People delaying their return to work after being injured in a car accident and continuing to accept income replacement payments from their insurance company, even though they have recovered from their injury	82%
People accepting extra rehabilitation treatments, such as massage or physiotherapy, even though they have recovered from their car accident injury	80%
Health care providers, such as chiropractors, recommending extra rehabilitation treatments that are not medically necessary	68%
People making fraudulent claims to insurance companies for accidents that never occurred	60%
People deliberately staging collisions with vehicles driven by other fraudsters and submitting claims for made-up injuries and vehicle damage	59%
People deliberately staging collisions with innocent drivers so that they can submit claims for made-up injuries and vehicle damage	53%

Notwithstanding this perceived prevalence of insurance fraud, attempts in Canada to measure the extent of insurance fraud have been relatively limited. Twenty years ago, it was reported that property and casualty (“P&C”) insurance fraud in Canada was a \$1 billion to \$2 billion problem, representing between 10% and 30% of total claims paid.<sup>11</sup> It was also observed at that time that “*fraud cost measurement usually involves some combination of survey evidence, focus group results and educated guesswork.*”<sup>12</sup>

More recently, there has been some effort to measure insurance fraud by reviewing information included in claims files (“closed claim file reviews”), as discussed in Sections 4 and 6 below. The relatively recent development of sophisticated computer-based data analysis tools (referred to as “data analytics”) has added another approach to assessing the extent of insurance fraud. However, regardless of the available approaches, measuring insurance fraud is not straight forward and there will always be an element of uncertainty with respect to the true cost of insurance fraud.

<sup>11</sup> *Insurance Fraud Literature Search/Summary of Key Findings*, Shawn McKenzie, Prepared for the Insurance Bureau of Canada, 1993, page 8.

<sup>12</sup> *Ibid.*



Despite the challenges in determining the extent of insurance fraud, available studies and research indicate that its prevalence is an accepted reality in many countries. The following indicates various estimates of P&C insurance fraud by country<sup>13</sup>:

Country	Product Line	Fraud Estimate
Australia (1994)	P&C	10% of claims value
Germany (1990)	Auto	11% of claims volume
Spain (1999)	Auto	22% of claims volume
United States (2008)	Auto	11 to 15% by value
United Kingdom (2009)	P&C	10% of claims value

### 2.2.2 Insurer Responses to Insurance Fraud

Canadian insurers universally recognize the existence and negative impacts of fraud on their business and stakeholders. As a result, significant resources have been expended by insurers to fight fraud. All companies who we spoke with<sup>14</sup> have established SIUs to investigate suspected claims fraud and have a process to attempt to identify suspicious claims. In addition, insurers are making or considering significant investments in technology to enhance fraud detection and investigation efforts. The importance of technology in fraud fighting is clearly recognized by P&C companies as insurers of 65% of the Ontario auto insurance market participated in projects to test the effectiveness of data analytic programs and approaches to identifying suspicious auto claims (see Section 7 below).

In 2008, Statistics Canada conducted its first Survey of Fraud Against Business<sup>15</sup> to assist in building a more comprehensive picture of the prevalence and characteristics of business fraud in Canada. With respect to insurance fraud, this survey found that:

- More than 75% of fraud against insurance companies involved false or inflated claims.
- Nearly half of all individual health and P&C insurance companies indicated that police are never or rarely contacted in cases of fraud, while 36% responded they do so on occasion. Fewer than 20% of all insurers said that police are informed often or always.

<sup>13</sup> Summarized from a table included in *General Insurance Claims Fraud*, Association of British Insurers, July 2009.

<sup>14</sup> These companies represent 68% of the Ontario auto insurance market.

<sup>15</sup> *Fraud Against Businesses in Canada: Results from a National Survey*, by Andrea Taylor-Butts and Samuel Perreault by Statistics Canada, 2007/2008



- The most common reasons given by insurers for not contacting police were: the incident was too minor (34%) and it was handled in some other way (33%).
- When insurers do report incidents of fraud to police, it is most likely in cases where the losses are considered sizable enough to warrant involving law enforcement (76%). The intention to pursue criminal charges was the next reason most commonly identified by insurers for informing police of fraud (57%).

In the same survey, insurers were asked what steps would assist in the further prevention of fraud:

Suggested Initiatives for Prevention of Fraud	Percentage
Cooperation and exchange of information among businesses in the same industry (e.g., through networks, associations, conferences, etc.)	74%
Better public awareness and public information campaigns	61%
Cooperation and exchange of information between all types of businesses (e.g. through networks, associations, conferences, etc.)	57%
Better employee and client training and awareness	56%
Partnerships between the police and businesses	56%

Section 9 below provides a summary of our interviews with insurance companies related to insurance fraud.

### 2.2.3 Insurance Fraud Definitions

There are a number ways that insurance fraud can be described or defined. In 1993, the following definition was referenced by IBC:

*“Insurance fraud is: (1) a fabricated claim perpetrated against an insurance company or agent for the purpose of financial gain; (2) the “build-up” of an otherwise legitimate claim for the purpose of financial gain; or (3) the deliberate misrepresentation of information on an insurance application for the purpose of obtaining a lower premium or to receive excessive compensation.”<sup>16</sup>*

<sup>16</sup> Insurance Fraud Literature Search/Summary of Key Findings, Shawn McKenzie, Prepared for the Insurance Bureau of Canada, 1993, page 6.

As suggested by the above definition, insurance fraud is not homogeneous. There is a wide variation in the schemes used to commit insurance fraud and, as a result, the nature of insurance fraud varies widely. Broadly speaking, insurance fraud is often grouped into the following three categories:

- Organized Fraud – Organized fraud is undertaken by a group of individuals working in concert. By working together, the group takes advantage of the insurance system in various and often multiple ways. Organized insurance fraud may involve staged (or “fake”) accidents or it may involve actual and often minor accidents with subsequent, purposeful and broad claims under various insurance coverages by one or more of individuals (some of whom may not have been involved in the claimed accident).

By its nature, organized fraud will directly impact many insurers. Organized groups spread their activities across insurers and this increases the difficulty of detection while increasing the opportunities for increasing proceeds of the crime. For example, staged accidents will target multiple insurers or similar schemes will be used against more than one insurance company at a time. As a result, organized fraud is best investigated, detected and prevented by insurance companies working in a consistent and coordinated way.

- Premeditated Fraud – Premeditated insurance fraud involves the purposeful claiming of improper insurance claim benefits by an individual (rather than a group). For example, a service provider may submit claims for damage or treatment that did not occur and/or was not provided. Premeditated fraud does not include the involvement of multiple parties that is found in organized fraud. That said, there can be some overlap between organized and premeditated fraud. For example, a body shop or other service provider may be part of organized fraud schemes and also be involved in premeditated insurance fraud.
- Opportunistic Fraud – Opportunistic fraud occurs when an individual increases or “pads” a legitimate claim. For example, a policyholder may claim for the repair of damage not caused by the accident which is the subject of the claim or may overstate the true value of some aspect of the claim (e.g., property lost). In the US, opportunistic fraud is also referred to as “buildup.” Surveys suggest that opportunistic fraud is relatively common.<sup>17</sup> However, this form of insurance fraud is generally more difficult to detect and prevent given that it generally impacts one insurer at a time, the fraudulent amounts claimed are often individually smaller, and those involved are generally not “professional” or regular offenders.

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<sup>17</sup> See Section 2.2.1



Examples of each classification of fraud are provided in Appendix C.

Variations on the above definitions of insurance fraud are used in different jurisdictions. In the US, the term “fraud” is used in many studies to relate to organized and premeditated fraud as defined above. Opportunistic fraud is called “buildup” in the US. In UK studies, “opportunistic” fraud is defined as including fabrication of claims while organized fraud only includes fraud by criminal gangs.<sup>18</sup>

Our interviews indicate that knowledgeable individuals in the insurance industry believe that each of these above defined categories of insurance fraud (opportunistic, premeditated and organized) is significant. However, it is the organized fraud category that has garnered much of the attention given the perceived growth of insurance fraud and the nature, severity and believed prevalence of organized groups committing insurance fraud. As discussed in Section 7 below, the organized fraud category was a prime focus of the three POCs.

The above three categories of insurance fraud are not unique to auto insurance fraud, Ontario or Canada. While terminology and the manner in which insurance fraud is described may vary in different jurisdictions, the core elements remain the same. Insurance fraud is a problem that affects the insurance industry broadly and deeply.

### **2.3 Relevant Insurance Organizations**

In Canada, there are approximately 210 private insurance companies (non-government-owned) that offer insurance coverage. In Manitoba, Saskatchewan and British Columbia, government-owned insurers provide mandatory auto insurance coverage. Quebec provides bodily injury insurance coverage through a government owned-insurer.<sup>19</sup>

In Ontario, there are approximately 54 insurance companies that offer auto insurance. These companies range dramatically in size with the top 10 companies accounting for approximately 72% of direct premiums in Ontario<sup>20</sup>:

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<sup>18</sup> *General Insurance Claims Fraud*, Association of British Insurers, October 2007

<sup>19</sup> [http://www.abc.ca/en/about\\_us/about\\_industry.asp](http://www.abc.ca/en/about_us/about_industry.asp)

<sup>20</sup> *Canada's Insurance and Risk Magazine*, Canadian Underwriter, 2011 Statistical Issue, June 2011



Company	Direct Auto Written Premiums in Ontario in 2010 \$'000	% of Direct Auto Premiums in Ontario %
1 Intact Financial Corporation	1,359,162	12%
2 State Farm Insurance Company	1,288,377	11%
3 TD General Insurance	1,135,372	10%
4 Aviva Canada Inc	1,012,596	9%
5 RSA Canada Group	670,859	6%
6 The Economical Insurance Group	625,616	6%
7 The Dominion Of Canada	620,384	5%
8 Co-operators General Insurance	593,333	5%
9 Desjardins General Ins Group	447,921	4%
10 Wawanesa Mutual Insurance	447,502	4%
Total	8,201,122	72%

IBC is the national industry association representing Canada's private home, car and business insurers. IBC was established in 1964 and has member companies representing 90% of the P&C insurance market in Canada.<sup>21</sup>

IBC is involved in various initiatives to address insurance fraud. IBC has partnered with numerous organizations, such as the National Insurance Crime Bureau in the US, the Canadian Police Information Center and the International Criminal Police Organization (Interpol) in various relevant initiatives.<sup>22</sup>

IBC's Investigative Services Division conducts insurance investigations through its offices in Atlantic Canada, Quebec, Ontario and Alberta. As an "investigative body," IBC is able to exchange information with insurance companies for the purpose of preventing and detecting insurance fraud. A focus of IBC's investigative efforts is organized fraud which by its nature has a tendency to affect multiple insurers. IBC also maintains a "TIPS" phone number and on-line service that the public can use to confidentially report suspected insurance crime.<sup>23</sup>

<sup>21</sup> [http://www.ibc.ca/en/about\\_us/index.asp](http://www.ibc.ca/en/about_us/index.asp)

<sup>22</sup> [http://www.ibc.ca/en/Insurance\\_Crime/Prevention\\_Investigation/Crime\\_Fighting\\_Partners.asp](http://www.ibc.ca/en/Insurance_Crime/Prevention_Investigation/Crime_Fighting_Partners.asp)

<sup>23</sup> [http://www.ibc.ca/en/Insurance\\_Crime/Report\\_Insurance\\_Crime.asp](http://www.ibc.ca/en/Insurance_Crime/Report_Insurance_Crime.asp)

In Ontario, there is sharing of some insurance data through the auspices of IBC and other bodies.<sup>24</sup> However, this data is not gathered for the purpose of investigating insurance fraud and the data available is limited in type and scope.

Outside of Canada, there are various organizations that address the issue of insurance fraud in their own jurisdictions. For example, in the US, the following organizations all play a role in insurance fraud prevention, detection and awareness:

- National Insurance Crime Bureau (“NICB”) – NICB is a not-for-profit organization that receives support from approximately 1,100 US P&C insurance companies. NICB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals.<sup>25</sup>
- Insurance Research Council (“IRC”) – IRC is an independent not-for-profit research organization supported by insurance companies and associations. IRC’s role is to collect and analyze insurance data for the purpose of providing timely and reliable information to insurers, customers and the general public.<sup>26</sup> As part of its mandate, IRC conducts research related to insurance fraud.
- Coalition Against Insurance Fraud (“CAIF”) – CAIF was founded in 1993 and it acts as an anti-fraud watchdog from the perspective of consumers, insurance companies, legislators, regulators and others. CAIF advocates for new anti-fraud laws and regulations, it educates the public on how to fight fraud, and it serves as a national clearinghouse of fraud information.<sup>27</sup>

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<sup>24</sup> For example Health Claims for Auto Insurance (“HCAI”) is an electronic system that is used for transmitting specific auto insurance claim forms between insurers and health care facilities in Ontario. In addition, Statistical Plan Data are collected as part of the General Insurance Statistical Agency (“GISA”). Data collected under GISA includes: Automobile Statistical Plan, Ontario Statutory Accident Benefits Statistical Plan and Ontario Commercial Liability Statistical Plan.

<sup>25</sup> <https://www.nicb.org/about-nicb>

<sup>26</sup> <http://www.insurance-research.org/about>

<sup>27</sup> <http://www.insurancefraud.org/aboutus.htm>



### 3 SCOPE OF REVIEW AND RESTRICTIONS

#### 3.1 Scope of Review

In preparing this report, we have reviewed various research studies, surveys, articles, books and other printed sources (see Appendix A).

In addition, we have also had discussions with representatives of the following organizations:

- Insurance Bureau of Canada
- Representatives from various insurance companies operating in Ontario and representing approximately 68% of the Ontario auto insurance market<sup>28</sup>, as follows:
  - Aviva
  - Allstate Insurance Company of Canada
  - Desjardins General Insurance Group
  - Dominion of Canada General Insurance Company
  - Intact Insurance Company
  - RBC Insurance Services Inc.
  - State Farm Insurance
  - TD Insurance
  - The Co-operators Group Limited
  - The Economical Insurance Group
- Representatives from provincial insurance companies, as follows:
  - Manitoba Public Insurance
  - Insurance Company of British Columbia

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<sup>28</sup> Based on *Insurance and Risk Magazine*, Canadian Underwriter, 2011 Statistical Issue, June 2011. The percentage of the market is measured by direct auto written premiums in 2010.



- Representatives from organizations connected with the three POCs discussed in this report:
  - CGI Group Inc.
  - Detica Limited
  - IBM Canada Ltd.
- National Insurance Crime Bureau (US)
- Insurance Research Council (US)
- Insurance Fraud Bureau (United Kingdom)
- Insurance Council of Australia
- Insurance Fraud Bureau of Australia

We also met with representatives of the Province of Ontario, the Task Force, and Ernst & Young who were retained by the Task Force.

### **3.2 Currency**

All amounts stated in this report are expressed in Canadian dollars unless otherwise noted. The translation of foreign currency into Canadian dollars has been performed using Bank of Canada's exchange rates as at April 30, 2012.

### **3.3 Restrictions**

The information and findings contained in this report are based on information that has been available to us to the date of this report. We have not carried out a financial statement audit nor have we attempted to verify the accuracy of the information used to produce our report. We reserve the right to review our comments and amend this report should additional information become available to us subsequent to the date of this report.

This report has been produced at the request of IBC and is intended for use by IBC. We understand that IBC may publicly communicate the findings of this report, that this report may be provided to and referenced by the Task Force and that this report may be otherwise distributed to assist IBC to fulfill its mandate and goals.

We will not assume any responsibility of liability for any costs, damages, losses, liabilities or expenses incurred by anyone as a result of circulation, publication, reproduction, use of



or reliance upon our report. Comments in our report are not intended, nor should they be interpreted to be, legal advice or opinion as we are not qualified to provide such advice or make such an opinion.

## 4 APPROACHES TO ESTIMATING INSURANCE FRAUD

As indicated above, we were retained to review available information in order to determine, if possible, the extent of auto insurance fraud in Ontario.

Measuring the extent of criminal activity such as insurance fraud is not a science. There is no precise or exact way to identify all such fraudulent activities or illicit transactions and the financial impact of such activities. As a result, various approaches have been used to estimate the extent of fraud and other crimes.

Of course, fraud is only proven when an individual is charged and found guilty (either through trial or a plea) of the appropriate criminal offence. However, it is our experience that many (some would say most) frauds are not discovered, investigated, charged and/or tried. This is due to many circumstances such as the fraudster's concerted efforts to conceal the crime, the nature of insurance fraud (i.e., generally a non-violent crime) and the lack of dedicated investigative and prosecutorial resources. As a result, the true extent of insurance fraud cannot be estimated by examining the amount of fraud proven by convictions.

As a result, one criticism which is often leveled against fraud estimate exercises relates to the fact the available approaches examine insurance claims that *may* be fraudulent but which do not provide unquestionable proof of the fraud. It is this lack certainty that is often seized upon by critics or skeptics to minimize the impact of insurance fraud estimates.

The following provides general approaches used to provide some estimates of criminal activity, including in some cases insurance fraud.

### 4.1 Individual Opinions

Opinions of individuals have been used as one basis for, or input into, insurance fraud estimates. These opinions are often obtained through surveys and targeted interviews.

#### 4.1.1 Public Opinion Surveys

Public opinion surveys are often conducted to obtain evidence of the existence, prevalence and extent of specific activities related to insurance use and claims.

Various surveys related to insurance fraud issues have been conducted in Canada, the US and elsewhere to collect public opinion information on critical issues that may be useful to insurance companies, regulators, and the general public. These surveys provide a useful perspective at a point in time in respect of various insurance fraud issues.

The following are examples of issues explored through targeted surveys: public attitudes on what is deemed acceptable in terms types of insurance fraud; whether certain situations, such as receiving poor service from the insurance company, are more likely to result in people committing insurance fraud; and whether consumers would be likely to report fraud if they witnessed an occurrence.

However, surveys related to the frequency of fraudulent behaviour or the amount of insurance fraud are likely to have limited usefulness in assessing the extent of insurance fraud. Generally such surveys are tainted by the requirement of individuals to self-report improper behaviour or by reporting of non-direct involvement with questionable activities (e.g., have you known anyone to commit insurance fraud or do you believe insurance fraud is common). Also, surveys generally lack the detail or specificity required to meaningful allow for financial analysis.

#### **4.1.2 Interviews**

The opinions and views of individuals knowledgeable about insurance fraud are also considered in some estimates of the extent of insurance fraud. Such knowledge may be gained from work experience in the insurance industry (in roles such as investigators, claims adjustors, etc.) or through research projects. In any event, as with surveys, information from this source is generally not detailed or specific and limits the depth of possible analysis. Also, anecdotal information may receive undue emphasis and weighting in interview situations.

## **4.2 Economic Approaches**

Economic approaches can be employed to hypothesize and draw conclusions regarding the extent of fraud and other crimes. Broad economic approaches are usefully applied when there is some benchmark that can be used to establish a norm against which changes are indicative of some other activity or behaviour. Such approaches have been used, for example, to estimate the extent of tobacco smuggling in Canada.

With such economic approaches, changes across periods of time or differences between jurisdictions require an examination for the reasons of noted variations. Many factors can lead to changes in observed trends and many of these factors will have no relationship to improper behaviour or fraud. For example, structural changes in insurance benefits, claims processes, driver licence requirements, etc. can all affect claims statistics and trends. Also, differences between insurance regimes across jurisdictions affect the comparability of cross-border insurance information and trends.



For these and other reasons, the usefulness of broad economic approaches to quantify the extent of insurance fraud is limited. Economic approaches can be used to demonstrate trends of claims and other insurance information, but in our view, the use of such analysis to comment on the quantum of fraudulent claims is limited.<sup>29</sup>

We have provided an overview of auto claims trends in Section 5 below.

In the UK, recent estimates of P&C insurance fraud have both relied on survey, interviews and literature reviews as well as economic and statistical modeling.<sup>30</sup> The statistical modeling approach relied on information related to detected insurance fraud (in the 2007 UK approach) and estimates by individual insurers of total fraud risk in comparison to actual fraud detection rates (in the 2009 UK approach).<sup>31</sup> These approaches are not possible in Canada given the nature of data required and the data actually collected and available.

#### **4.3 Closed Claim Studies**

Insurance companies have a wealth of information about each claim filed and each policyholder who made a claim. As a result, a common approach used to estimate the extent and nature of insurance fraud has been to conduct a review of completed (or closed) claims.

In a closed claim review, the files of selected claims are examined to ascertain if the available information provides any indications of potential fraud. Closed claims reviews rely on trained file reviewers to evaluate each claim. A questionnaire is designed which highlights whether and to what extent indicators of potential fraudulent activity exist within the file documentation. The questionnaire is completed for each claim reviewed and is used to identify whether the claim contains indicators of fraud.

Based upon the number and nature of the noted fraud indicators, the claim will be appropriately classified with respect to potential fraud. Some of the factors that are considered in a closed claim questionnaire may include: nature and extent of property damage, claim and accident circumstances, geographic location, injuries reported, treatment

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<sup>29</sup> It is interesting to note that the conclusion on the limitations of economic analysis was noted in a report almost 20 years ago: *“There is a shortage of statistical information pertaining to insurance fraud which has inhibited the use of quantitative measurement techniques to this point.”* (Insurance Fraud Literature Search/Summary of Key Findings, Shawn McKenzie, prepared for IBC, 1993, page 8)

<sup>30</sup> *General Insurance Claims Fraud*, Association of British Insurers, October 2007 and *General Insurance Claims Fraud*, Association of British Insurers, July 2009.

<sup>31</sup> Detailed technical explanations of the UK modeling approaches are provided in the referenced reports.

required, diagnostic procedures used, professionals involved in providing treatment and providing advice, claimed losses, and total payments.

This approach is usually applied to a statistically valid sample of claims across many insurance companies. The results are then analyzed and extrapolated to arrive at a conclusion of the extent of the estimated insurance fraud. Well designed closed claim reviews incorporate qualified and trained reviewers, a robust questionnaire, strong quality control and review, and a properly selected sample.

The closed claims study approach uses information on completed claims to reassess whether, in hindsight, and with the benefit of a targeted questionnaire and process, there is an indication of potential insurance fraud. The quality of results from this approach is a function of the sample selected, quality and diligence of the reviewers, the questionnaire used and the overall process followed. The granularity of the review and the selection of a statistically valid sample results in a more supportable process and reliable results.

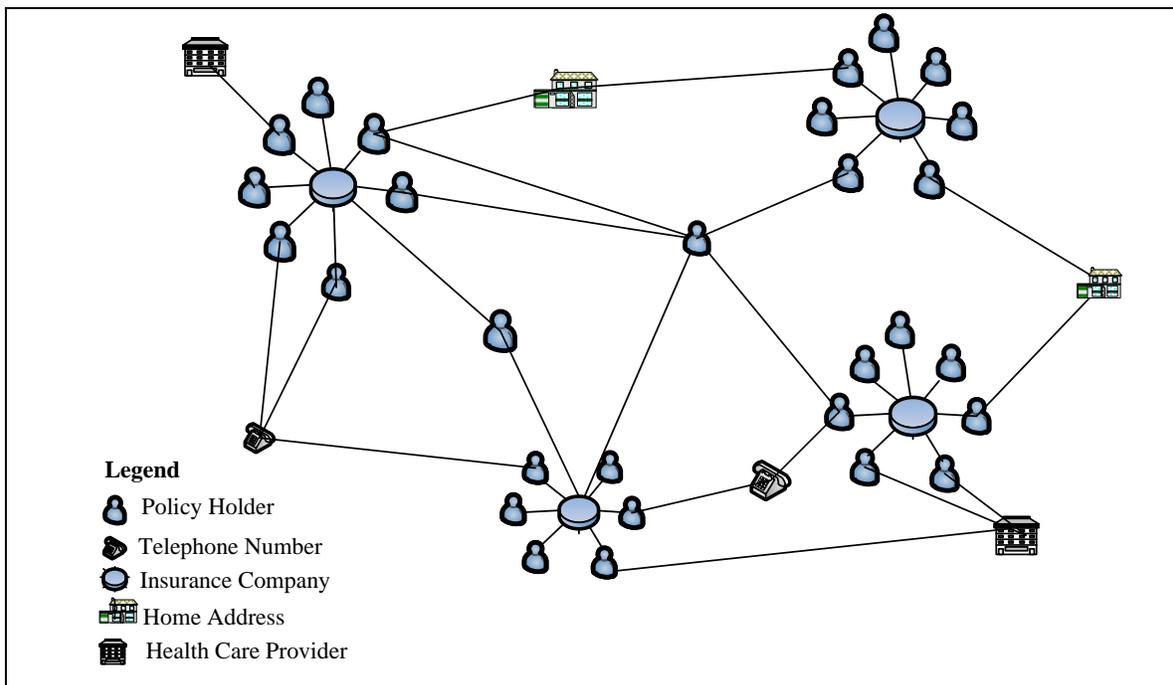
This approach has been used in Canada and the US to provide an estimate of the extent of fraud (see Section 6 below).

#### **4.4 Data Analytic Approaches**

The analysis of significant volumes of data maintained in electronic form is called “data analytics.” The ability to conduct meaningful data analytics generally, and the use of such techniques has increased dramatically in the last several years. There has been a large increase in the number and sophistication of tools available to conduct meaningful data analysis of insurance claims information. When combined with the significant and growing insurance claims data that is maintained in electronic form, the power of data analytics to assist with insurance fraud analyses is now well recognized.

In simple terms, data analytics provides the ability to troll through an entire database of claims data to identify patterns and specific attributes that are associated with fraudulent activities. Sophisticated computer programs consistently look for, identify, categorize and summarize indicators or hallmarks of suspicious claims. The obvious advantage of this process is that instead of relying on a sample of claims (statistically selected or otherwise), the entire record of all claims is accessed and evaluated. Data analytic programs also bring consistency of review to the process (compared to multiple human reviewers with varying experiences, attention levels and interpretation of information). Of course, such approaches are limited to data that is in electronic form and accessible (e.g., claims adjuster notes may not be in a form that allows inclusion within a data analytic approach).

Data analytic programs generally provide relationship mapping capabilities whereby connections between those involved with claims are identified. This facility allows for the identification of linkages between claims that otherwise would not be noted. For example, connections between claimants by way of common names, addresses, postal codes, phone numbers, etc. provide data of interest. Similarly service providers connected with multiple claims or claimants can be noted. Relationship analysis provides a powerful tool to identify organized groups of interest and this is important for obvious reasons when identifying organized fraud schemes and affected claims. The following chart illustrates an example of data relationship mapping<sup>32</sup>:



The benefits of data analytics expands as the pool of available data grows. By using data analytic approaches using information from numerous insurance companies, patterns and relationships between claims filed with various insurers can be identified and assessed. Similarly, data that includes claims from different insurance lines of business (e.g., auto, personal, commercial, property, etc.) expands the data pool and increases the power of the data analytic process. This approach recognizes the obvious reality that fraudsters do not necessarily target a single company or product line and that similar fraud schemes are purposefully used against multiple companies or product lines. This benefit is especially pertinent with respect to organized and premeditated insurance fraud.

<sup>32</sup> The relationship chart shown is illustrative.



The recognition of the benefits of data analytics is growing amongst insurance companies in Canada.<sup>33</sup> Each of the three POCs discussed in this report (see Section 7 below) use data analytic tools to analyze specific sets of data.

Data analytics can provide some basis for examining the extent of insurance fraud by examining historical closed claims on a broad basis. However, this is not the reason insurance organizations make an investment in data analytic tools. The information developed from data analytics is best used to provide a real time tool to identify claims with the greatest risk of fraud. In this way, an insurance company can focus its claims adjusting and investigative resources on those claims that are most likely to contain some form of claim inflation or fraud. The obvious goal is to avoid paying claims that are fraudulent or otherwise overstated. In addition, data analytic information can assist insurance companies identify risks that can be considered at the underwriting stage of the insurance process.

With respect to attempting to quantify the extent of insurance fraud, data analytic approaches provide some assistance. However, while there are advantages of data analytics over a closed claim review process (e.g., more and broader data reviewed on a consistent basis and the elimination of human error and potential bias), some of the issues related to closed claims reviews remain. For example, while data analytics identifies patterns indicative of claims fraud it does not prove that a claim is in fact fraudulent. Inevitably, there will be claims that include indicators of fraud that are not fraudulent (false positives) and claims that are in fact fraudulent that are not flagged as such (false negatives).

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<sup>33</sup> Our interviews with Canadian insurance companies indicated that some Canadian P&C insurance companies currently use data analytics in their claims analysis. In our interviews, we noted that of the ten Ontario auto insurers we spoke with, two companies currently use data analytic tools and one company is developing that capability (not including insurance companies involved in the data analytic POCs). Data analytics is also used by insurance companies in other countries. For example, insurance companies in the US and the UK use data analytics in their operations. Even in 2001, “specialized computer software” was used by 15% of US insurance companies to detect fraudulent insurance claims (*Fighting Insurance Fraud, Survey of Insurer Anti-Fraud Efforts*, Insurance Research Council, December 2001, Page 20).



## 5 OVERVIEW OF FINANCIAL TRENDS

As discussed in Section 4 above, in our view economic analysis and financial trends are not of great assistance to reasonably quantify the extent of auto insurance fraud in Ontario. That said, such information does provide some useful context to understand trends and the environment in which insurance fraud is occurring. Also, such economic analysis when combined with anecdotal and other information, provides interesting indications that suggest a growing trend in insurance fraud in Ontario.

The following provides some overview information to assist with demonstrating financial trends and other related information. We have purposefully limited the extent of information presented in this section.<sup>34</sup>

### 5.1 Auto Insurance Claims Trends in Ontario

There have been significant changes in the trends of auto insurance claims in Ontario in the past ten years. The number of auto insurance claims has declined by 28% from 812,800 claims in 2001 to 583,700 claims in 2010. At the same time, the average value of auto claims has increased by 135% from \$6,370 per claim in 2001 to \$14,970 per claim in 2010. With respect to accident benefit claims in Ontario, the average claim value has increased by 174% from \$20,460 per claim in 2001 to \$56,090 per claim in 2010.<sup>35</sup>

#### 5.1.1 Ontario Compared to the Rest of Canada

The profile of auto insurance claims in Ontario is very different from that of other Canadian provinces both with respect to the volume of claims as well as the average amount claimed. The following table summarizes the changes in certain relevant metrics between 2001 and 2010 in the provinces not served by a provincial insurer:

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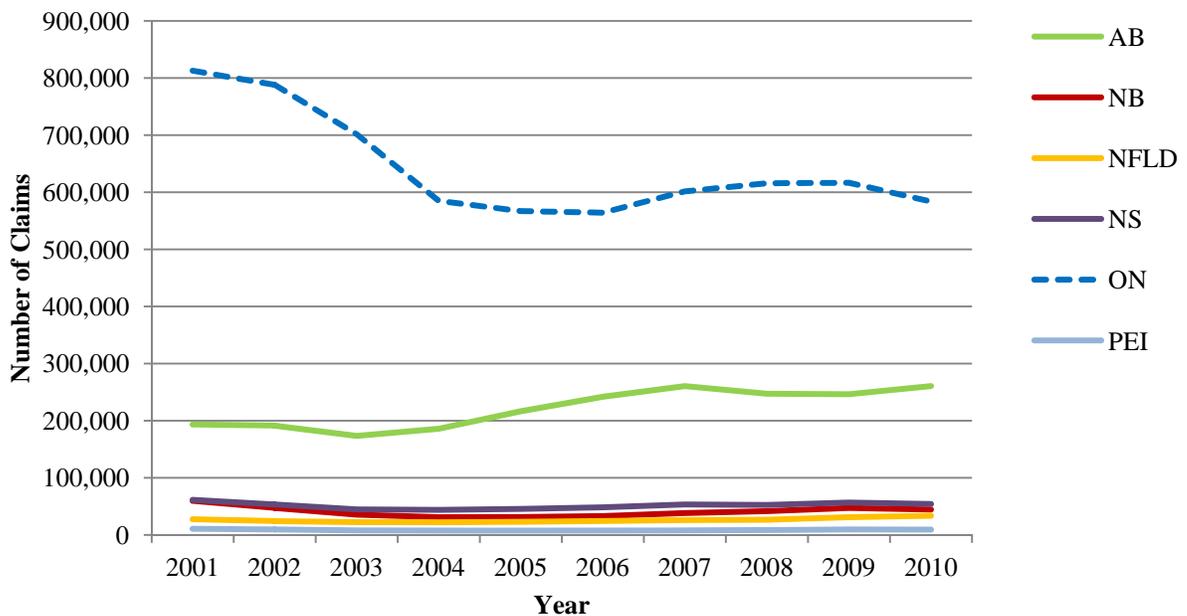
<sup>34</sup> The insurance industry maintains significant statistical information. We have not performed an extensive analysis of the available data to study broad trends and developments.

<sup>35</sup> The rate of overall inflation in Canada during from 2001 to 2010 was 19% (based on the change in the Consumer Price Index) and the overall increase in Total Health Expenditure in Ontario from 2001 to 2010 was 81% (based on National Health Expenditure Trends Data Tables from Canadian Institute for Health Information, <http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001>)

Province	Percentage Change Between 2001 and 2010			
	Change in Number of Auto Claims	Change in Value of Average Auto Claim	Change in Value of Average Accident Benefit Claim	Change in Value of Average Bodily Injury Claim
Ontario	-28%	135%	174%	20%
Alberta	35%	7%	13%	-20%
New Brunswick	-25%	-5%	28%	-17%
Newfoundland	23%	15%	93%	62%
Nova Scotia	-11%	-6%	25%	-22%
Prince Edward Island	-11%	15%	74%	43%

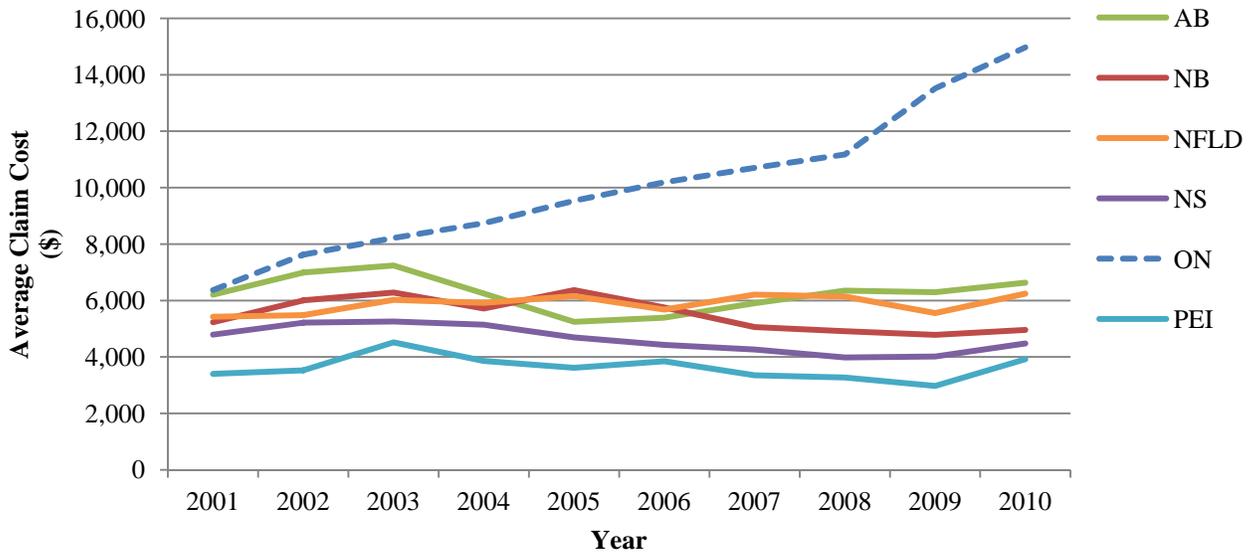
The following graphs compare various auto insurance metrics each year between 2001 and 2010 for Ontario and the other provinces served by private insurance companies.<sup>36</sup>

**Total Number of Auto Claims by Province**

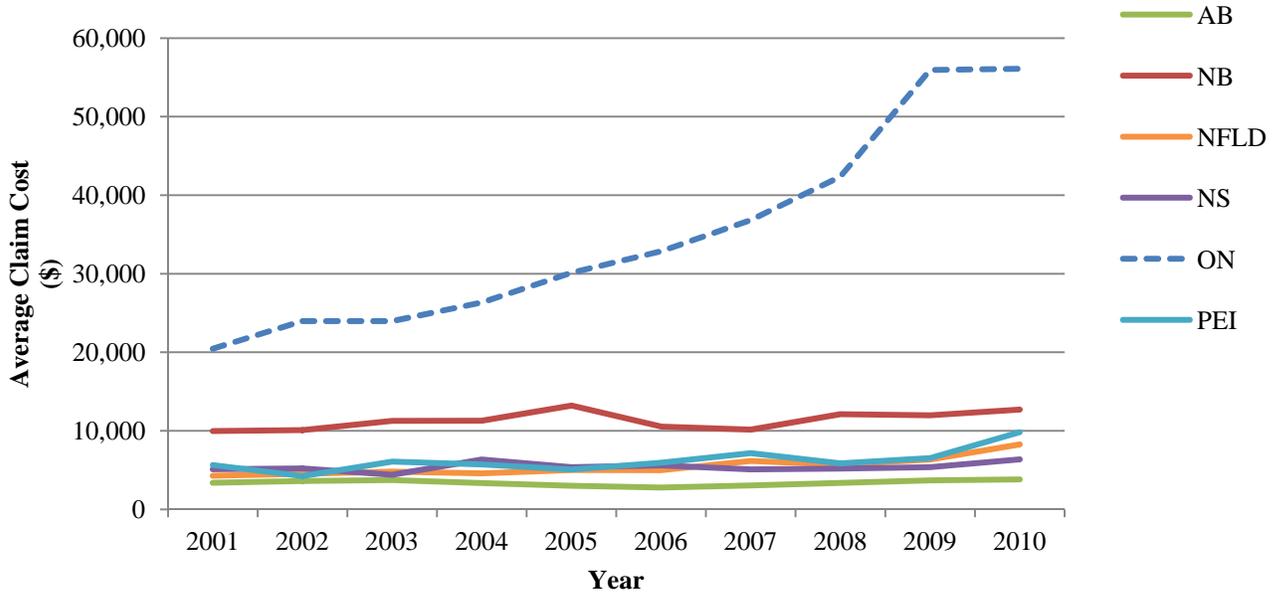


<sup>36</sup> The charts do not include British Columbia, Saskatchewan, Manitoba and Quebec.

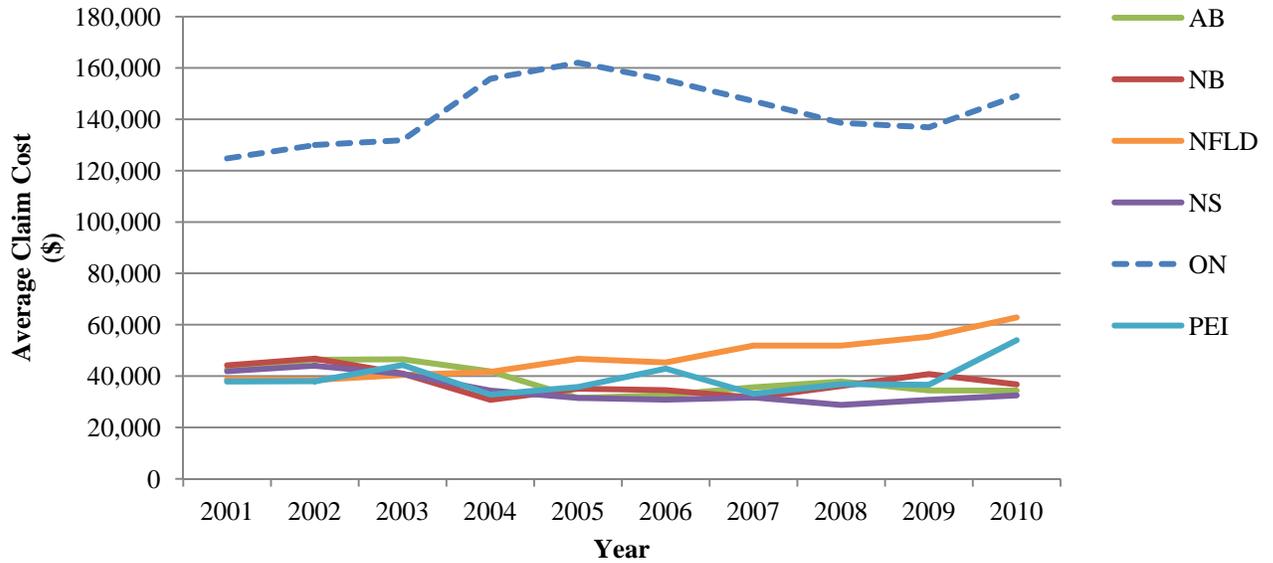
### Average Auto Claim Cost by Province - Total



### Average Auto Claim Cost by Province - Accident Benefits



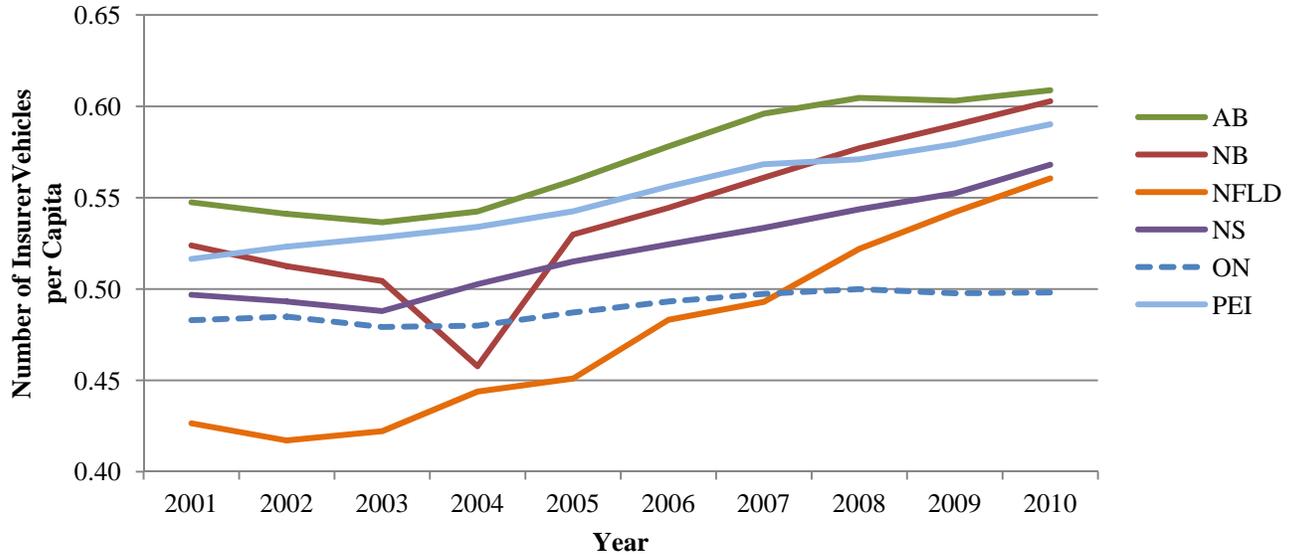
### Average Auto Claim Cost by Province - Bolidy Injury



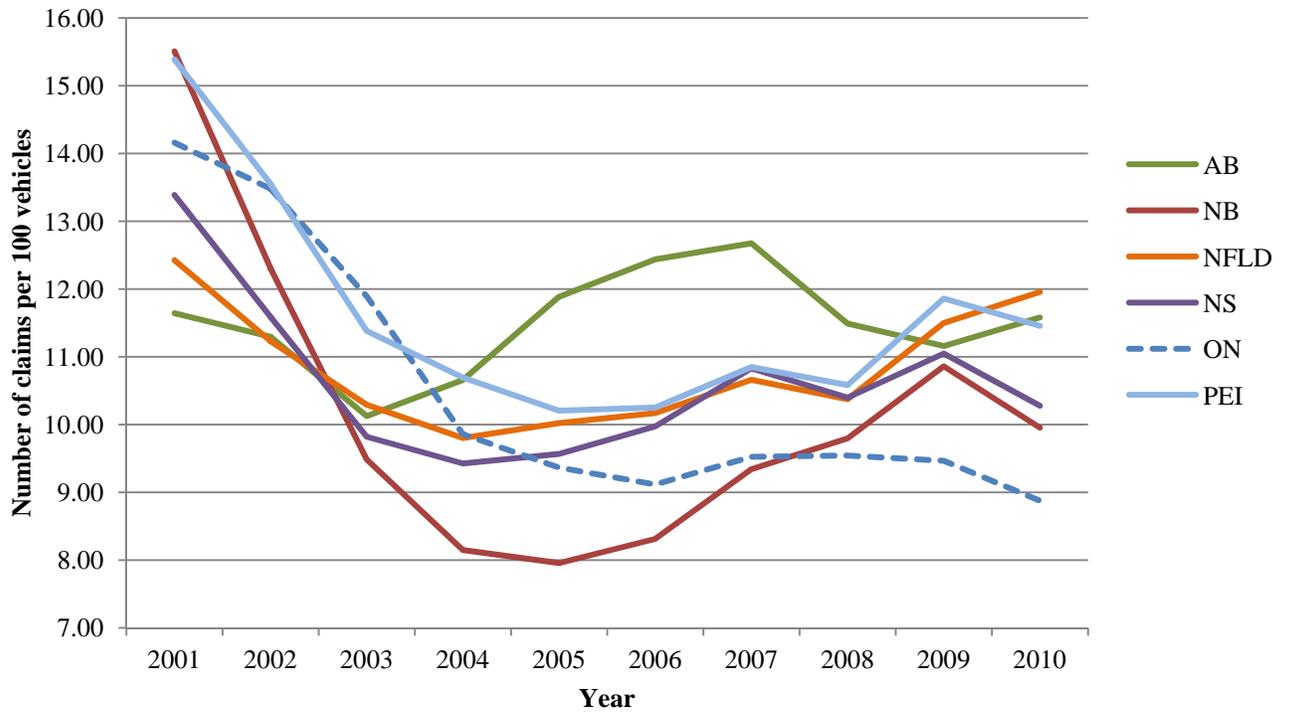
The above charts clearly demonstrate the dichotomy in Ontario between falling claims numbers and rising costs of claims. The charts also illustrate the marked differences between Ontario and the other provinces in respect of the average size and trend in claims.

The following graphs provide additional relevant comparisons related to the number of insured vehicles, claim frequency and cost each year between 2001 and 2010 for Ontario and the other provinces served by private insurance companies.

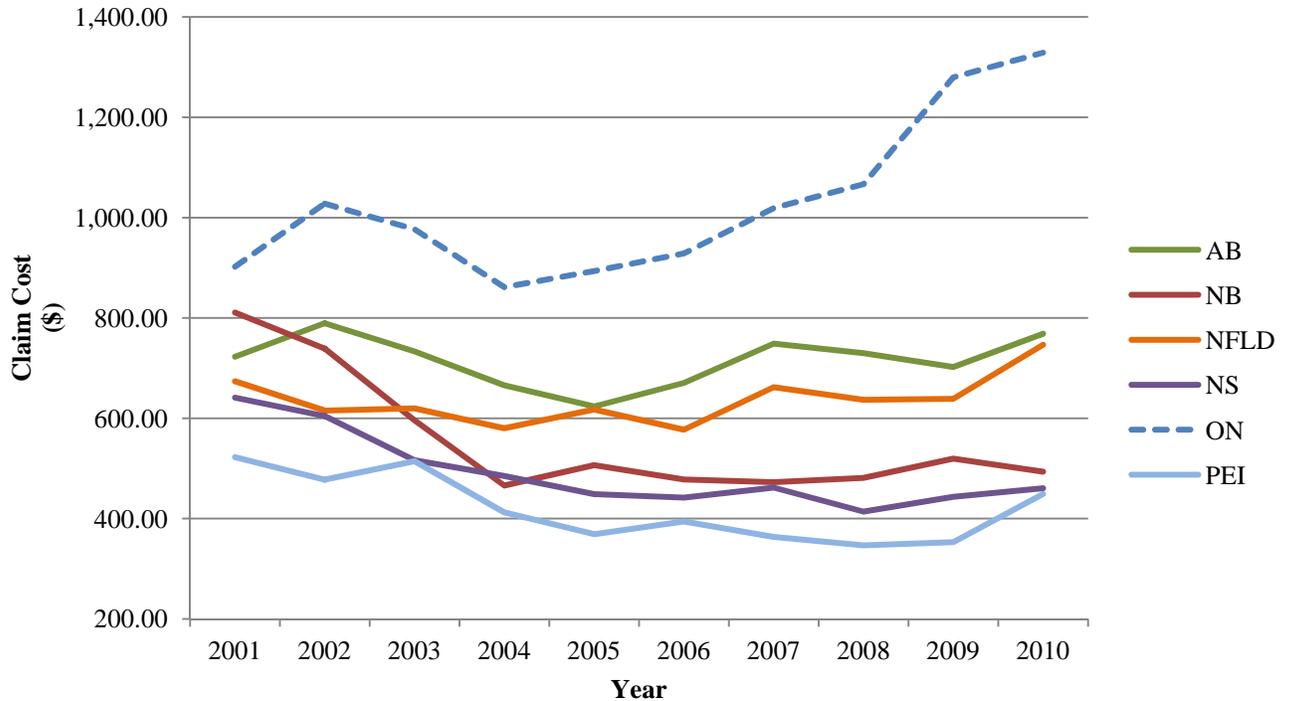
**Number of Insured Vehicles Per Capita by Province**



**Number of claims per Hundred Insured Vehicles**



### Claim Cost Per Insured Vehicle



The above graphs clearly show that on a consistent basis the number of claims in Ontario is relatively low compared to other provinces but that claim costs per vehicle are much higher. This further illustrates that while claim frequency is declining in Ontario, claim cost per vehicle is highest when compared to other provinces and has been increasing at a significant rate. Also, these charts show that the gap in average claim costs between Ontario and the other provinces is rapidly increasing.

To try and fully explain the indicated trends, it would be necessary to undertake a comparative analysis of the various insurance regimes, insurance benefits and other factors. Such an analysis is outside of the scope of this study. That said, the statistical information is consistent with the views we heard from insurance companies that insurance fraud is a particular and serious issue for Ontario and one that costs all stakeholders (including the public at large) significant amounts.



### 5.1.2 Trends Within Ontario

Within Ontario, the profile of auto insurance claims is very different between Metropolitan Toronto and Surrounding Areas<sup>37</sup> and the rest of Ontario<sup>38</sup> both with respect to the volume of claims as well as the average amount claimed. The following table summarizes the changes in certain metrics between 2001 and 2010 in Ontario:

	Percentage Change Between 2001 and 2010			
	Change in Number of Auto Claims	Change in Value of Average Auto Claim	Change in Value of Average Accident Benefit Claim	Change in Value of Average Bodily Injury Claim
Metropolitan Toronto and Surrounding Areas	-29%	188%	241%	11%
Rest of Ontario	-26%	99%	114%	35%

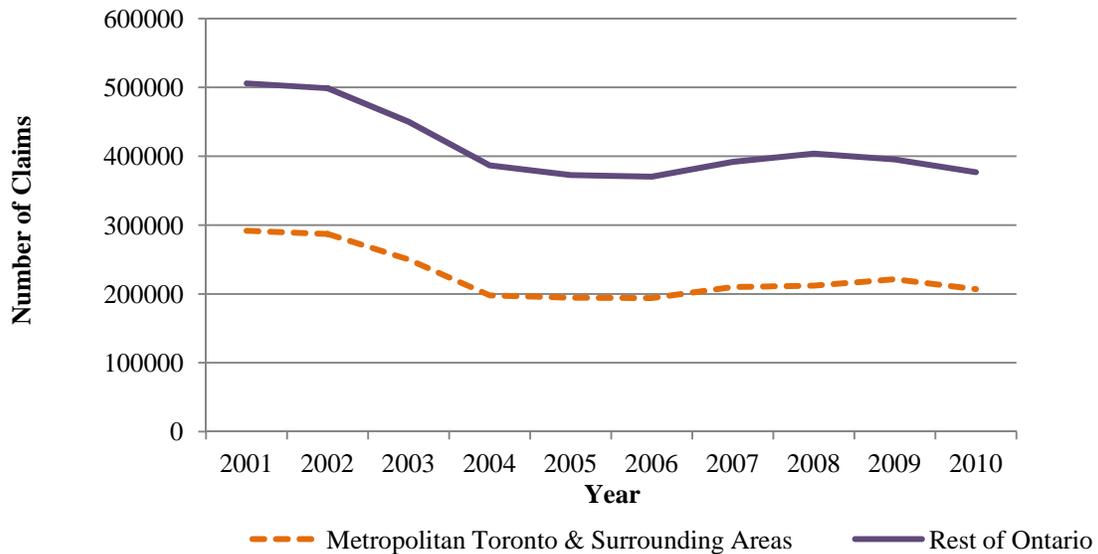
Therefore, notwithstanding that the number of claims has decreased at a consistent rate right across Ontario, the total cost of those claims has increased at twice the rate in Toronto compared to the rest of the province. This disparity between the relative increases in the average cost of claims is even more significant when no-fault claims are considered.

The following graphs compare various auto insurance metrics each year between 2001 and 2010 for Metropolitan Toronto and Surrounding Areas and rest of Ontario.

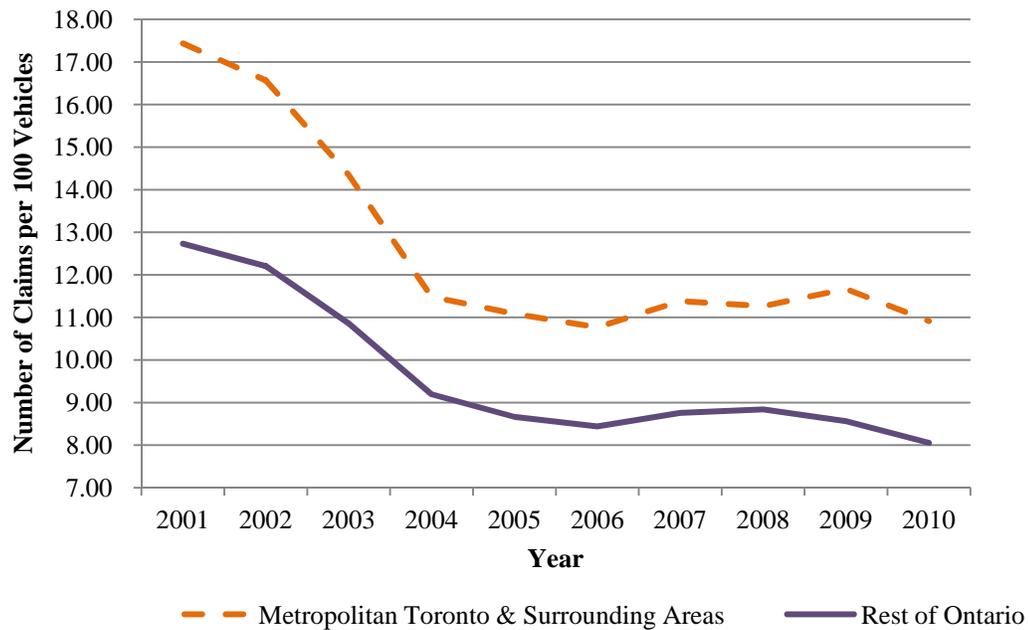
<sup>37</sup> Surrounding areas include Markham, Richmond Hill and Vaughan.

<sup>38</sup> Rest of Ontario amounts are calculated by taking Ontario figures as a whole and deducting the Metropolitan Toronto and Surrounding Areas statistics. The source of the statistics is GISA Territorial Exhibit Including Third Party Liability Large Losses, Table AU30.

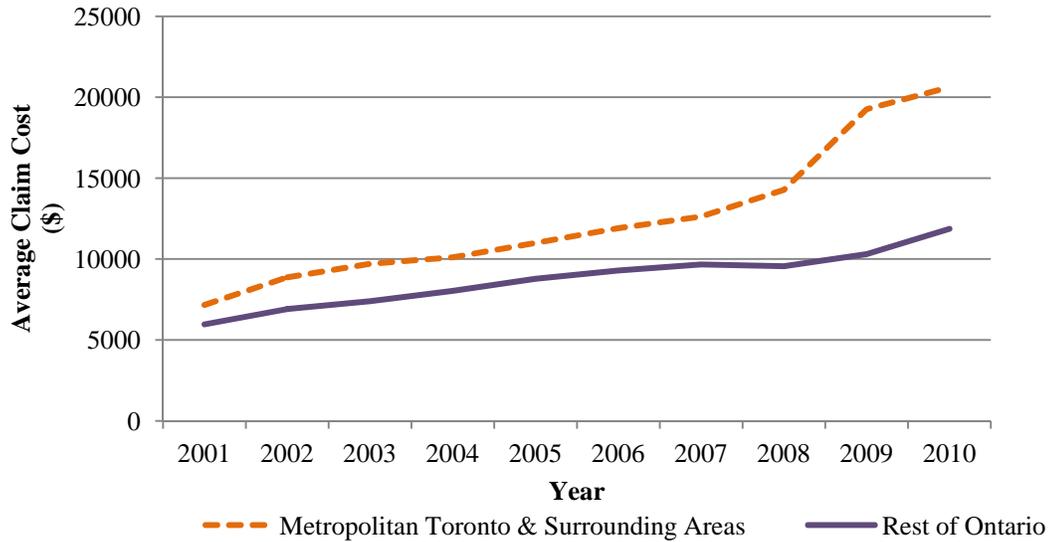
### Total Number of Auto Claims Metropolitan Toronto & Surrounding Areas versus Ontario



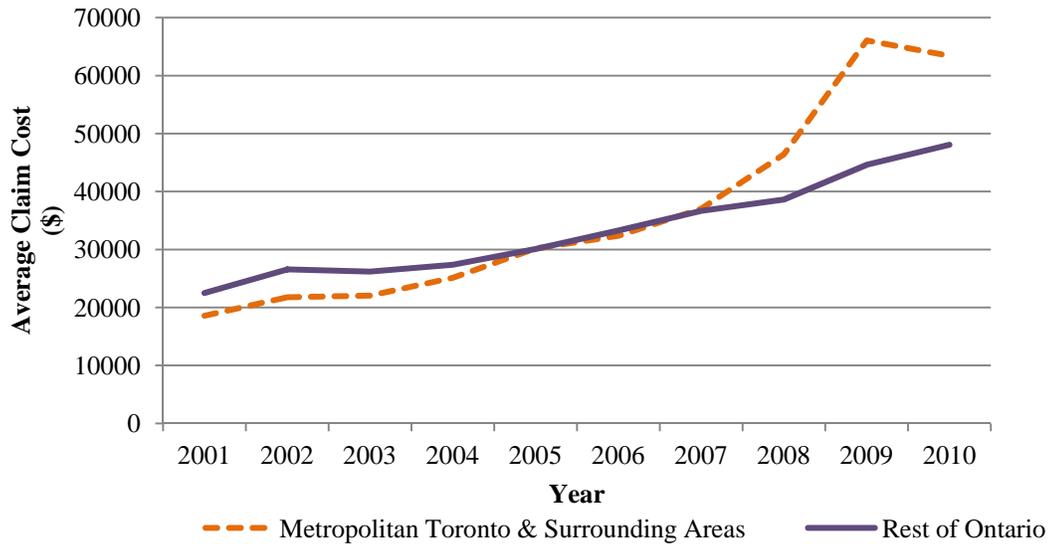
### Number of Claims Per Hundred Vehicles Metropolitan Toronto & Surrounding Areas versus Ontario



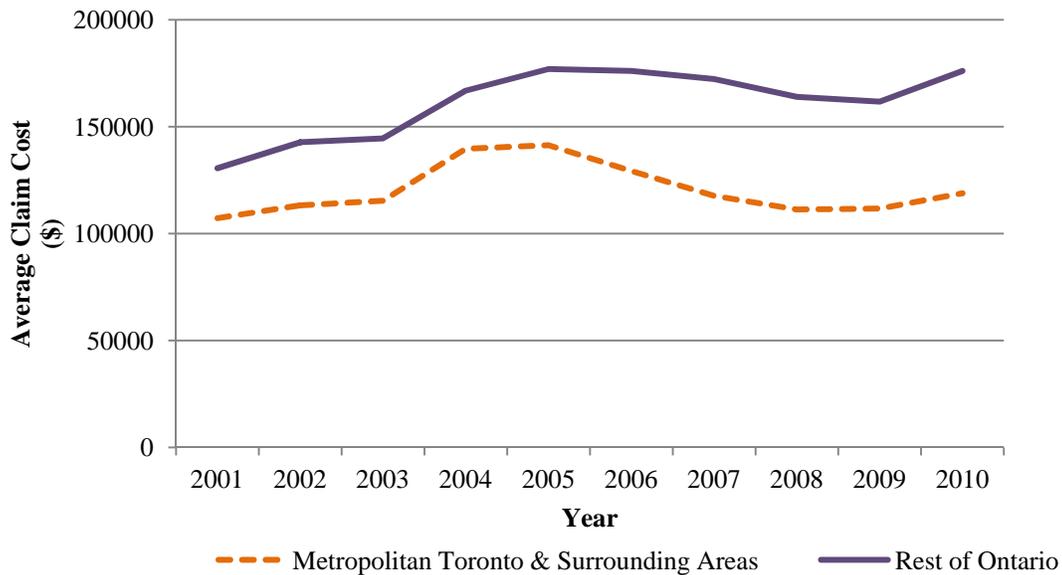
### Average Auto Claim Cost Metropolitan Toronto & Surrounding Areas versus Ontario



### Average Auto Claim Cost - Accident Benefits Metropolitan Toronto & Surrounding Areas versus Ontario



### Average Auto Claim Cost - Bodily Injury Metropolitan Toronto & Surrounding Areas versus Ontario



The above charts illustrate the following:

- The total number of auto claims has declined in both Toronto and rest of the province between 2001 and 2010.
- The number of claims per 100 vehicles has remained persistently more than 30% higher in Toronto than in the rest of Ontario.
- The increase in the average cost of accident benefit claims has accelerated in the Toronto area since 2008. Prior to 2008, the average cost of accident benefit claims in Toronto was about the same or slightly less than those of the rest of the province. By 2010, accident benefit claims in Toronto were, on average, \$63,400 or 32% greater than in the rest of the province. In addition, in 2010, there were 2.2 accident benefit claims for every 100 vehicles in Toronto while in the rest of Ontario, there were only 0.8 accident benefit claims for every 100 vehicles. Therefore, in 2010, the accident benefit claims frequency was 172% higher in Toronto than in the rest of the province.
- The average amount of bodily injury claims has been consistently greater outside of Toronto between 2001 and 2010. However, the relative number of bodily injury claims



in 2010 is more than double in Toronto compared to the rest of Ontario.<sup>39</sup> Therefore, while the value of each bodily injury claim is, on average, lower in Toronto, the likelihood of a bodily injury claim occurring in Toronto is twice that of elsewhere in Ontario.

As with the comparison between Ontario and the other provinces, the above noted trends between Toronto and the rest of Ontario may find an explanation, at least in part, through insurance fraud. This would be consistent with what we heard from discussions with representatives of insurers (i.e., claims fraud was found to be more of a problem in Toronto than in the rest of the province). A higher incidence of insurance fraud activity in Toronto would also be consistent with the findings of a US study that examined auto insurance in New York City compared to the rest of New York State (see Section 6.2.2 below).

## **5.2 IBC “TIPS” Program**

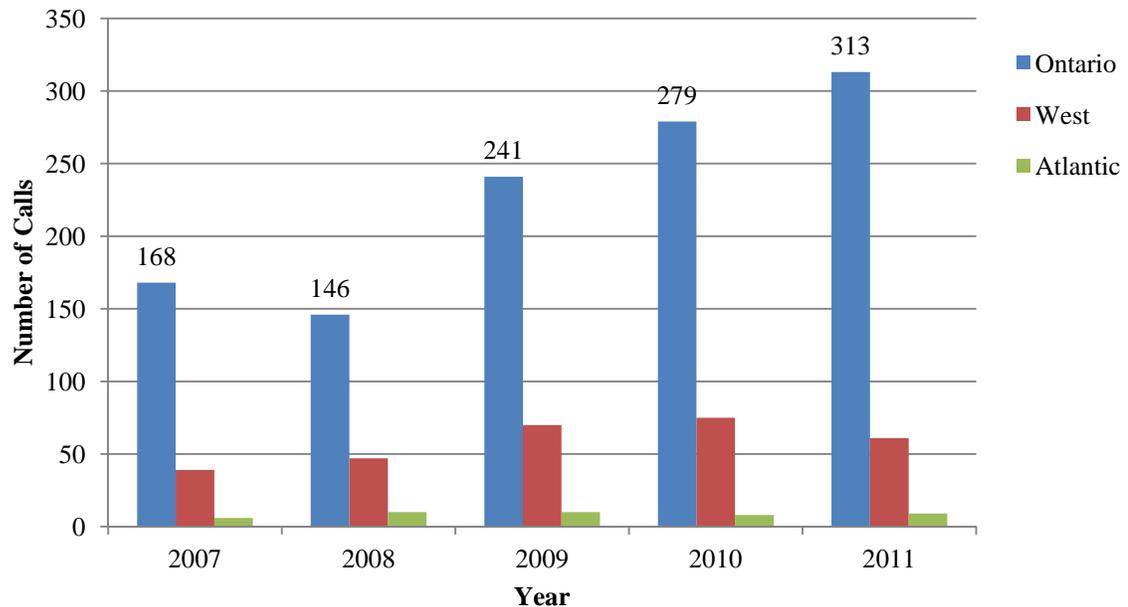
As indicated above, IBC’s “TIPS” program allows the public to submit information relating to suspected insurance crimes through a confidential phone number or online. When a tip is received it is checked against IBC databases for claims and history. Once an insurer is connected with the tip, it is sent to the insurer electronically. Based on feedback from insurers who receive the tips, about 23% of tips received generally relate to suspected organized insurance crime.

The following chart summarizes call activity received through the Tips program over the past few years, broken out by region:

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<sup>39</sup> In 2010, the number of bodily injury claims per 100 vehicles was 0.33 in Toronto while in the rest of the province, the number of bodily injury claims per 100 vehicles was 0.15. Therefore, the relative number of bodily injury claims was 120% higher in Toronto than in the rest of the province.

### IBC Tips Line Program Number of Calls Received



From this data, the number of tips in Ontario (related to all insurance and not just auto claims) has increased by 86% between 2007 and 2011 and there has been a fairly consistent increase each year since 2008. By comparison, the increase in the number of tips from 2007 to 2011 was 56% in the West and 50% in the Atlantic region.

The indicated trend of insurance crime tips in Ontario is at odds with the relatively stable number of auto claims in Ontario after 2006. However, the number of tips is consistent with the increasing average value of auto claims in Ontario. This is suggestive of increased suspicious or fraudulent auto insurance claims activity in Ontario compared to other regions.



## 6 CLOSED CLAIM FILE REVIEWS

As discussed in Section 4 above, closed claims file reviews can be used to provide an indication of the extent of insurance fraud. In Canada, larger closed claim reviews are rare. In the US, such studies are performed and reported on relatively regularly.

### 6.1 Closed Claim Reviews in Canada

We are aware of two larger closed claim studies in Canada. These were performed in 1992 and 2001.

#### 6.1.1 1992 Closed Claims Study

In 1992, IBC undertook its first closed claim review by examining personal lines claims from across Canada which were closed in 1992. The study was based upon claims files from five insurers accounting for 17% of the private P&C insurance market in Canada. Based upon the results of this study, which included 491 files, it was indicated that 15% of personal line claims in 1992 included signs of apparent fraud. This suggested a total estimated claims fraud potential of \$1.3 billion for 1992 for the Canadian-wide P&C industry.<sup>40</sup>

This study included both auto and property claims and when segregated between these two broad categories, approximately 10% of the auto claims were found to be “suspect” with indicators of potential fraud.<sup>41</sup>

The following provides the available regional information of the results of this review:

Region	Number of Files Reviewed	Number of Suspect Files	% of Files Classified as “Suspect”
East	82	10	12.2%
Quebec	35	3	8.6%
Ontario	298	53	17.8%
West	76	13	17.1%
Total	491	79	16.0%

<sup>40</sup> *Initial Estimates of Property and Casualty Insurance Fraud in Canada, Evidence from a Review of Closed Claims Files*, Insurance Bureau of Canada, September 1993.

<sup>41</sup> 23% of the property line claims were found to be suspect.

The closed claim report clearly indicated that the suspect claims were heavily weighted to theft and property damage claims. It was hypothesized in the report that the claims selection process may have under-represented personal injury claims. As indicated in Section 6.1.2 below, the 2001 closed claims study focused on personal injury claims.

The report's conclusion stated that the closed claim review process was a "workable and promising approach to estimating the cost of insurance fraud."

### **6.1.2 2001 Closed Claims Study**

In 2001, a study was conducted by the Canadian Coalition against Insurance Fraud<sup>42</sup> ("CCAIF") for the purpose of determining the role of fraud in personal injury auto claims. This study was larger and more focused than the 1992 study discussed above. More companies representing a larger portion of the Canadian P&C industry were involved and the study was centred on personal injury claims.

Companies representing more than 60% of the Canadian P&C insurance market participated in the study and 4,066 closed claims files were reviewed. Claims files were provided for Accident Benefit ("AB") and Bodily Injury ("BI") claims for four regions in Canada: Atlantic Canada; Ontario; the Prairies (Manitoba and Saskatchewan) and Alberta.<sup>43</sup>

As noted in the study, "*according to the claims experts who reviewed the closed claim files (n=4,066), 33.6% of all AB claims and 25.6% of all BI claims involve premeditated or opportunistic fraud.*"<sup>44</sup> The study also found, "*the total cost to private insurers of AB and BI fraud is estimated to be 15% to 22% of all paid losses or as high as \$430 million. For government and private insurers combined, the cost could be as high as \$540 million.*" The study also found differences between regions, with the number and dollar amounts of claims being highest in Ontario and lowest in Alberta.

Furthermore, the study showed that for both AB and BI claims, the incidence and frequency of both premeditated and opportunistic fraud was highest in large cities and suburbs and lowest in small towns and rural areas across the provinces covered in the study. For AB

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<sup>42</sup> The Canadian Coalition against Insurance Fraud was created in 1994 to decrease insurance fraud through a variety of initiatives including public awareness, improved business practices, and legislative and regulatory changes. Members included private insurance companies, consumer advocacy groups, and public auto insurers. <http://www.insurance-canada.ca/claims/canada/CCAIF200110.php>

<sup>43</sup> *Premeditated and Opportunistic Fraud in Personal Injury Claims*, Hynes, T., MacAulay, K., Mahaffey, T., Wright, B, 2001.

<sup>44</sup> The 2001 closed claims study did not reference "organized fraud" and it appears that organized and premeditated fraud were considered together in this study.



claims in Ontario, it was found that the fraud rate for both premeditated and opportunistic fraud declined with decreasing urbanization. For BI claims, the rate of premeditated fraud declined with decreasing urbanization while opportunistic fraud, the rate is approximately equal for all locations.

The charts below summarize the estimated percentage of payment that contained elements of fraud with respect to Accident Benefit (“AB”) claims reviewed, and Bodily Injury (“BI”) claims reviewed.

***1. Accident Benefits Claims***

Fraud Assessment	Amount of Total Claim \$	% of Total Paid Losses %	Percentage Excessive		Excess as a Percentage of Total Losses Paid	
			Low	High	Low	High
			%	%	%	%
Staged accident	262,515	1.0	100	100	1.0	1.0
Caused accident	120,968	0.4	100	100	0.4	0.4
Fictitious injury	1,468,256	5.4	80	100	4.3	5.4
Other types of premeditated fraud	2,321,231	8.5	40	80	3.4	6.8
Opportunistic fraud only	7,631,522	27.9	25	40	7.0	11.2
Fully legitimate claims	15,505,068	56.8	-	-	-	-
<b>Total</b>	<b>27,309,560</b>	<b>100.0</b>			<b>16.1</b>	<b>24.8</b>



## 2. Bodily Injury Claims

Fraud Assessment	Amount of Total Claim \$	% of Total Paid Losses %	Percentage Excessive		Excess as a Percentage of Total Losses Paid	
			Low	High	Low	High
			%	%	%	%
Staged accident	103,354	0.3	100	100	0.3	0.3
Caused accident	132,021	0.3	100	100	0.3	0.3
Fictitious injury	1,778,714	4.5	80	100	3.6	4.5
Other types of premeditated fraud	2,298,879	5.8	40	80	2.3	4.6
Opportunistic fraud only	6,847,105	17.2	25	40	4.3	6.9
Fully legitimate	28,547,893	71.9	-	-	-	-
<b>Total</b>	<b>39,707,966</b>	<b>100.0</b>			<b>10.8</b>	<b>16.6</b>

The study concluded that the cost of AB and BI fraud was between 15% and 22% of all paid losses and that the estimated cost to government and private P&C insurers was as high as \$540 million.<sup>45</sup>

This study also provided results specific to the four Canadian regions that participated in the study (Atlantic Canada, Ontario, the Prairies and Alberta). For Ontario, 670 Accident Benefit and 415 Bodily Injury auto claims were reviewed. The study concluded that 37% of all auto claims in Ontario contain elements of fraud, and it was estimated that the combined total annual cost of fraud in both AB and BI claims in Ontario was between \$219 million and \$327 million.<sup>46</sup> This amounts to estimated fraud of between 18% and 26% of total claims paid.<sup>47</sup>

The charts below summarize the estimated percentage of payments in Ontario that contain elements of fraud for the AB and BI claims reviewed in the study:

<sup>45</sup> *Premeditated and Opportunistic Fraud in Personal Injury Claims*, Hynes, T., MacAulay, K., Mahaffey, T., Wright, B, 2001, page 7.

<sup>46</sup> *Ibid.*, page 49.

<sup>47</sup> The 18% to 26% fraud rates have been calculated based upon the details included in the study.



**1. Accident Benefits Claims in Ontario**

Fraud Assessment	Amount of Total Claim	% of Total Paid Losses	Percentage Excessive		Excess as a Percentage of Total Losses Paid	
			Low	High	Low	High
	\$	%	%	%	%	%
Staged accident	111,688	1.0	100	100	1.0	1.0
Caused accident	69,789	0.6	100	100	0.6	0.6
Fictitious injury	907,621	7.7	80	100	6.2	7.7
Other types of premeditated fraud	627,324	5.3	40	80	2.1	4.2
Opportunistic fraud only	5,022,460	42.8	25	40	10.7	17.1
Fully legitimate	4,987,091	42.6	-	-	-	-
<b>Total</b>	<b>11,725,973</b>	<b>100.0</b>			<b>20.6</b>	<b>30.6</b>

**2. Bodily Injury Claims in Ontario**

Fraud Assessment	Amount of Total Claim	% of Total Paid Losses	Percentage Excessive		Excess as a Percentage of Total Losses Paid	
			Low	High	Low	High
	\$	%	%	%	%	%
Staged accident	66,000	0.3	100	100	0.3	0.3
Caused accident	29,705	0.2	100	100	0.2	0.2
Fictitious injury	630,722	3.3	80	100	2.6	3.3
Other types of premeditated fraud	794,468	4.2	40	80	1.7	3.4
Opportunistic fraud only	3,944,176	20.6	25	40	5.2	8.2
Fully legitimate	13,674,785	71.4	-	-	-	-
<b>Total</b>	<b>19,139,856</b>	<b>100.0</b>			<b>10.0</b>	<b>15.4</b>

From the information presented in the closed claims study, we have calculated that the Ontario fraud estimate as a percentage of all claims paid when allocated between opportunistic and premeditated fraud is as follows:

	Estimated Fraud as Percentage of Total Losses Paid	
	Low %	High %
Opportunistic fraud	9.2%	14.7%
Premeditated fraud	8.5%	11.7%
Total estimated fraud	17.7%	26.4%

## 6.2 Closed Claim Reviews in the US

Large scale closed claim reviews are conducted in the US fairly regularly by the Insurance Research Council (“IRC”). IRC is an independent not-for-profit research organization supported by US insurance companies and associations.

### 6.2.1 2007 Closed Claim Study Concerning Auto Injury Insurance Fraud in the US

In 2007, IRC collected detailed claim information for 42,013 closed auto claims with payment under five principal private passenger coverages.<sup>48</sup> Twenty-two insurers representing 57% of the US private passenger auto insurance market in 2006 participated in the study.<sup>49</sup>

In summary, IRC estimated that in 2007, total excess auto insurance payments from fraud and buildup in the US ranged from \$4.8 billion to \$6.8 billion or between 13% and 18% of all amounts paid. The following chart summarizes estimates of excess payments:

<sup>48</sup> The five types of coverage referenced in the study are: Bodily Injury (BI), Personal Injury Protection (PIP), Medical Payment (MP), Uninsured Motorists (UM), and Underinsured Motorists (UIM).

<sup>49</sup> *Fraud and Buildup in Auto Injury Insurance Claims*, Insurance Research Council, November 2008.

Type of Coverage	Total Payment \$B	Excess as a Percent of Total Payments		Estimated Fraud Impact	
		Low %	High %	Low \$B	High \$B
Bodily Injury <sup>50</sup>	22.2	13.4%	19.5%	3.0	4.3
Personal Injury Protection <sup>51</sup>	8.6	14.4%	18.8%	1.2	1.6
Medical Payment	2.6	5.5%	7.8%	0.1	0.2
Uninsured and Underinsured Motorists	4.6	9.9%	14.8%	0.5	0.7
<b>Total</b>	<b>38.0</b>	<b>12.6%</b>	<b>17.9%</b>	<b>4.8</b>	<b>6.8</b>

This research distinguished between “fraud” which is defined as the deliberate misrepresentation of a material aspect of a claim and “buildup” which occurs when some aspect of a claim is inflated (similar to aspects of what we have referred to as “opportunistic” fraud). The above table includes both fraud and buildup.

The IRC report also separately considered fraud and buildup and the following summarizes the fraud and buildup in the bodily injury and personal injury protection coverages:

<sup>50</sup> In the US, “bodily injury” coverage relates to liability for bodily injury caused to someone else as a result of the ownership, maintenance and use of a vehicle when the driver is legally at fault. In Canada, claims under this coverage are often called third party claims (*Fraud and Buildup in Auto Injury Claims*, Insurance Research Council., November 2008, page 63).

<sup>51</sup> In the US, “personal injury protection” coverage pays benefits to persons injured in auto accidents without regard to fault and include reimbursement of medical expenses, lost wages, funeral expenses and rehabilitation costs. In Canada, claims under this coverage are more generally called first party claims or no-fault coverage (Ibid).

		Bodily Injury		Personal Injury Protection		Total	
		Low	High	Low	High	Low	High
Buildup only	% of claims pd	6.1%	7.7%	7.9%	9.5%	6.8%	8.1%
	Excess pay'ts (\$B)	1.4	1.7	0.7	0.8	2.1	2.5
Fraud (may include buildup)	% of claims pd	7.3%	11.8%	6.5%	9.3%	6.8%	11.0%
	Excess pay'ts (\$B)	1.6	2.6	0.5	0.8	2.1	3.4
Total	% of claims pd	13.4%	19.5%	14.4%	18.8%	13.6%	19.1%
	Excess pay'ts (\$B)	3.0	4.3	1.2	1.6	4.2	5.9

Excluding the medical payment coverage, between 15% and 24% of examined claims provided some evidence of “fraud” or claims overstatement (buildup), as summarized below:

Type of Claim Abuse	Bodily injury	Personal Injury Protection	Medical Payment	Uninsured Motorists	Under-insured Motorists
	%	%	%	%	%
No appearance of fraud or buildup	76	85	93	82	79
Appearance of fraud only	4	1	1	2	3
Appearance of buildup only	13	9	4	11	11
Appearance of fraud and buildup	8	5	2	6	7

The study also provided a comparison to the results of a similar study undertaken in 2002. This comparison indicated that the assessed occurrence of fraud increased during this five-year period, as follows:

	2007 Study Results	2002 Study Results
<b>Percentage With Appearance of Fraud:</b>		
Bodily Injury	11%	9%
Personal Injury Protection	6%	5%
<b>Percentage With Appearance of Buildup:</b>		
Bodily Injury	20%	18%
Personal Injury Protection	14%	12%



This study also provided an interesting insight into the use of medical and health professionals in claims with indications of fraud, as summarized below:

	BI Claims			PIP Claims		
	No Apparent of Fraud or Buildup	Indications of Fraud	Indications of Buildup	No Apparent of Fraud or Buildup	Indications of Fraud	Indications of Buildup
	%	%	%	%	%	%
Chiropractor	29	56	67	26	69	72
Neurologist	4	9	9	4	13	16
Occupational therapist	1	1	*	1	1	1
Orthopedist	11	17	16	13	20	22
Osteopath	1	2	2	2	2	4
Physical therapist	17	24	26	18	25	31
Psychotherapist	*	1	1	1	6	6

\* less than 0.5%

### 6.2.2 2011 Closed Claim Study Concerning Auto Injury Fraud in New York State

In October 2011, IRC published a report on New York’s No-Fault Insurance System relating to auto injury claims. This study was based upon a sample of 4,552 closed claims from 2010.<sup>52</sup>

The study focused on the Personal Injury Protection (“PIP”) auto coverage and concluded that in New York 44% of claims had some indication of fraud or buildup with an estimate of excess insurance payments of between \$385 million to \$512 million (between 26% and 34% of total PIP payments).

The IRC report also separately considered fraud and buildup and the following summarizes the fraud and buildup in the personal injury protection coverage<sup>53</sup>:

<sup>52</sup> *New York’s No-Fault System: Final Report on Closed Auto Injury Claims*, Insurance Research Council, October 2011

<sup>53</sup> Some of the figures in this table are calculated from information the IRC report. There are some rounding differences.



		Personal Injury Protection	
		Low	High
Buildup only	% of claims paid	8.8%	12.3%
	Excess payments (\$M)	132	185
Fraud (may include buildup)	% of claims paid	16.8%	21.8%
	Excess payments (\$M)	252	327
Total	% of claims paid	25.6%	34.1%
	Excess payments (\$M)	385	512

Amongst other things, the report compared the prevalence of fraud and buildup in New York City (“NYC”) and the rest of New York State. This indicated, for example, that the appearance of buildup in 2010 was present in 35% of NYC claims compared with only 7% in claims in the rest of New York State. Consistent with this, the study also noted that in 2010 the average claimed losses (which include expenses for medical bills, lost wages, rehabilitation, and other expenses) was \$15,086 in NYC compared to \$6,870 in the rest of the state.

### 6.2.3 2011 Closed Claim Study Concerning Auto Injury Fraud in Florida

IRC published a report in February 2011 on Personal Injury Protection claims under Florida’s no-fault insurance system. The report was based on an analysis of 1,359 Florida closed PIP claims with payment in 2007.<sup>54</sup> This IRC study provided no estimate of the financial extent of insurance claims fraud or buildup.

Consistent with the IRC New York study, it was found that economic losses in the major urban areas (Miami in the Florida study) were notably greater than claimed economic losses elsewhere in the state.<sup>55</sup> The study noted claims fraud in 10% of claims examined and claims buildup in 30% of claims examined.

The following chart summarizes the percentage of 2007 Florida claims with various elements of fraud:

Elements of Claim Fraud	
Fictitious injury	38%
Bills submitted for treatment not rendered	31%
Claimed injury unrelated to accident	23%
Staged accident	13%
Intentionally caused accident	10%
Duplicate claims for the same injury	6%
Deliberate misrepresentation of lost wages	2%
Collusion between claimant and insured	2%
Claimant not involved in accident	2%
Other material misrepresentation	42%

### 6.3 Summary of Closed Claim Studies

Each of five closed claims studies discussed above has addressed the issue of insurance claims fraud for different geographic areas, coverage types and periods. Notwithstanding this variation, overall there has been a consistent finding: insurance claim fraud is significant and the cost to the industry and its stakeholders is estimated at between 13% and 34% of total claims paid.

<sup>54</sup> *PIP Claiming Behaviour and Claim Outcomes in Florida’s No-Fault Insurance System*, Insurance Research Council, February 2011

<sup>55</sup> Miami claim costs were indicated to be about one-third higher than elsewhere in Florida.



The following provides a summary of the five closed claims studies:

	Number of Claims Reviewed	Percentage of Claims With Indication of Potential Fraud %	Annual Claims Paid That Are Considered Fraudulent \$	Percentage of Total Annual Claims Paid Considered Fraudulent %
<b>Canada</b>				
1992 IBC study (Canada-wide, all P&C insurance)	491	15%	\$1.3 billion	15% (auto only – 10%)
2001 CCAIF study (Ontario portion only)	1,085	37%	\$219 to \$327 million	18% to 26%
<b>United States</b>				
2007 auto injury study – US	42,013	15% to 24%	\$4.8 to \$6.8 billion	13% to 18%
2011 auto injury study – New York (AB only)	4,552	44%	\$385 to \$512 million	26% to 34%
2011 auto injury study – Florida (AB only)	1,359	40%	N/A	N/A

## 7 DATA ANALYTIC ANALYSES

In 2011, three groups separately initiated reviews of pools of electronic auto insurance information using data analytic tools for indications of fraudulent auto insurance claims. Each of these projects was started with the view of determining the utility of data analytic approaches and tools for the identification of claims that have indicators of fraudulent activity (thus each of these initiatives was called a “proof of concept” or “POC”).<sup>56</sup>

None of the POCs was undertaken with the express purpose of quantifying the extent of fraud in the auto sector in Ontario for this report. However, the results of the POCs are, in our view useful, in better understanding the extent of auto insurance fraud in Ontario.

The purpose of each of the POCs was to demonstrate that the use of quality data analytics on claims information supplied by multiple insurers assists with identifying claims which are suspicious and should be further reviewed. The use of cross-insurer data directly increases the likelihood of identifying organized insurance fraud and the detection of organized insurance fraud was the primary focus of each of the POCs. While data analytics can assist with identifying premeditated and opportunistic insurance fraud, this was not the focus of the POCs and is not directly addressed in the results of the POCs reviewed below.

Each of the POCs was considered by the respective sponsors to be a success in achieving the stated purpose of demonstrating the use of cross-insurer data and the value of data analytics in identifying claims that are potentially fraudulent.

Based upon our review of the outputs of the POCs and discussions conducted during this study, the use of data analytic tools in an organized and systematic way across multiple insurers will greatly strengthen the ability to identify those insurance claims that contain hallmarks of fraud and should, as a result, be further and closely reviewed as part of the claims review process. One issue mentioned repeatedly to us in connection with the pooling of data from multiple insurers relates to privacy legislation and related concerns. This legal issue is discussed further in Sections 9 and 10 below.

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<sup>56</sup> A “proof of concept” is intended to demonstrate the feasibility of an approach or methodology. It often uses smaller sample sizes or smaller amounts of data. As a result, a proof of concept is not a comprehensive and complete analysis. Decisions are usually made to limit the extent of a proof of concept and to keep the process manageable and within a reasonable scope.

## 7.1 Overview of the POCs

The three POCs are as follows:

- Detica Limited (“Detica”) initiated a POC with cross-insurer data using their data analytic tool called “Detica NetReveal.” Detica personnel were closely involved with the POC throughout the process.
- IBC initiated a POC using data analytic tools owned and operated by International Business Machines Corporation (“IBM”) including IBM’s “Identity Insight,” “SPSS” and i2 analytics software. IBM personnel were closely involved with the POC throughout the process.
- CGI Group Inc. (“CGI”) initiated a POC using a data analytic tool owned and operated by SAS Institute Inc. (“SAS”) and called “SAS Fraud Framework.” SAS personnel were closely involved with the POC throughout the process.

In total, 15 insurance companies accounting for approximately 65% of the Ontario auto insurance market (based upon 2010 written premiums) participated in the POCs. The market share of companies involved with each POC ranged between 8% and 35%.

Each of Detica, IBM and SAS have devoted significant resources to the development of data analytics for the insurance and other sectors and some details of the data analytic tools used in the POCs are available on-line at each companies’ web site. It was not our role to comment on the functionality, operation or use of the data analytic tools in each of the POCs. However, it was clear from our discussions with those involved in each of the POCs that each of the data analytic tools used are well developed and sophisticated.

The basic process followed by each of the POCs was similar:

- Data was obtained by the POC sponsors. Data of participating insurance companies was obtained for specific time periods. The data provided and related periods included is a factor that directly impacts the review performed with the data analytic tools and the results. Each of the POCs started with different pools of data (different insurance companies, data fields and time periods).
  - With respect to the Detica POC, data with specific characteristics and time frames was provided directly by the participating insurance companies.
  - With respect to the POC sponsored by IBC, the available data was provided from a data set specifically collected for and geared toward investigations. However, participation in the data collection process is not mandatory and not all insurers

currently supply information to this data set. Data for consenting insurance companies was included in the POC.

- With respect to the POC sponsored by CGI, the available data was provided from a pool of data previously submitted by insurance companies related to detailed automobile insurance information. We understand that CGI is the custodian of this data. Data for consenting insurance companies was included in the POC.
- The data was loaded into the data analytic tools and processed using various analysis routines. The exact manner in which the data was processed varied by POC and the approach is a matter that is proprietary to each of the data analytic vendors. Generally, the data was processed through different analytic routines and iterative processing was performed to enhance the results based upon increasing familiarity with the available data and review of the results of the data processed.
- The output of the data analytics process was reviewed by the POC sponsors. This review process was important as it permitted the quality of the output to be evaluated and based upon this review, refinements to enhance the analysis were determined.

The results of the three POCs are not directly comparable. Our discussions indicated that while the data analytic tools generally used similar concepts, the programs are different and algorithms and details of each tool are proprietary and unique. Each of the POCs relied on data for different periods and from different companies. Also, different data fields were available for each POC and this affects the strength and usefulness of the various analysis routines that were used. As a result, each POC is best viewed as a separate exercise and should be considered to be a standalone process.

We also note that claims identified by data analytic processes need to be reviewed and confirmed by qualified adjusters and investigators to determine whether and what type of action is required in respect of the flagged claims.

For proprietary reasons, our discussion of the POCs below has been anonymized. We have purposefully used the labels POC1, POC2 and POC3 in our discussion of these studies and we have avoided description or comments that would allow the reader to link a discussion of a POC to any one of the sponsoring groups.

## 7.2 POC1

The data used for POC1 consisted of approximately 233,000 Ontario auto claims and \$6.8 billion of claims and covered claims data from 2005 to 2010. This data was processed using specific and applicable data analytics software. By identifying connected individuals and claims with indicators of fraud, the process identified approximately 56,000 claims with \$1.6 billion of payments that contained some indicators of potential fraud.

These identified claims were further processed and 222 “clusters” of connected individuals or groups were found with a total of 2,600 claims which received claims payments of \$54 million. These identified claims were labelled as being “suspect” and included criminal organized rings.

In reviewing these claims, previously identified organized insurance fraud groups were found within the flagged claims and groups.

The suspect claims identified by the data analytic process were extrapolated by the data analytic provider to arrive at an estimate of “suspect claims” of between \$1.19 billion and \$1.66 billion for the 6 years that data was provided for the auto industry in Ontario. This was averaged to an annual suspect claim amount of between \$200 million and \$275 million.

## 7.3 POC2

POC2 used claims data from participating insurers from across Canada<sup>57</sup> from May 2008 to May 2011. In total, the data used for POC2 consisted of approximately 759,000 auto policies and 1.2 million claims with a value of \$4.5 billion. For Ontario, 496,651 policies were included in POC2 with 799,280 claims and a claims value of \$3.3 billion.

The data analytic process tool scored each claim based upon the level of suspicion associated with each claim. Based upon this scoring approach and the threshold used for suspicious claims, a total of 9,678 suspect claims were identified with a claims value of \$126 million. For Ontario, 6,298 claims with a claims value of \$89 million were identified as being suspicious.

Following the initial analysis, POC2 refined and narrowed its processing period to between January 2011 and March 2012 for the purpose of identifying suspicious claims to be reviewed in light of claims files. For this period, a total of 375,000 claims were analyzed

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<sup>57</sup> POC2 included claims from the following provinces: Alberta, New Brunswick, Newfoundland, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan.

and the 1% of all claims (or 3,750 claims) found by the process to be the most suspicious were flagged. From these claims, a total of 106 claims were reviewed by the participating insurers and 23% of these claims were found to be “confidently suspicious” based upon the available documentation and information. The available documentation and information for a further, 32% of the reviewed claims were considered to be worthwhile for further investigation, although the documentation was less categorical concerning the likelihood of fraud.

The suspect claims identified by POC2 were extrapolated by the POC sponsor to arrive at an estimate of “suspect claims” of between \$268 million and \$313 million per year for all of Canada or between \$175 million to \$203 million per year for Ontario.

#### **7.4 POC3**

POC3 was based upon auto claims in Ontario that were open in 2010 and it used a tightly defined concept of claims that would fall within the scope of the project. Specifically, only claims that had a connection to more than one insurer in the POC sponsoring group were considered. Within these cross-insurer claims, further criteria were used to select the claims considered in the POC which resulted in a sample that would not allow for a statistically viable extrapolation of the results. For example, claims that had previously been identified as fraudulent by a sponsoring company’s SIU were excluded to ensure the savings projected from the POC were 100% incremental. In addition, claims of no value or those with a claimed amount of more than \$200,000 which could skew results were excluded from the data analyzed.

In total, 562,000 claims from just over a two year period were made available for the POC. After applying the parameters for claims to be considered in scope for the study, 45,000 claims from an annual period with a value of approximately \$700 million were included in the conducted analysis.

Of the “in scope” claims, 7,600 claims with a value of \$290 million were found to be suspicious by the data analytic tool. A sample of these claims was then subject to a review by the insurance companies sponsoring the POC. A total of 1,691 claims flagged by the data analytic process were reviewed by the insurers and 454 claims were found to be suspicious based on information obtained from data analytic process and the claims files.

At the end of this review, the analytic tool processor estimated that for the 7,600 suspicious claims detected by the data analytic process, an estimate of the annual cross-insurer incremental fraud detection from the data analytic process would have been \$91 million.

Those involved with POC3 are of the view that an extrapolation of the indicated results of the POC to arrive at an estimate of auto insurance fraud in Ontario would not be meaningful or appropriate as the POC calculated incremental benefit only and did not in any way quantify the value of fraud contained within each single insurer. A linear extrapolation of the amount of incremental organized auto insurance fraud detectable across the whole of Ontario, is possible but is likely to be conservative. Other reasons provided for not extrapolating the results of POC3 are listed in Section 7.5 below which provides our comments as to why, in our view, the estimated organized auto insurance fraud in this report is understated. We understand and appreciate the perspective of sponsors of POC3 and note that some of the stated reasons are specific to POC3.

## **7.5 Summary of POC Findings**

As discussed in Section 7.1 above, the three POCs are not comparable as they used different approaches to data inclusion and analysis. However, the results of the POCs do assist in providing information that can be used to give some perspective on the extent of organized insurance fraud in Ontario.

As noted above, the sponsors of POC3 do not believe that it is appropriate to extrapolate an estimate of the potential for fraud from its study. From the remaining two POCs, the range of organized auto insurance fraud in Ontario was estimated to be between \$175 million and \$275 million.

It is important that the purpose of the POCs be considered in assessing these results. Specifically, the POCs focused on organized claims fraud where more than one insurer was impacted by an organized ring. As a result, the above amounts do not necessarily include fraud connected with premeditated or opportunistic insurance fraud. However, we would expect that the identified claims will include some element of these types of insurance fraud.

In addition, the information available in respect of the POCs suggests that the amounts quantified through the POCs as relating to organized fraud are likely to be understated for various reasons including the following:

- Organized fraud is best and most completely recognized by having data from all companies in the industry. Larger pools of data increase the ability to identify the claims characteristics, relationships and linkages that data analytics relies on to identify organized claims fraud. The estimate of organized insurance fraud referenced above implicitly assumes that the extent of fraud as estimated by the sponsors of POC1 and POC2 may be extended to the entire market based upon the market share of the

participants in each POC. For various reasons, this assumption is conservative and likely understates the total estimate.

- The data included in the POCs were subsets of data for the sponsoring companies. Two of the POCs relied on preexisting data sets for the analysis. Data with additional fields and type of data expands the effectiveness of data analytics (i.e., more and better data would be expected to result in additional identified suspicious claims).
- The data included in the POCs were limited to specific periods. For example, POC3 used just over two year's worth of data to build sufficient history to detect claims for a one-year period (2010). The inclusion of data for additional years would be expected to allow more suspicious claims in the year(s) under review to have been identified.<sup>58</sup>
- The POCs were limited to auto insurance policy data. By expanding data available for data analytic processing to other insurance lines of business, it is expected that additional fraud would be found in the auto insurance.<sup>59</sup>
- The POCs were established for specific purposes and the protocols for the POCs established how the data was to be analyzed and the scope of the study. For example, POC3 excluded claims with value of more than \$200,000 and claims that had previously been identified as being suspicious by sponsoring insurers.
- It would be expected that the approaches used in the POCs, if fine tuned and refined based upon further analysis and experience, will result in increased rates of detection of suspicious claims.<sup>60</sup>

From the above, it is clear that the results from the POCs cannot be interpreted as providing an estimate of the total exposure to auto insurance claims fraud in Ontario, or even of all organized auto insurance fraud in Ontario. That said, in our view, the POCs provide a well structured and significant review of claims data resulting in a quality, if understated, estimate of organized auto insurance fraud in Ontario. We provide additional comments on the use of data analytics in Section 10 below.

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<sup>58</sup> In addition, losses reported as being "incurred but not reported" (IBNR) are not included in some or all of the POC data. This has the effect of understating the financial impact of claims found to be suspicious.

<sup>59</sup> Organized rings do not limit fraud to only auto insurance and fraud identified in other insurance lines of business would be expected to provide additional detail to help identify auto insurance fraud.

<sup>60</sup> Given the purpose of POCs, it is usually expected that, if continued or expanded, enhancements and additional analysis will increase the utility of the process and the quality of the overall results.



In Section 8, we have considered the total potential for auto insurance claims fraud in Ontario taking into account the POCs in respect of organized fraud as well as other indicators of potential fraud rates.



## 8 ESTIMATE OF THE EXTENT OF AUTO INSURANCE FRAUD IN ONTARIO

We were requested to review available and relevant information to provide an estimate of auto insurance fraud in Ontario. In the sections above, we have provided an overview of the information we have reviewed. Based upon our review, it is our view that:

- Auto insurance fraud in Ontario is a significant problem;
- There is insufficient information to provide a precise and statistically based estimate of auto insurance fraud in Ontario. While the recent POCs provide some indication of the potential extent of organized auto insurance fraud in Ontario, these studies are not statistically based and likely understate the true extent of organized auto insurance fraud. In addition, no comprehensive and large-scale insurance fraud estimate studies have been conducted in Canada since 2001<sup>61</sup>;
- Available studies indicate that insurance fraud is a broad-based problem that is prevalent in Canada, the US, UK and other countries and that there are at least some consistencies in the nature, prevalence and extent of insurance fraud in these jurisdictions. Quality studies and information have been developed in the US and the UK which provide an indication of the extent of insurance fraud in those countries.

Given the above, in order to provide an estimate of the potential extent of auto insurance fraud in Ontario, we have referenced available information from the POCs and closed claim studies in Canada and the US. We then compared the result of the estimate prepared to the results of other studies we have referenced. As noted, we have provided a broad estimate of auto insurance fraud which is based upon information from various sources. This is not a statistical analysis<sup>62</sup> but, in our view, it provides an indication of the seriousness of and potential extent of auto insurance fraud in Ontario.

Based upon our review of the available information (using the approach outlined in Section 8.1), we estimate that auto insurance fraud in Ontario ranges between \$770 million and \$1.6 billion per year. This amounts to between 9% and 18% of total auto insurance premiums.

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<sup>61</sup> Some would argue that there has never been a comprehensive insurance fraud study in Canada.

<sup>62</sup> Such an analysis is not possible given the available data.

## 8.1 Our Approach

From our review of the available information concerning auto insurance fraud in Ontario, it is clear that recent attention has been given to organized insurance fraud. There are no recent (since 2001) and larger studies in Canada that consider the full extent of P&C insurance fraud in Canada (or Ontario).

As a result, in order to provide an assessment of the total extent of auto insurance fraud in Ontario, it is necessary to consider other fraud-related reports and the potential uses of such studies and analysis in conjunction with the recent analyses through the POCs. In our view, after an approach that uses data analytics, closed claim studies provide the best available information for estimating the extent of insurance fraud.

Our approach to estimating the extent auto insurance fraud in Ontario uses both the results of two of the POCs and information from closed claims studies. Specifically our approach is as follows:

- Include an estimate of organized auto insurance fraud in Ontario based upon two of the POCs as discussed in Section 7 above.
- Include an estimate of opportunistic auto insurance fraud based upon information from closed claim studies that divided estimated fraud between organized/premeditated fraud and opportunistic fraud.

As discussed in Section 6 above, we reviewed five closed claim studies (two in Canada and three in the US). From the 2001 Canadian closed claim study, we were able to calculate an opportunistic fraud rate for Ontario from the available information (see Section 6.1.2 above). Two of the closed claims studies conducted by IRC in the US separated the analyses between what was termed “fraud” and “buildup.” Buildup is very similar to the concept of opportunistic fraud as described in Section 2.2 above.<sup>63</sup> We have used these three closed claim studies to provide a range of the estimated opportunistic fraud.

This indicated use of closed claims studies that are not directly related to current auto insurance fraud in Ontario is, in our view, appropriate for our broad-based estimate. Our review and discussions have indicated that insurance fraud has been noted as a significant and important issue for many years. There is consistency in the nature and broad extent of insurance fraud across multiple jurisdictions over time.

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<sup>63</sup> Opportunistic fraud is where an individual increases or “pads” a claim for an actual and legitimate claims situation. This compares to buildup when some aspect of a claim is inflated.



- The total estimated insurance claims fraud from the above approach was compared to the conclusions of various studies to assess the comparability and consistency of our estimate.

Our approach does not explicitly address what has been called “premeditated fraud” (as described in Section 2.2 above). Premeditated fraud is clearly not included in the opportunistic fraud we estimate. We expect that, given the nature and hallmarks of premeditated fraud, a portion, but likely not all, of premeditated fraud will be addressed by the POC results. Also, as discussed in Section 7 above, the estimate of organized insurance fraud derived from the POCs is likely understated. As a result, our approach potentially understates the true extent of auto insurance fraud in Ontario.

## **8.2 Our Estimate of Auto Insurance Fraud in Ontario**

As noted above, we have relied upon estimates in closed claim studies to estimate the range of opportunistic insurance fraud. By adding this estimate of opportunistic fraud to the indicated range of organized insurance fraud, we obtain an estimate of the potential extent of auto insurance fraud in Ontario.

Our estimate of auto insurance fraud in Ontario is summarized below:

			Low Estimate	High Estimate
Total auto claims in Ontario in 2010 <sup>64</sup>	<i>A</i>	\$M	8,739	8,739
Estimated opportunistic fraud as a percentage of claims paid <sup>65</sup>	<i>B</i>		6.8%	14.7%
Estimated annual opportunistic auto insurance fraud in Ontario	$C=A*B$	\$M	594	1,285
Conservative estimate of annual organized auto insurance fraud <sup>66</sup>	<i>D</i>		175	275
Total estimated annual auto insurance fraud in Ontario	$E=C+D$	\$M	769	1,560
Annual auto insurance fraud in Ontario as a percentage of total claims cost	$E/A*100$		9%	18%

We were asked to indicate the average per policy cost of auto insurance fraud based upon our estimate. We calculated such an average cost by dividing the indicated potential extent of auto insurance fraud in Ontario by the number of policies in 2010. On this basis, the estimated auto insurance fraud amounts to an average of between \$116 and \$236 per auto insurance policy in Ontario.<sup>67</sup>

Based upon this approach, the estimated annual fraud ranges between 9% and 18% of total claims paid. This compares to the estimate of between 18% and 26% from the 2001 closed claims study in respect of Ontario auto insurance fraud (see Section 6.1.2 above).

In our view, our estimate of the extent of Ontario auto insurance fraud is understated because premeditated fraud is not directly addressed. Also, as discussed in Section 7.5, the indicated estimate of organized insurance fraud is likely understated for various reasons.

On an overall basis, the following table compares the results of our analysis to that presented in other studies we reviewed:

<sup>64</sup> GISA Tables AU-05 and AU-10 provided by IBC. The indicated amount includes auto claims under Third Party Liability, Bodily Injury, Accident Benefits, Collision and Comprehensive coverages.

<sup>65</sup> The low estimate of opportunistic fraud as a percentage of claims paid is from the IRC's 2007 US closed claims study (see Section 6.2.1) and the high estimate of opportunistic fraud as a percentage of claims paid is from the 2001 Canadian closed claims study as related to Ontario (see Section 6.1.2).

<sup>66</sup> The estimate of organized fraud is discussed in Section 7.5 above.

<sup>67</sup> The average auto insurance premium in Ontario is approximately \$1,480. This has been calculated as the total of written premiums of \$9.8 billion in 2010 divided by number of written vehicles of 6.6 million.



	Percentage of Total Claims Paid		
	Opportunistic Fraud <sup>68</sup>	Organized and Premeditated Fraud <sup>69</sup>	Total
KPMG Forensic Estimate of Auto Insurance Fraud in Ontario	7% to 15%	2% to 3%	9% to 18%
2007 IRC US closed claims study (see Section 6.2.1)	7% to 8%	7% to 11%	14% to 19%
2011 IRC New York closed claims study (see Section 6.2.2)	9% to 12%	17% to 22%	26% to 34%
1992 IBC closed claims study (auto only) (Section 6.1.1)	N/A	N/A	10%
2001 CCAIF closed claims study (Ontario only) (see Section 6.1.2)	9% to 15%	9% to 11%	18% to 26%
2008 Association of British Insurers UK insurance fraud estimate (see Section 9.4)	N/A	N/A	8%
1994 Australia estimate (see Section 2.2.1)	N/A	N/A	10%
1990 Germany estimate (see Section 2.2.1)	N/A	N/A	11% <sup>70</sup>
1999 Spain estimate (see Section 2.2.1)	N/A	N/A	22% <sup>71</sup>

<sup>68</sup> Opportunistic fraud is referred to as “buildup” in the US studies.

<sup>69</sup> Organized and premeditated fraud is referred to as “fraud” in the US studies.

<sup>70</sup> The indicated percentage is the estimated insurance fraud of claims volume.

<sup>71</sup> The indicated percentage is the estimated insurance fraud of claims volume.

## 9 OTHER INFORMATION FROM INTERVIEWS

During the course of our research, we met with representatives of a number of insurers and industry associations to discuss insurance fraud-related topics. The following provides information of potential interest from these discussions.

### 9.1 Interviews with Insurers in Ontario

We met with ten insurers representing 68% of market of auto insurance in Ontario to obtain their views on auto insurance fraud. The following provides a highlight of comments received by us:

- All insurers recognize auto insurance fraud as a serious issue and have increased efforts within their companies to combat auto insurance fraud. Real and tangible efforts are being taken to identify, investigate and address insurance fraud. For example, most insurers have increased the number of investigators in their Special Investigative Units (“SIU”) to combat insurance fraud.
- All insurers stated that organized crime rings are among the most pressing of issues. Based upon their individual experiences, insurers believe that organized crime rings are more sophisticated than ever before. We consistently heard that organized auto insurance fraud involves many service providers such as body shops, tow truck companies, health service providers and facilities and paralegal firms. Most of the insurers we spoke with voiced concern over clinics not being regulated as this limits effective action when fraud is suspected.
- Insurers stated that they recognize the power and benefits of data analytic tools. Two insurers who we interviewed are currently using data analytics in their operations to identify suspicious claims. In addition, other insurers we interviewed are participating in the POC initiatives discussed in this report. The benefit of having data available from multiple insurers for use by data analytic programs is also clearly recognized by insurers. The issue of privacy legislation related to the sharing of information is an issue as discussed below.
- Insurers stated that there is currently no centralized database that can be accessed when organized crime rings are suspected which would increase the efficiency and success of investigations.
- All insurers recognize that the ability to share data between companies would be very powerful in preventing, identifying and investigating fraud. However, there is an overall concern of how such an initiative would be implemented given, and/or impacted by, privacy legislation and regulation. Some of the insurers we interviewed were

reluctant to participate in the POC initiatives due to privacy concerns. These insurers thought that a centralized body was required to formally set out specific guidelines governing how information can be shared amongst the individual insurers.

- Sharing of information on suspicious claims between insurers was said to be difficult due to privacy issues and concerns. The SIUs of some insurers informally share some information with SIUs of other insurers. Some insurers prohibit their SIUs from providing to, or receiving from, other insurers any information due to concerns that evidence provided or received will be entered as evidence in Court if legal action is taken against the parties involved in the suspect claims.
- While data analytics, is recognized as a significant advancement in the detection and investigation of insurance fraud, for some insurers, the process of identifying suspicious claims is at this time still a relatively manual one. These insurers use internally developed fraud red flags to identify suspicious claims and also rely heavily on the experiences of their front-line claims adjustors. Once suspicious claims are identified, they are referred to the SIU for further investigation and to determine the appropriate course of action.
- The extent of insurance fraud identified, prevented or suspected, is not generally tracked or reported by insurers in Ontario. There was a concern shared with us that insurance companies could be exposed to liability in civil litigation if fraud-related information was tracked, reported and/or shared.<sup>72</sup> We were told that immunity from such actions in Ontario would assist with the pursuit of insurance fraud.<sup>73</sup>
- Insurers also stated that, in their view, there needs to be increased collaboration with law enforcement authorities. Historically, insurers have often addressed fraud issues on their own without direct involvement of law enforcement.<sup>74</sup> However, as a result of the perceived increase of organized crime activities, insurers believe that law enforcement has much to contribute as organized crime rings are thought to be involved in other criminal activities in addition to insurance fraud. Law enforcement agencies may

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<sup>72</sup> “An insurer...is often reluctant to disclose its suspicions about possible fraud or to disclose incriminating information about its insured, because, that often results in various charges like defamation, harassment, malicious prosecution, bad faith, breach of privacy, etc. Thus, under the common law there is only limited protection for insurance companies when they make disclosures of information to law enforcement.” (Insurance Fraud Reporting and Immunity Laws Limitations on the Disclosure of Information, Rick Hammond)

<sup>73</sup> There are extensive and varying immunity laws for the reporting of insurance fraud in the US. For example, in 2009, 28 US states had laws which provided insurer-to-insurer immunity related to the reporting of suspected fraud (Guide to Immunity Laws for Reporting Insurance Fraud, Coalition Against Insurance Fraud, January 2009).

<sup>74</sup> See Section 2.2.2 for survey information related to insurer reporting to law enforcement.



possess information on these crime rings that will assist insurers with their investigation processes.

- Some insurers stated the Health Claims of Auto Insurance<sup>75</sup> (“HCAI”) system contains “rich” claims data which can be used to identify medical fraud.

## **9.2 Interviews with Canadian Insurers Outside of Ontario**

### **9.2.1 British Columbia**

The Insurance Corporation of British Columbia (“ICBC”) is a Crown Corporation established in 1973 to provide auto insurance to British Columbia (“BC”) motorists. ICBC is the sole provider of basic mandatory coverage and it also sells optional auto insurance along with other insurance companies in the competitive market.<sup>76</sup>

ICBC’s website has a link to a witness information form that the public can fill out and submit on line, as well as a hotline used for reporting fraud tips or witness reports.

In BC, an Integrated Municipal Provincial Auto Crime Team (“IMPACT”)<sup>77</sup> has been formed and is responsible for auto theft. IMPACT is staffed by RCMP officers and municipal police officers. ICBC has a dedicated liaison officer who works with IMPACT.

We interviewed a senior member of ICBC’s claims team and we were told the following concerning insurance fraud in BC:

- No studies have been completed on the quantum of auto insurance fraud in BC. However, it is believed that ICBC’s exposure to auto insurance fraud is not impacted by the degree of organized fraud faced by insurance companies in Ontario. It was noted that fraud is not identified by ICBC as a top corporate strategic risk.
- ICBC’s auto fraud prevention initiatives revolve mainly around auto theft with assistance provided by ICBC to provincial policing programs. ICBC’s internal SIU does not have proactive auto fraud prevention as part of its mandate.

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<sup>75</sup> HCAI is an electronic system for transmitting specific auto insurance claim forms between insurers and health care facilities in Ontario. It supports the need for access to timely, accurate data to monitor the auto insurance system.

<sup>76</sup> [http://www.icbc.com/about-ICBC/company\\_info/service\\_plans](http://www.icbc.com/about-ICBC/company_info/service_plans)

<sup>77</sup> <http://bc.rcmp.ca>

- Suspicious claims files are referred to ICBC’s SIU based on adjustors’ experience. ICBC also automatically flags any persons who have been convicted of a criminal or quasi-criminal fraud offence against ICBC or have had an ICBC claim denied.
- ICBC currently does not use data analytics. However, a new system under development will allow ICBC to access and analyze more information with respect to policy holders and claims. The new system will allow ICBC to set business rules with specific risk ratings and will provide adjustors a risk rating for each claim. For example, if the risk rating is “red”, then the adjustor must refer the claim to the SIU.
- ICBC purchased a Social Network Analysis Software tool about a year ago and this is currently going through a learning phase to determine how this tool will best be used.
- Most of ICBC’s SIU claims investigators are special provincial police constables who have formal enforcement powers investigate. The investigators are accountable for investigating claims and service provider conduct which have criminal elements, and if a legal basis for a criminal or quasi-criminal charge exists, to submit a formal report to Crown Counsel on potential charges to the Crown Counsel’s office which will then assess and decide whether to lay charges. ICBC believes that its SIU structure deters criminal activities away from the auto insurance industry in British Columbia.
- ICBC takes a proactive approach to deter the general public and service providers from committing auto insurance fraud. Some of the proactive approaches are as follows:
  - Claims managers have accountability for periodic review for claims files to ensure appropriateness of claims handling and claims payments. A certain percentage of payments require manager authority before they can be made, adding a second level of scrutiny to those payments;
  - Many auto repair shops have agreements with ICBC with key performance indicators that include industry severity targets and individual shop severities, and about 93% of all repairs are performed by auto repairs shops with such an agreement. In addition, ICBC performs numerous *ad hoc* audits throughout the year on auto repair shops; and
  - Health providers must obtain a Supplier Number before they can bill ICBC for any services.

### 9.2.2 *Manitoba*

Manitoba Public Insurance (“MPI”) is a non-profit Crown Corporation that has provided automobile coverage to all Manitobans since 1971. Similar to ICBC and Saskatchewan Government Insurance, MPI is the sole provider of basic mandatory coverage and it also sells optional auto insurance along with other insurance companies in the competitive market.<sup>78</sup>

We interviewed a senior member of MPI’s claims team and we were told the following concerning insurance fraud in Manitoba:

- MPI has not conducted any recent study to determine the quantum of insurance fraud in Manitoba. MPI has conducted a Risk and Vulnerability assessment to identify key areas of risk (with broad estimates of the degree of insurance fraud) and has developed strategies to address those risks.
- MPI recognizes the risk associated with organized crime, however, it does not see organized crime as a significant issue.
- MPI has recently started to use data analytics to look for claims patterns and fraudulent claims activities. Given that MPI is the sole provider of basic mandatory coverage and has access significant amounts of data associated with claims, policyholders and business partners, anomalies in claims activities can be readily identified. As a result, there MPI sees limited need to collaborate with private insurers to look at information relating to all aspects of individual claims and policyholder.
- MPI works closely with service providers and all have agreements with MPI and have agreed upon rates with service providers that indicate amounts that can be charged under a claim for various services.
- All damages go through MPI’s claims department whereby adjustors assess the damage before repairs take place.

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<sup>78</sup> <http://www.mpi.mb.ca>

### 9.3 The United States

National Insurance Crime Bureau (“NICB”) is a not-for-profit organization that receives support from approximately 1,100 P&C insurance companies based in the US. NICB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals in a combined effort to prevent and combat insurance fraud and crime.

NICB uses data analytics and other approaches to identify and investigate questionable claims. NICB maintains a training department that integrates multiple fraud-fighting disciplines (i.e., law enforcement and insurance expertise). NICB also participates in legislative insurance advocacy and works to increase public awareness about insurance fraud.<sup>79</sup>

In our discussion with senior NICB executives, we were told the following:

- NICB does not perform any studies or academic research on the topic of insurance fraud including the extent of insurance fraud. Rather, Insurance Research Council (“IRC”) independently prepares studies related to insurance fraud (see Section 6.2 above). NICB references and uses the results from IRC studies to assist with assessing areas of its specific focus.
- NICB focuses their initiatives in the following five discipline areas:
  - Data Analytics – NICB’s data analytics department serves as the insurance industry focal point for collective analysis. NICB’s analysts gather, analyze, and report industry trends and questionable claim activity to NICB members and law enforcement agencies. Results of the data analytics indicate interrelations between certain individuals and organizations committing fraud. The data analytic tools are not used to assess the extent of insurance fraud, but rather such tools are used to assist with investigations and proactive fraud prevention.
  - Investigation – NICB’s investigations unit has approximately 175 investigators many of whom are former law enforcement officers with relationships with local law enforcement agencies. The investigators, working closely with NICB’s data analytics group, conduct investigations to determine the involvement of organized fraud groups and present their findings to law enforcement. Also, NICB Agents send alerts to individual insurers who may be affected by a suspicious claim or

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<sup>79</sup> NICB 2010 Annual Report

situation based upon information learned from its investigations. The determination of whether a claim should be paid lies solely with the individual insurers.

- Training – On an annual basis, NICB provides classroom training to approximately 15,000 insurance personnel and 15,000 law enforcement officers. In addition, NICB provides on-line training to over 25,000 insurance personnel annually and maintains an on-line training site for law enforcement.
  - Legislative Advocacy – NICB keeps abreast of the different US state insurance regimes and acts as an advocate for desired relevant changes to state insurance laws.
  - Public Awareness – NICB works with the news media to raise U.S. public awareness of insurance fraud and its impact. Paid advertising is usually limited to targeted local or regional issue-specific campaigns.
- NICB focuses on organized fraud rings with particular interest in all parties involved with fraud rings such as body shops, medical practitioners, lawyers, runners and the claimants.
  - NICB was invited to present to the Ontario Task Force and it provided various recommendations, based upon its experience.<sup>80</sup> These recommendations were a mix of legislative and regulatory initiatives, information sharing and analysis suggestions, public awareness and fraud awareness training.

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<sup>80</sup> In our interview with NICB these recommendations were referenced and we were directed to the presentation by NICB to the Task Force dated August 8, 2011.

## 9.4 The United Kingdom

The Insurance Fraud Bureau (“IFB”) of the UK is a not-for-profit organization set up and funded by the insurance industry in order to co-ordinate action to counter organized insurance crime in the UK. In our discussions with a representative of IFB, we were told the following:

- IFB has developed a robust data sharing protocol with the Motor Insurance Database, the national centralized database to which all auto insurers must submit information (including policy and vehicle details). Data is also received from the Claims Underwriting Exchange, a voluntary subscription database used by UK insurers to record motor, home and injury claims and claimants.
- IFB has established a data sharing agreement with about 40 insurers. IFB uses data analytics in respect of this data to examine trends and patterns. Suspicious information noted through the data analytics process is provided to the specific insurers affected.
- The main focus for IFB is staged and induced accidents with a focus on professional enablers such as accident management companies, paralegal and medical providers. IFB annually sends more than 1,000 intelligence reports to insurers.
- Currently, IFB’s fraud detection efforts operate on both a reactive and proactive basis, as follows:
  - IFB’s reactive model uses reported suspicious information received from external parties, such as individual insurers or law enforcement to look at the history of a claim or organized rings. Based upon IFB’s assessment, it sends out alerts to affected insurers.
  - IFB’s proactive model using data analytics and the data in the Motor Insurance Database to look for networks of entities (i.e., suspicious claims, individuals, enablers, etc.). The data analytics tool applies a score to a claim and gives risk factors associated to the entities. On a weekly basis, the system automatically generates a report based on real time information. IFB fraud analysts send out the relevant reports to individual insurers.
- IFB operates a Fraud Cheat Line where members of the public can report suspicious activities.
- IFB attempts to measure its success by asking insurers to report back on the alerts received and whether they are being investigated and whether they resulted in any fraud savings for the insurers. The purpose is to attempt to measure the savings which can be

attributed to IFB's alerts. Only about 30% of the insurers actually report back to IFB on the efficacy of the IFB alerts.

- IFB also referred to other UK organizations which are directly relevant to fighting auto insurance fraud in the UK:
  - The Association of British Insurers (“ABI”) represents the general insurance, investment and long-term savings industry in the United Kingdom. ABI was formed in 1985 and has over 300 members, accounting for some 90% of premiums in the UK.<sup>81</sup> Amongst other things, ABI conducts insurance fraud-related research and advocates for the general insurance industry on this topic.
  - The National Fraud Authority (“NFA”) is a group in the government with a responsibility to coordinate law enforcement, industry and voluntary/charity sectors to address insurance fraud in the UK.<sup>82</sup>
  - The Insurance Fraud Enforcement Department (“IFED”) is a specialized police unit dedicated to fighting insurance fraud. IFED is funded by insurance companies, and is composed of 34 trained detectives, who work closely with insurance industry professionals.<sup>83</sup>

IFB referred KPMG Forensic to research conducted by ABI which attempted to quantify undetected general insurance claims fraud in the UK. ABI has conducted numerous studies and surveys on the topic of insurance fraud. The most recent study was published in 2009 and related to claims data for the 2008 year.

This 2008 ABI research estimated that undetected general insurance claims fraud was £1.9 billion (C\$3 billion) annually, which equates to 6% of insurance premiums or £44 (C\$71) per policy.<sup>84</sup>

The following tables shows the change of undetected general insurance claims fraud between 2006 and 2008 and the total undetected general insurance claims fraud relative to the size of UK's general insurance market:

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<sup>81</sup> [http://www.abi.org.uk/About\\_The\\_ABI/role](http://www.abi.org.uk/About_The_ABI/role)

<sup>82</sup> <http://www.homeoffice.gov.uk/agencies-public-bodies/nfa/about-us/>

<sup>83</sup> <http://www.cityoflondon.police.uk/CityPolice/Departments/ECD/IFED/>

<sup>84</sup> Association of British Insurers, *General Insurance Claims Fraud*, July 2009.

Type of Fraud	Estimate of Undetected General Insurance Claims Fraud		
	2006 £B	2008 £B	Change %
Retail (personal lines) insurance fraud	1.0	1.2	18%
Opportunistic commercial insurance fraud	0.6	0.7	35%
<b>Total undetected fraud</b>	<b>1.6</b>	<b>1.9</b>	<b>24%</b>

In addition, it was reported that P&C insurers in the UK detected insurance fraud of £730 million (C\$1.2 billion), an amount that has increased on average by 30% each year between 2004 and 2008.<sup>85</sup> When the indicated detected fraud is combined with the estimated undetected insurance fraud, the total annual fraud is £2.6 billion (C\$4.2 billion) or about 7.8% of insurance premiums or about £60 (C\$100) per policy.

This estimate of insurance fraud in the UK used a statistical model that relied upon information that combined statistics related to insurance fraud detected by insurers<sup>86</sup> and estimates of the undetected fraud rates. Various techniques were used in the study including interviews with insurers and insurance organizations, a survey of insurance customers and a review of literature.

## 9.5 Australia

The Insurance Council of Australia (“ICA”) is the representative body of the general insurance industry in Australia. ICA’s members represent more than 90 percent of total premium income written by private sector general insurers.<sup>87</sup>

The Insurance Fraud Bureau of Australia (“IFBA”) is a part of ICA and was established to help combat insurance fraud through information collection, sharing and analysis of insurance fraud information and other specific activities.<sup>88</sup>

We discussed auto insurance fraud initiatives with a senior representative of IFBA and we were told that:

- A 2003 study<sup>89</sup> completed by the Economic Intelligence Unit and Insurance Australian Group estimated the cost of fraudulent P&C claims to be A\$2 billion (C\$2.1 billion)

<sup>85</sup> Ibid.

<sup>86</sup> Detected insurance has been reported centrally in the UK since 2003.

<sup>87</sup> <http://www.insurancecouncil.com.au/about-us>

<sup>88</sup> <http://ifba.org.au/about/>

annually. This estimate was not based upon a closed claim study or other empirical approach but was based on the often-quoted industry figure that 10% of all insurance claims are fraudulent.

- IFBA regularly meets with its members (representatives from 85% to 90% of the market participate in these meetings) to discuss the latest auto fraud trends and to share information concerning suspected fraud rings. Individual insurers can use this information to perform their own investigations concerning named individuals, groups and organizations suspected of being involved in fraudulent claims.
- There is a need for a more collaborative and coordinated effort and to create trust amongst the insurers to share information.
- Organized crime is recognized as the most pressing insurance fraud issue.
- Privacy of information is a major issue facing organized and concerted anti-fraud initiatives. Australia privacy legislation was said to preclude “fishing expeditions.”<sup>90</sup> While Australian insurance companies see the value of pooling information in a central repository for fraud analysis, privacy issues are seen as an impediment.

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<sup>89</sup> *The Hidden Costs of Insurance Fraud*, 2003.

<sup>90</sup> Fishing expedition is defined as “any inquiry carried on without any clearly defined plan or purpose in the hope of discovering useful information” (<http://dictionary.reference.com/>).

## **10 IDENTIFICATION AND PRIORITIZATION OF AUTO INSURANCE FRAUD IN ONTARIO**

We were requested to provide comments based upon our review related to the identification and prioritization of auto insurance fraud in Ontario. Based upon our review of documentation and interviews, the following summarizes our relevant observations.

### **10.1 Identification of Auto Insurance Fraud in Ontario**

Data analytics provides a robust and effective approach to identify suspicious claims for enhanced review and/or investigation. The POCs discussed in this report confirmed the utility of data analytic approaches to identify suspicious claims. Each of the POCs was considered by the sponsoring organizations to be a success in that, as a result of access and analysis of cross-insurer data, suspicious claims were identified that otherwise would not have been noted. The POCs identified a large number of claims as having a high fraud risk and being suitable for further possible investigation. Two of the POCs identified as suspicious those claims that had previously been found by insurers to be fraudulent as a result of insurer investigations (the third POC excluded data related to previously identified fraudulent claims).

With respect to data analytics and the usefulness of this approach to identify suspicious claims, the following comments are important:

- There are a number of advanced data analysis tools that are tailored to the insurance business and insurance claims in particular. Three of these tools were successfully used in the three POCs. These tools are robust and have the ability to identify suspicious claims based upon data contained within the electronic records of insurance companies.
- Data analytics has been used extensively for a number of years in the US and in the UK both by individual insurance companies and more broadly by the industry working in concert in some fashion. The purpose of this use of data analytics has been the identification of suspicious claims for further review and investigation. Some Canadian insurance companies are starting to use data analytic tools in addition to other more traditional approaches to identify suspicious claims.
- Data analysis programs are specifically structured to identify claims with the greatest risk of fraud. These tools provide a fraud risk rating for each claim. This risk-based approach when applied early in the claims adjustment process permits an insurance company to strategically allocate its claims adjusting and investigation resources to the highest risk claims. This provides the opportunity to increase the effectiveness and efficiency of claims adjudication and investigation. The timely identification of

suspicious claims for further review is critical and allows for the best opportunity to properly assess and address fraudulent claims.

- The benefits and strengths of data analytics to detect suspicious claims increases significantly and incrementally with the ability to access claims data for multiple insurers, multiple lines of business and multiple years. Overall, larger the pools of claims data permits the data analysis tools to increase the ability to connect related parties and identify common claims patterns which are key attributes of organized groups. Given that organized groups target multiple insurers, broad access to such data enhances the positive attributes of these tools. Such pooling approaches are used in the US and the UK. In Canada, a single cross-insurer approach to data analytics will result in the most effective and successful use of data analytics to detect suspicious claims.
- A critical issue to be addressed and resolved is relates to privacy concerns connected with the sharing of cross-insurer data. This legal issue was mentioned by many insurers and organizations that we spoke with.
- Data analytics may also be used to assist companies at the underwriting stage of its business by identifying risks related to new insurance applicants that might not otherwise be recognized.

As indicated above, data analytic tools provide enhanced opportunities to identify suspicious claims. However, such tools should supplement not replace, hands-on investigation. As a means of identifying, confirming and addressing fraudulent claims, hands-on, qualified and dedicated investigators are critical.

## **10.2 Prioritization of Auto Insurance Fraud in Ontario**

The overall need to address auto insurance fraud in Ontario has been identified as a key priority by the insurance industry. While this recognition is not new, it has been overtly confirmed in the past year in many ways including the initiation of the three POCs and the launch of the Task Force.

The Task Force and others are examining the issue of auto insurance fraud from many perspectives and are addressing issues that are beyond the scope of our mandate. Strictly from the perspective of our review, we have the following comments and observations related to priorities:

- The three POCs were focused on organized insurance claims fraud. As indicated by information from the POCs, organized fraud is a significant problem. A general focus on organized insurance fraud was also apparent to us from our discussions with industry experts in the US, UK and Australia.

An emphasis on organized fraud also reflects the ability to identify such activity through the recognition of connections between individuals, organizations and commonalities between claims.

It is important to recognize the deterrent value of successful prosecution of organized insurance fraud. Various approaches and initiatives can increase the success of criminal investigations and prosecution of organized insurance fraud. Issues such as immunity for provision of information by insurers to law enforcement and dedicated investigation and prosecution resources are often mentioned as important aspects of successful prosecutions of insurance fraud.

- The attributes of organized insurance fraud are easier to identify than the hallmarks of opportunistic insurance fraud, which can make organized fraud an easier target in some ways. As a result, there is a general perception that opportunistic fraud is more difficult to identify and prevent, given that it is seen as widespread across a relatively large portion of the public and is seen by many as relatively acceptable activity.<sup>91</sup> In addition, the nature and size of opportunistic fraud is seen to vary widely (i.e., there is less of a “standard modus operandi”). Thus, as a priority, opportunistic fraud is generally given a lower standing than organized fraud. However, it is recognized that opportunistic fraud activities result in significant losses to the insurance industry and some opportunistic frauds can individually result in significant costs and losses. As noted above, data analysis techniques can be used to identify opportunistic insurance fraud as well as organized fraud.

An important aspect of combating opportunistic fraud has been and will remain informing the public at large of the problem and impacts of insurance fraud. Public perceptions are a significant influence on the nature and extent of opportunistic insurance fraud. How these perceptions can be changed and the best approaches to accomplish this are matters for continuing discussion. That said, the tools for combating opportunistic insurance fraud are, in some ways, very different from organized/premeditated insurance fraud. This will impact approaches best adopted to address each type of fraud.

- The priorities assigned to the fight against insurance fraud are significantly influenced by available resources and the best use of those resources. As a result, it is understandable and expected that there is and will continue to be a focus on organized/premeditated insurance fraud.

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<sup>91</sup> Refer to Section 2.2.1 and various survey information on this topic.



## APPENDIX A

### DOCUMENTATION REVIEWED

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We have reviewed the following information sources:

#### **1. Books, Articles and Journals**

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## APPENDIX B

### GLOSSARY OF TERMS

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<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
Accident Benefits	AB	Pays benefits regardless of fault for injuries sustained in an automobile accident. The coverage varies by province but typically provides for payments for benefits such as medical expenses, rehabilitation, disability income, death and funeral expenses. <sup>92</sup>
Association of British Insurers	ABI	ABI represents the general insurance, investment and long-term savings industry in the United Kingdom. ABI was formed in 1985 and has over 300 members, accounting for some 90% of premiums in the UK. <sup>93</sup>
Automobile Insurance Anti-Fraud Task Force	Task Force	The Task Force was initiated by the Ontario government in July 2011 to examine the issue of auto insurance fraud in Ontario.
Bodily Injury	BI	Pays for special damages (lost wages, medical bills, etc.) to a claimant as a result of an injury caused by a negligent driver. <sup>94</sup>
Buildup		Deliberate inflation of losses in an otherwise legitimate claim. <sup>95</sup>
Canadian Coalition Against Insurance Fraud	CCAIF	CCAIF was created in 1994 to decrease insurance fraud through a variety of initiatives including public awareness, improved business practices, and legislative and regulatory changes. Members included private insurance companies, consumer advocacy groups, and public auto insurers. <sup>96</sup>

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<sup>92</sup> *Premeditated and Opportunistic Fraud in Personal Injury Claims*, Hynes, T., MacAulay, K., Mahaffey, T., and Wright, B., 2001, Canadian Coalition Against Insurance Fraud.

<sup>93</sup> [http://www.abi.org.uk/About\\_The\\_ABI/role](http://www.abi.org.uk/About_The_ABI/role)

<sup>94</sup> Ibid.

<sup>95</sup> *Fraud and Buildup in Auto Injury Insurance Claims*, Insurance Research Council, November 2008.

<sup>96</sup> <http://www.insurance-canada.ca/claims/canada/CCAIF200110.php>



<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
Coalition Against Insurance Fraud	CAIF	CAIF was founded in the US in 1993 and it acts as an anti-fraud watchdog from the perspective of consumers, insurance companies, legislators, regulators and others. CAIF advocates for new anti-fraud laws and regulations, it educates the public on how to fight fraud, and it serves as a national clearinghouse of fraud information. <sup>97</sup>
Commercial Auto Insurance		This policy is designed to protect a business in the event of accident, theft, injury and/or other damages involving business vehicles and business staff while driving those insured company vehicles, or their own vehicles or rented vehicles for business purposes. There are a variety of coverages for commercial autos, depending on the business being operated and who owns the vehicles being used. <sup>98</sup>
False losses		The insured makes a claim that did not occur, or attempts to include a loss that was not insured. <sup>99</sup>
Fraudulent Misrepresentation		<p>A false statement made knowing it to be false and intending another to act on it to his detriment, or made carelessly or recklessly without regard to whether it is true or false.</p> <p>In insurance it is most frequently found in the intentional misrepresentation of a risk to obtain insurance or in proof of loss after the loss occurs.<sup>100</sup></p>

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<sup>97</sup> <http://www.insurancefraud.org/aboutus.htm>

<sup>98</sup> [http://www.ibc.ca/en/Need\\_More\\_Info/Glossary/C.asp](http://www.ibc.ca/en/Need_More_Info/Glossary/C.asp)

<sup>99</sup> *Insurance Fraud*, Proceedings of the Symposium organized by the Insurance Bureau of Canada and the Foundation Conrad-LeBlanc in collaboration with the Universite de Montreal held in Montreal on February 26, Fortin, Jean-Louis and Girard, Jacques D., 1992.

<sup>100</sup> Ibid.



<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
General Insurance Statistical Agency	GISA	GISA was appointed in April 2006 to carry out the activities of a statistical agent on behalf of eight participating insurance regulatory authorities across Canada. As a federally incorporated, not-for-profit corporation, GISA provides governance, accountability and oversight of the mandated statistical plans of the participating jurisdictions. <sup>101</sup>
Health Claims of Auto Insurance	HCAI	An electronic system for transmitting specific auto insurance claim forms between insurers and health care facilities in Ontario. It supports the need for access to timely, accurate data to monitor the auto insurance system. <sup>102</sup>
Insurance Bureau of Canada	IBC	IBC is the national industry association representing Canada's private home, car and business insurers. Its member companies represent 90% of the P&C insurance market in Canada. <sup>103</sup>
Insurance Council of Australia	ICA	ICA is the representative body of the general insurance industry in Australia. ICA's members represent more than 90% of total premium income written by private sector general insurers. <sup>104</sup>
Insurance Fraud Bureau	IFB	IFB is a not for profit organization set up and funded by the insurance industry in order to disrupt and co-ordinate action against individuals committing organized insurance crime in the UK. <sup>105</sup>

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<sup>101</sup> <http://www.gisa.ca/en/about/default.asp>

<sup>102</sup> [http://www.hcaiinfo.ca/Media\\_Public/About\\_HCAI.asp](http://www.hcaiinfo.ca/Media_Public/About_HCAI.asp)

<sup>103</sup> [http://www.ibr.ca/en/About\\_Us/index.asp](http://www.ibr.ca/en/About_Us/index.asp)

<sup>104</sup> <http://www.insurancecouncil.com.au/about-us>

<sup>105</sup> <http://www.insurancefraudbureau.org/>



<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
Insurance Fraud Bureau of Australia	IFBA	IFBA is a part of ICA and was established to help combat insurance fraud through information collection, sharing and analysis of insurance fraud information and other specific activities. <sup>106</sup>
Insurance Fraud Enforcement Department	IFED	IFED is a specialized UK police unit dedicated to fighting insurance fraud in the UK. IFED is funded by insurance companies, and is composed of 34 trained detectives, who work closely with insurance industry professionals. <sup>107</sup>
Insurance Research Council	IRC	An independent not-for-profit research organization in the US supported by US insurance companies and associations. <sup>108</sup>
Intentional Losses		The insured causes or has a third party cause a loss, and subsequently declares it either as an accident or as a criminal act. <sup>109</sup>
Manitoba Public Insurance	MPI	A non-profit Crown Corporation that provides automobile coverage since 1971 to all Manitobans. <sup>110</sup>
National Fraud Authority	NFA	NFA is a group in the British government with a responsibility to coordinate law enforcement, industry and voluntary/charity sectors to address insurance fraud in the UK. <sup>111</sup>

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<sup>106</sup> <http://ifba.org.au/about/>

<sup>107</sup> <http://www.cityoflondon.police.uk/CityPolice/Departments/ECD/IFED/>

<sup>108</sup> <http://www.ircweb.org/About/Index.htm>

<sup>109</sup> *Insurance Fraud*, Proceedings of the Symposium organized by the Insurance Bureau of Canada and the Foundation Conrad-LeBlanc in collaboration with the Universite de Montreal held in Montreal on February 26, Fortin, Jean-Louis and Girard, Jacques D., 1992.

<sup>110</sup> <http://www.mpi.mb.ca>

<sup>111</sup> <http://www.homeoffice.gov.uk/agencies-public-bodies/nfa/about-us/>



<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
National Insurance Crime Bureau	NICB	A not-for-profit US organization that receives support from approximately 1,000 US P&C insurance companies. The NICB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals. <sup>112</sup>
Opportunistic Fraud		The inflation of otherwise legitimate expenses that result from a real injury. <sup>113</sup> Opportunistic fraud occurs when an individual increases or “pads” a legitimate claim.
Organized Fraud		Organized fraud is undertaken by a group of individuals working in concert. By working together, the group takes advantage of the insurance system in various and often multiple ways.
Personal Injury Protection	PIP	A US coverage that pays benefits to persons injured in auto accidents without regard to fault. Payments include reimbursement for medical expenses, lost wages, funeral expenses, and the cost of rehabilitation and replacement services necessitated by the injury. <sup>114</sup>
Personal Liability		Liability insurance, often purchased with property insurance by homeowners, tenants and businesses. It provides the purchaser with protection from legal liability to others for injury or death. Examples include expenses for rehabilitation treatment, and pain and suffering. <sup>115</sup>
Premeditated Fraud		Premeditated insurance fraud involves the purposeful claiming of improper insurance claim benefits by an individual (rather than a group). Premeditated fraud does not include the involvement of multiple parties that is found in organized fraud.

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<sup>112</sup> <https://www.nicb.org/about-nicb>

<sup>113</sup> *Premeditated and Opportunistic Fraud in Personal Injury Claims*, Hynes, T., MacAulay, K., Mahaffey, T., and Wright, B. 2001, Canadian Coalition against Insurance Fraud

<sup>114</sup> *Fraud and Buildup in Auto Injury Insurance Claims*, Insurance Research Council, 2008

<sup>115</sup> *Premeditated and Opportunistic Fraud in Personal Injury Claims*, Hynes, T., MacAulay, K., Mahaffey, T., and Wright, B. 2001, Canadian Coalition against Insurance Fraud



<b>Term</b>	<b>Short Form</b>	<b>Explanation</b>
Private Passenger Vehicle		A vehicle not used as a commercial vehicle. For example, if a small van is used as a family vehicle, it is considered a private passenger vehicle. However, if this same van is used as a full-time delivery vehicle, it is considered a commercial vehicle. <sup>116</sup>
Property & Casualty Insurance	P&C	This is the branch of the insurance industry that covers home, car and business insurance. <sup>117</sup> Also known as “general” insurance.
Special Investigation Unit	SIU	SIUs are part of insurance companies and are charged with investigating suspected insurance fraud claims. Generally comprised of individuals who have law enforcement and/or investigations experience as well as insurance knowledge. The main responsibility of SIU is investigating potential fraudulent claims.

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<sup>116</sup> [http://www.ibc.ca/en/Need\\_More\\_Info/Glossary/P.asp](http://www.ibc.ca/en/Need_More_Info/Glossary/P.asp)

<sup>117</sup> Ibid.



## APPENDIX C

### EXAMPLES OF INSURANCE FRAUD

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The following are a number of examples of insurance fraud based upon information obtained from materials that we reviewed during the preparation of this report:

#### Organized Insurance Fraud

- Staged accidents where drivers work in teams to create an accident involving an innocent victim. For example, an innocent driver is signaled to turn left and the oncoming car waves him through while his teammate speeds up and crashes into the innocent driver.<sup>118</sup>
- Staged accidents involving one or more cars where all of the occupants of the cars are part of the scheme. These schemes can involve repair facilities, medical care providers, and other professionals who become involved in the filing and support of claims.
- An insurance policy on a non-existent automobile using a vehicle identification number (VIN) lifted from a salvage vehicle. A claim is later made on this 'paper car'.<sup>119</sup>
- A city bus was stopped on the street when a truck rammed into its rear end. The impact wasn't that great in fact it was a minor fender bender but 44 passengers on board claimed to have been injured. It turned out that wasn't all the passengers had in common. They had all been recruited to take the fateful bus ride with the promise of a \$100 now and more down the road. It was a bold scheme on a big scale and the payoff would have been huge. The organizers planned to run the fake claims through the insurance system.<sup>120</sup>
- An older vehicle is filled with passengers. The driver positions his car in front of the victim's while a backseat passenger in the criminal's vehicle watches and waits for the innocent driver to be distracted, for example, by a cell phone call. As soon as the victim is distracted, the driver slams on the brakes, causing the innocent motorist to rear-end the criminal's vehicle.<sup>121</sup>

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<sup>118</sup> <http://www.france24.com/en/20110110-insurance-fraud-rings-find-fertile-ground-canada>

<sup>119</sup> McKenzie, Shawn, Institute of Insurance and Pension Research, University of Waterloo.

<sup>120</sup> *Truth is stranger than fiction – Top insurance frauds in 2003*, The High River Times, 2003

<sup>121</sup> *5 ways to detect staged accidents*, Top Canadian Insurance Broker, April 25, 2011

## Premeditated Insurance Fraud

- A vehicle repair shop may intentionally increase the amount of work needed to repair vehicles brought in for repairs after collisions. A vehicle may be brought to the shop with minor damage but be presented to an insurer with significantly more damage. By causing further damage on the vehicle before it is inspected by an insurer, the shop increases the value of the goods and services it will provide to the claimant. The cost of these goods and services will ultimately be paid by the claimant's insurer.<sup>122</sup>
- Instead of developing an individualized assessment request for each victim, a health care practitioner may submit the same assessment request or treatment information without changing the information. The practitioner would leave the victim's name blank and submit requests recommending certain treatments to the insurer without the victim's knowledge.
- A car owner purchases automobile insurance and subsequently 'ditches' the car and reports it stolen to cash in on the insurance policy.<sup>123</sup>
- A car owner reports his car as stolen and files an insurance claim but the car was actually hidden in a rental storage unit.<sup>124</sup>
- An innocent driver merges his or her vehicle into traffic after being motioned to do so by the fraudster. As the driver begins to merge, the fraudster speeds up and causes a collision. When questioned, the fraudster denies motioning the victim to merge into traffic or gives excuses.<sup>125</sup>
- A person deliberately causes a car collision and then collects benefits from his or her insurance company for a nonexistent injury.<sup>126</sup>
- A cyclist was left bleeding and in serious pain after being hit by a car. It seemed like a clear-cut case at the time and he received \$22,000 in compensation from his insurance company. Then his tangled web of lies began to unravel and the accident turned out to be not exactly accidental. The case ended up in court where the evidence included a toothpick and an overly helpful girlfriend. She was behind the wheel and had

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<sup>122</sup> Ontario Auto Insurance Anti-Fraud Task Force Interim Report, December 2011.

<sup>123</sup> McKenzie, Shawn. Institute of Insurance and Pension Research, University of Waterloo.

<sup>124</sup> *Truth is stranger than fiction – Top insurance frauds in 2003*, The High River Times, 2003

<sup>125</sup> *5 ways to detect staged accidents*, Top Canadian Insurance Broker, April 25, 2011

<sup>126</sup> *The reality of personal injury fraud*, Accident Direct, June 29, 2008.



deliberately run into the man, gently she'd hoped. The man had stuck it up his nose to get some blood and the insurance money flowing.<sup>127</sup>

### **Opportunistic Fraud**

- Deliberately misrepresenting facts on an insurance claim to increase the amount of money collected from an insurance company.<sup>128</sup> This can be done in numerous ways such as:
  - Claiming for damage not caused in the claimed accident;
  - Claiming for property damaged at a value greater than actual;
  - Claiming for property that was not actually damaged or lost in the accident;
  - Submitting duplicate claims for the same injury;
  - Submitting bills for treatment that was never received;
  - Claiming a fictitious injuries;
  - Staying off work following an accident for longer than required;
  - Under-reporting income actually earned after an accident while receiving accident benefits;
  - Misrepresenting wage losses.<sup>129</sup>
- Giving misleading information to the insurance company that causes them to make an underwriting decision that they would not otherwise make. For example, an insured may have a high-risk driver in the household and intentionally withhold this information.<sup>130</sup>

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<sup>127</sup> <http://www.highrivertimes.com/ArticleDisplay.aspx?archive=true&e=1999415>

<sup>128</sup> *Insurance Fraud: A Public View*, Insurance Research Council June 2003.

<sup>129</sup> *Insurance Fraud*, Derrig, Richard, *The Journal of Risk and Insurance*, 2002, Vol. 69, No. 3.

<sup>130</sup> *An Analytical Approach to Detecting Insurance Fraud Using Logistic Regression*, Wilson, J. Holton, Central Michigan University.