Several Factors Hinder Homeowner and Auto Glass Insurance Fraud Processing

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OPPAGA

Office of Program Policy Analysis and Government Accountability

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Department of Financial Services' (DFS) Division of Investigative and Forensic Services (DIFS) is the lead state entity involved in reporting and investigating insurance fraud in Florida. DIFS investigators also provide investigative support to state prosecutors once they present a case for prosecution.

REPORT SCOPE

As directed by the Legislature, OPPAGA examined how effectively homeowner and auto glass insurance fraud is being handled in Florida. While more potential cases of fraud are being referred to DFS than six or seven years ago, there is interest in factors that may be driving these increases as well as concern that too few cases are investigated and prosecuted.

Most reports of suspected insurance fraud (i.e., referrals) from Fiscal Year 2014-15 through 2019-20 came from insurance companies, which are required to maintain a special investigative unit (SIU) and report suspected fraud to DIFS. In recent years, reports of suspected homeowner and auto glass fraud to DIFS have increased substantially, while the number of fraud cases presented to prosecutors has not risen in tandem. Overall, homeowner fraud referrals followed Florida's population patterns by county. While auto glass fraud referrals also occurred throughout the state and generally followed population patterns, some large counties have fewer referrals than expected given their population size.

Processing suspected fraud referrals and investigating fraud cases takes substantial time, work, and experience. Most suspected fraud referrals were closed without resulting in a subsequent fraud case because they lacked sufficient evidence to proceed, and most fraud cases did not result in presentations to prosecutors for similar reasons. Regardless of their outcome, evaluating fraud referrals and investigating fraud cases can take months. DIFS staffing issues affect the division's ability to investigate complex insurance fraud cases.

Stakeholders suggested several options to deter fraud and improve the quality of data DIFS receives from insurance companies. These include eliminating one-way and contingency risk/fee multiplier fee provisions, restricting assignment of benefits (AOB) guidelines for auto glass claims, reducing the time frame for filing hurricane/windstorm homeowner claims, revising statutory requirements for insurance company fraud reporting, providing for SIU auditing, and modifying the Anti-Fraud Reward Program.

BACKGROUND

Insurance fraud occurs when an actor such as an insurance company employee or agent, public adjuster, or policyholder commits a deliberate deception to obtain an illegitimate gain. Insurance fraud can occur during the process of buying, using, selling, or underwriting insurance. Insurance fraud may be committed at different points in the insurance transaction by individuals applying for insurance, policyholders, third party claimants, or professionals who provide services to claimants. Common frauds include inflating claims, misrepresenting facts on an insurance application, submitting claims for injuries or damages that never occurred, and staging accidents. Insurance fraud perpetrators range from individuals committing fraud against consumers to individuals committing fraud against insurance companies; often, teams of individuals participate in fraud plans that have become more sophisticated over time.

Multiple entities have responsibilities in reporting, investigating, and prosecuting insurance fraud. The Department of Financial Services' (DFS) Division of Investigative and Forensic Services (DIFS) is the lead state entity involved in reporting, investigating, and prosecuting insurance fraud in Florida. DIFS houses the Bureau of Insurance Fraud (BIF), which conducts investigations and maintains the case management information system.[1,2] According to DIFS, no other state agency actively pursues property or auto glass insurance fraud in Florida.[3] Other state agencies, such as the Office of Insurance Regulation and the Department of Agriculture and Consumer Services, simply report fraud or refer consumers to DIFS.

Private entities such as insurance companies provide most of the fraud reports (i.e., referrals) made to DIFS. While any individual may report insurance fraud to DIFS, state law requires companies that provide insurance in Florida to report fraud to DIFS, via their special investigative units (SIU). Florida law requires that all insurance companies admitted to do business in the state establish and maintain an SIU that is staffed either internally or by contract to investigate and report possible insurance fraud.[4] Insurance companies must also provide an anti-fraud plan acknowledging procedures and guidelines for investigation of possible fraudulent insurance acts, procedures for reporting to DIFS, organizational structure of the anti-fraud unit, and education and training provided to the anti-fraud unit.

DIFS may also coordinate with other law enforcement agencies and prosecutors. Local law enforcement offices may also investigate insurance fraud cases. In addition, DIFS reports that it may coordinate with local or federal law enforcement on particular cases it is investigating. Further, if DFS makes an arrest in a case, it can present the case to the applicable prosecuting authority, such as the state attorney's office, the statewide prosecutor, or the United States Attorney General's Office. (See Exhibit 1 for descriptions of the public and private organizations involved in investigating and prosecuting insurance fraud.)

[1] For clarity, we refer to DIFS both for data and investigative discussions throughout the report.
[2] Including BIF, the division provides services through the following units: Workers Compensation Fraud; Fiscal Integrity; Fire, Arson, and Explosives Investigations; and Forensic Services.
[3] OPPAGA also interviewed officials from the Florida Department of Agriculture and Consumer Services, who said that if the department receives an insurance fraud complaint from a consumer, the complaint is forwarded to DFS.
[4] See s. 626.9891, *F.S.*

Exhibit 1
State and Local Entities Respond to Insurance Fraud in Florida

Organization	Activities
DFS, Division of Investigative and Forensic Services	• Receives insurance fraud referrals from consumers and insurance companies • Conducts investigations related to insurance fraud; workers' compensation fraud; and fire, arson, and explosives[1] • Maintains related case management data • Determines if an insurance fraud crime has occurred • Presents insurance fraud cases to prosecutors
DFS, Office of Insurance Regulation	• Responsible for the regulation, compliance, and enforcement of statutes related to insurance and the monitoring of industry markets • Reports malfeasance by insurance companies to DIFS
Insurance Company Special Investigative Units	• Responsible for the regulation, compliance, and enforcement of statutes related to insurance and the monitoring of industry markets • Reports malfeasance by insurance companies to DIFS
Prosecutors	• State attorneys and the statewide prosecutor collaborate and review criminal investigations and complaints submitted by DIFS and other law enforcement agencies; file formal charges supported by the law and the evidence; and present these cases in court o State attorneys are the prosecuting authority for cases that take place within a single jurisdiction or circuit o Statewide prosecutor is the prosecuting authority for multi-circuit fraud cases
Other Law Enforcement Agencies (e.g., local police or federal law enforcement)	• Receive reports and investigate insurance fraud • Present insurance fraud cases to prosecutors • May assist DIFS with its investigations

[1] Included within these categories are organized plans to defraud the public and insurance companies, insolvency of insurance companies due to internal fraud, criminal activity by unauthorized entities illegally doing business in Florida, and viatical-related fraud.
Source: OPPAGA analysis.

The Legislature dedicates state resources for fraud reporting, investigation, and prosecution, which are mostly provided to DIFS and prosecutors. For Fiscal Year 2020-21, the Division of Investigative and Forensic Services was allocated 334 positions and a budget of $40 million. Of this allocation, BIF received 194 positions and $22.8 million, which was 58% of DIFS overall positions and approximately 57% of the DIFS budget. In addition, since Fiscal Year 2001-2002, the Legislature has appropriated $100,000 annually to the Department of Financial Services Anti-Fraud Award Program. The program awards up to $25,000 to persons providing information leading to the arrest and conviction of individuals that commit insurance fraud crimes. Over the last 19 years, the Legislature has allocated a total of $1.9 million for the rewards program.

In addition, because the prosecution of insurance fraud requires specialty training and expertise, the Legislature created the Dedicated Prosecutor Program, which funds the salaries of prosecutors, paralegals, and investigators dedicated solely to prosecuting fraud and related cases. The Legislature allocated the program $2.5 million for funded positions in each of Fiscal Years 2018-19 and 2019-20. Of this amount, $1.9 million was specified for positions dedicated to prosecuting general insurance fraud cases, and $604,104 was designated for positions dedicated to prosecuting workers' compensation fraud cases. These funds were allocated to seven state attorneys' offices for 29 positions across these circuits.[5] Of these positions, 16 were for prosecutors and 13 were for paralegals and investigators.

[5] These judicial circuits include the metropolitan areas of Ft. Lauderdale, Ft. Myers, Jacksonville, Miami, Orlando, Tampa, and West Palm Beach.

FINDINGS

Homeowner and auto glass insurance fraud referrals made to DIFS increased over the past six years and are concentrated in Florida's population centers

Most suspected insurance fraud referrals from Fiscal year 2014-15 through 2019-20 came from insurance companies, which are required to maintain a special investigative unit and report suspected fraud to the Division of Investigative and Forensic Services. In recent years, reports of suspected homeowner and auto glass fraud to DIFS have increased substantially, while the number of fraud cases presented to prosecutors has not risen in tandem. Overall, homeowner fraud referrals followed Florida's population patterns by county. While auto glass fraud referrals also occur throughout the state and generally follow population patterns, some large counties have fewer referrals than expected given their population size. Stakeholders reported that insurance fraud has patterns that can be interrupted by policy changes and prosecution.

Referrals for homeowner and auto glass fraud increased during the review period

Insurance companies are the primary source of fraud referrals but are not required to provide much supporting evidence for their referrals. Insurance companies submitted most reports of suspected insurance fraud that DIFS received during our review period, Fiscal Years 2014-15 through 2019-20. Insurance companies reported suspected fraud either through the DFS website and hotline or through the National Insurance Crime Bureau (NICB), which has an electronic link between its member companies doing business in Florida and DFS.

Florida law requires insurance companies to establish procedures for detecting and investigating possible fraudulent acts. The insurance company must maintain a special investigative unit that is staffed either internally or by contract.[6] Insurance company SIUs are required to report possible fraudulent insurance acts to DIFS as suspected fraud referrals.[7] The Florida Administrative Code specifies reporting requirements for insurance company SIUs on suspected fraudulent referrals, including clearly defined information supporting the allegation of suspicious activity and the dates of that activity.[8]

While insurance companies are statutorily required to investigate and report fraud, insurance company SIUs are not subject to routine state audits to ensure compliance. When asked what would happen if DIFS had the authority to audit company SIU anti-fraud plans, responding SIUs reported that such audits would verify the existence and gauge the relative health of a company's SIU. Audits would also require that SIUs prove they are conducting anti-fraud activities in accordance with the plans they have on file with DIFS. Lastly, audits could improve the quality of referrals and expose any training needs of the SIU.

DIFS provides SIUs with an insurance referral form on the Department of Financial Services web portal. The required fields of the online submission form are the name of person(s) suspected of

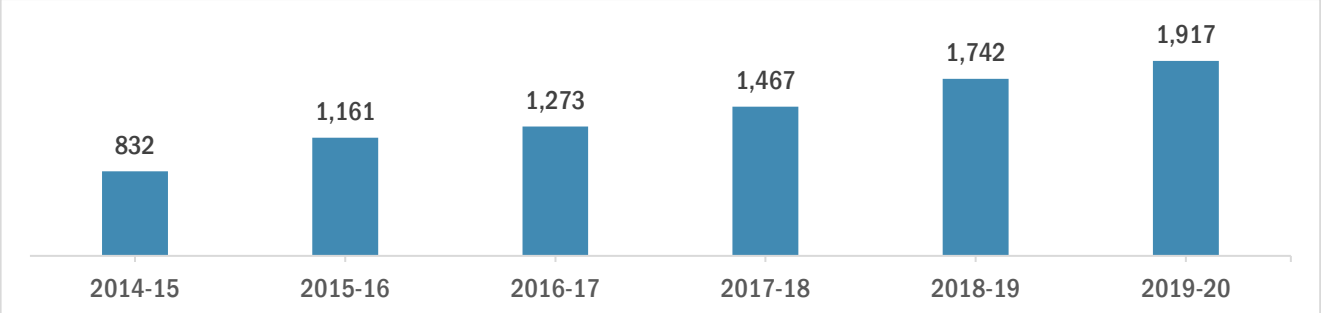
[6] Section 626.9891(2), *F.S.*
[7] Section 626.989(6), *F.S.*
[8] Rule 69D-2.003, *F.A.C.*

fraudulent activity, nature of the suspected fraudulent activity, facts that support suspicion of fraudulent claim, and any prior history of fraudulent claim activity. The referral form also contains optional data elements, such as date of loss, the amount of any payments made on the claim, narrative or evidence that corroborates or supports suspicion of fraud, and the insured and claimant information. DIFS stated that the referrer's inclusion of optional information would increase the number of cases they investigate each year because each referral would take less time to verify and pursue.[9]

Several insurance company SIUs that provided information to OPPAGA noted different opportunities to improve the information they provide to DIFS and other law enforcement entities. One SIU noted that the referral form could be improved by clarifying some questions and including "help text" to make the form more intuitive. Another SIU added that the referral form currently is geared toward auto and liability claims and that adding more elements relating to homeowners claims would be helpful. To that end, an SIU suggested DIFS provide an improved feedback loop to SIUs regarding referral quality, such as training webinars on the fundamentals of evaluating and referring suspected fraud. According to DIFS, while they do have quarterly meetings with SIU staff to communicate expectations for referral submissions, they do not have staff or funding to establish a formal training program.

Homeowner and auto glass referrals increased between Fiscal Years 2014-15 and 2019-20. OPPAGA reviewed DIFS data on referrals for the past six state fiscal years. During the review period, DIFS received 99,287 referrals for fraud, 8.5% of which were for homeowner fraud and 2.1% of which were related to auto glass.[10,11,12] During this time, homeowner fraud was one of the five most common types of insurance fraud referrals. Auto glass fraud is a subtype of vehicle fraud, which was also one of the five most common types of referrals. Our review of fraud referrals submitted to DIFS from Fiscal Year 2014-15 through Fiscal Year 2019-20 revealed increases in the reporting of suspected fraud. A total of 8,392 suspected homeowner fraud referrals were submitted to DFS during the review period. Notably, DIFS data showed that homeowner fraud referrals more than doubled during that time, from 832 in Fiscal Year 2014-15 to 1,917 in Fiscal Year 2019-20. (See Exhibit 2.)

Exhibit 2
Homeowner Fraud Referrals More Than Doubled From Fiscal Year 2014-15 Through Fiscal Year 2019-20

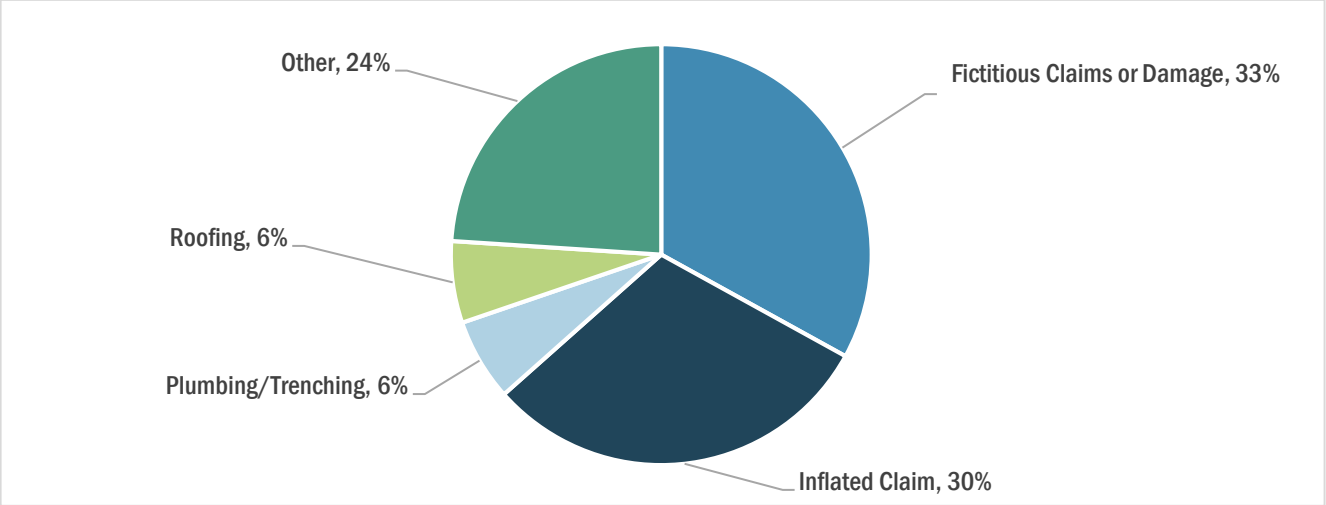


Source: OPPAGA analysis of DIFS/Augmented Criminal Investigation Support System (ACISS) data.

[9] Because of the way optional data elements are recorded in the Augmented Criminal Investigation Support System, we were unable to document how frequently this information is absent for all referrals in the system.
[10] Total fraud referral counts are from DIFS publications. Homeowner and auto glass figures are based on OPPAGA's analysis of DIFS Augmented Criminal Investigation Support System data.
[11] The number of auto glass referrals we report is larger than those reported through DIFS publications because we include referrals that report "windshield/glass" as either a subtype or "additional subtype," as well as those that referenced auto glass in the referral description, while DIFS Annual Statistical Reports include only those referrals with the primary subtype "windshield/glass."
[12] As of June 30, 2020, there were 6.9 million residential property policies in force in Florida.

During the review period, the most common subtypes of suspected homeowner fraud activity reported in referrals were fictitious claims and inflated claims. Other common types included plumbing and roofing fraud. This general pattern held throughout the review period. During the period, 2,771 (33%) of all homeowner fraud referrals were for fictitious claims, and 2,553 (30%) were for inflated claims. (See Exhibit 3.)

Exhibit 3
During the Review Period, Most Homeowner Fraud Referrals Were for Fictitious Claims and Inflated Claims[1]



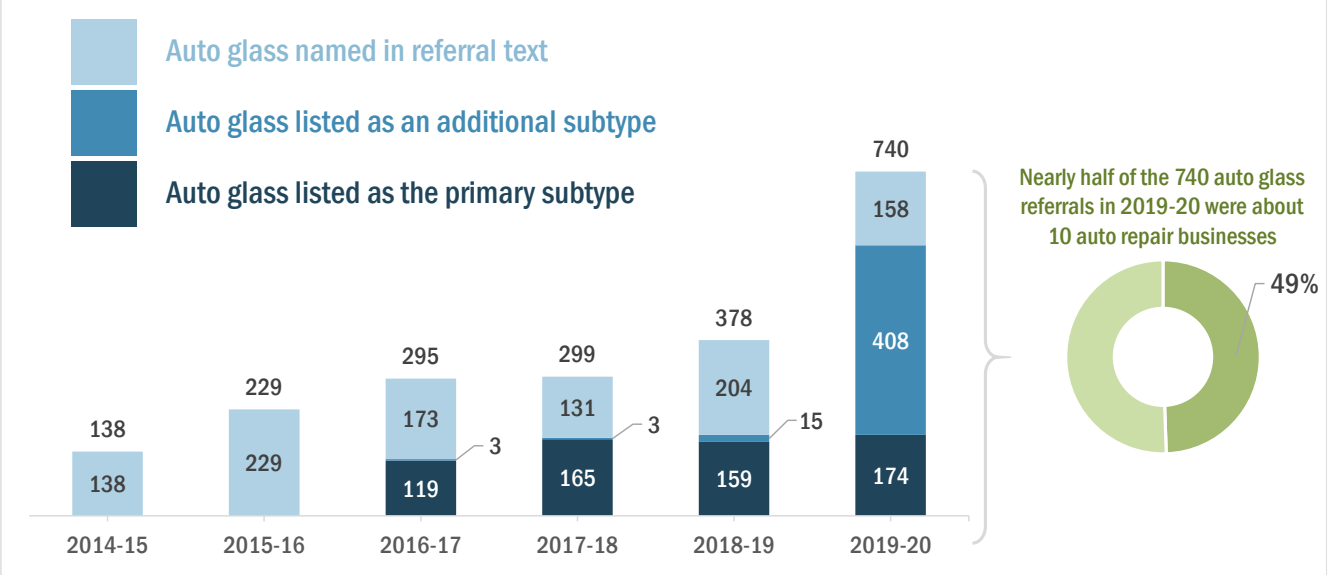
[1] Other types (in order of frequency) included forgery, water extraction, contractor, assignment of benefits, public adjuster, Hurricane Irma, fictitious liability, waiving deductible, unlicensed adjuster, fire, sinkhole, and Hurricane Michael.
Source: OPPAGA analysis of DIFS/ACISS data.

Auto glass referrals also increased during the review period**.** DIFS began specifically monitoring suspected fraud referrals for auto glass claims as a subtype of vehicle fraud in February 2017. Prior to this, DIFS recorded auto glass referrals as other subtypes of vehicle fraud, primarily using the categories "damage to vehicle" and "body shop." DIFS publications show increasing reports of auto glass fraud submitted since the division began tracking this specific fraud subtype.

Although DFS has formally tracked suspected fraud referrals for auto glass claims for only three years, OPPAGA's more detailed analysis identified additional claims and shows increases in auto glass referrals over the full review period.[13] OPPAGA identified auto glass referrals in three ways: the listing of auto glass as the primary subtype (DIFS definition), as an additional subtype, or named in the text of the referral. From this, OPPAGA identified auto glass referrals beyond those presented in DIFS reports, including many reported prior to 2017.[14] In Fiscal Year 2019-20, a total 740 referrals pertained to auto glass, and only 174 of those listed auto glass as the primary subtype. Another 408 referrals listed auto glass as an additional subtype, and 158 were recorded as a different type of vehicle fraud (primarily as "damage to vehicle") but included words such as "auto glass" or "windshield" in the details of the referral text. Nearly half of the referrals in Fiscal Year 2019-20 (367) were related to 10 auto repair businesses.[15] (See Exhibit 4.)

[13] DIFS publications document auto glass referrals categorized as "windshield/glass" as the primary subtype.
[14] Counts of auto glass referrals for those based on the detailed text information may include other types of auto repair fraud, particularly in recent years. A more precise count would require a manual, case-by-case examination.
[15] We treat auto repair businesses with referrals in more than one county and the same business name as the same company.

Exhibit 4
Total Auto Glass Referrals Increased During the Review Period[1]



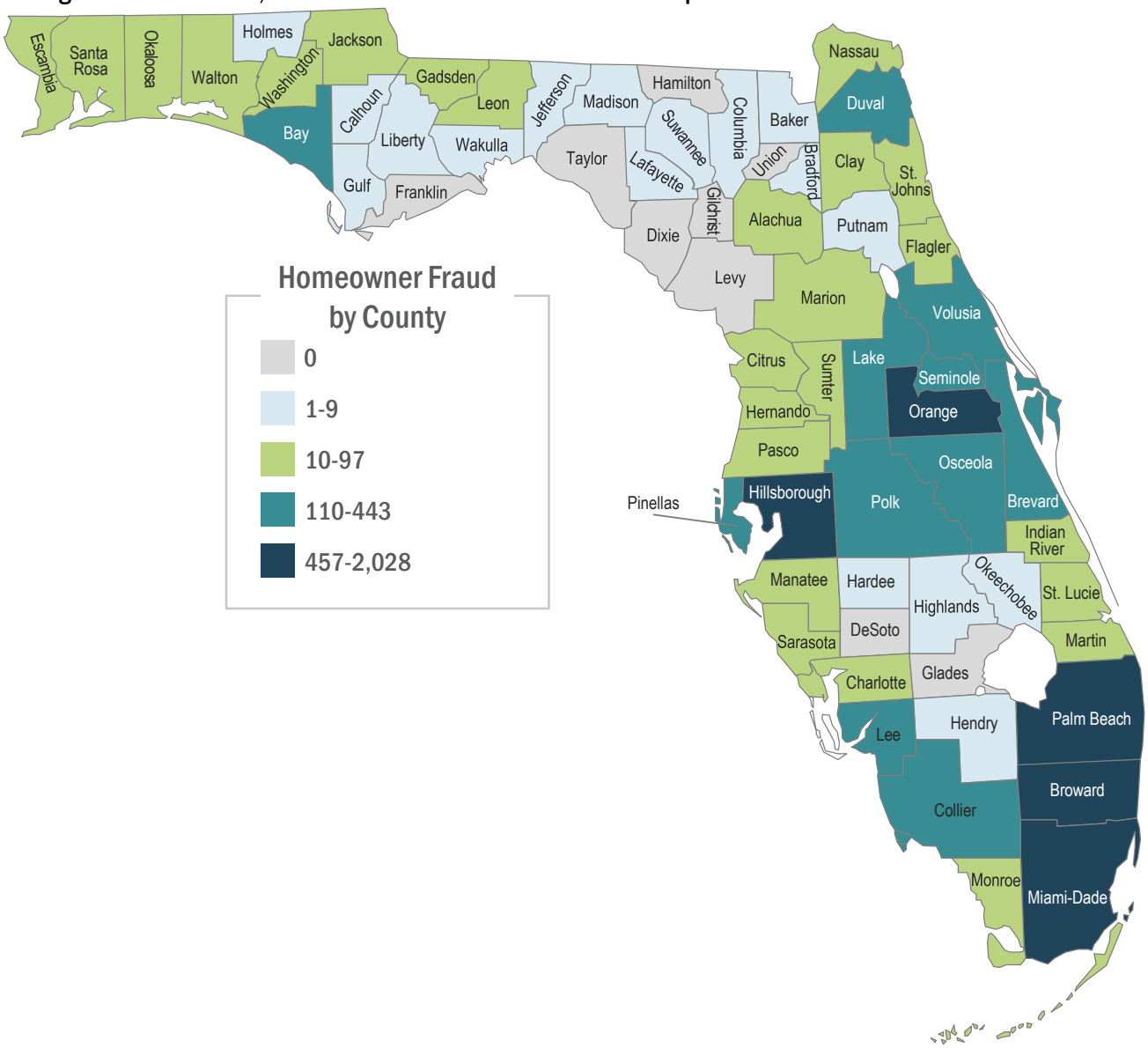
[1] DIFS began specifically tracking auto glass as a primary subtype in February 2017. Counts presented here differ from those in DIFS Annual Statistical Reports because we include the additional sources of referrals presented above.
Source: OPPAGA analysis of DIFS/ACISS data.

Homeowner and auto glass fraud referrals were generally concentrated in large population centers

OPPAGA mapped insurance fraud referrals by type to see how alleged fraud is distributed across the state. We found that homeowner (all types combined) and auto glass fraud referrals followed population patterns, with counties generally experiencing fraud referrals in proportion to their population; although for specific types of referrals, this may vary.

Overall, homeowner fraud referrals followed Florida's population patterns by county. Homeowner referrals are generally concentrated in Florida's population centers of southeast and central Florida, including the Tampa Bay region. (See Exhibit 5.) The Panhandle, Big Bend, and inland Okeechobee regions experienced far fewer referrals. Over the six-year review period, 26 counties had fewer than 10 referrals for homeowner fraud of any type. Of these predominately rural counties, nine had no homeowner fraud referrals. Five counties—Broward, Hillsborough, Miami-Dade, Orange, and Palm Beach—accounted for over 59% of all referrals. (See Appendix A for total referrals by county during the review period.)

Exhibit 5
During the Review Period, Homeowner Fraud Referrals Followed Population Patterns



[1] Numbers in legend represent actual number of referrals. OPPAGA categories illustrate county variation, thus, categories show zero and low incidents of fraud, midrange incidents, and the top five counties for fraud incidents.
Source: OPPAGA analysis of DIFS/ACISS data.

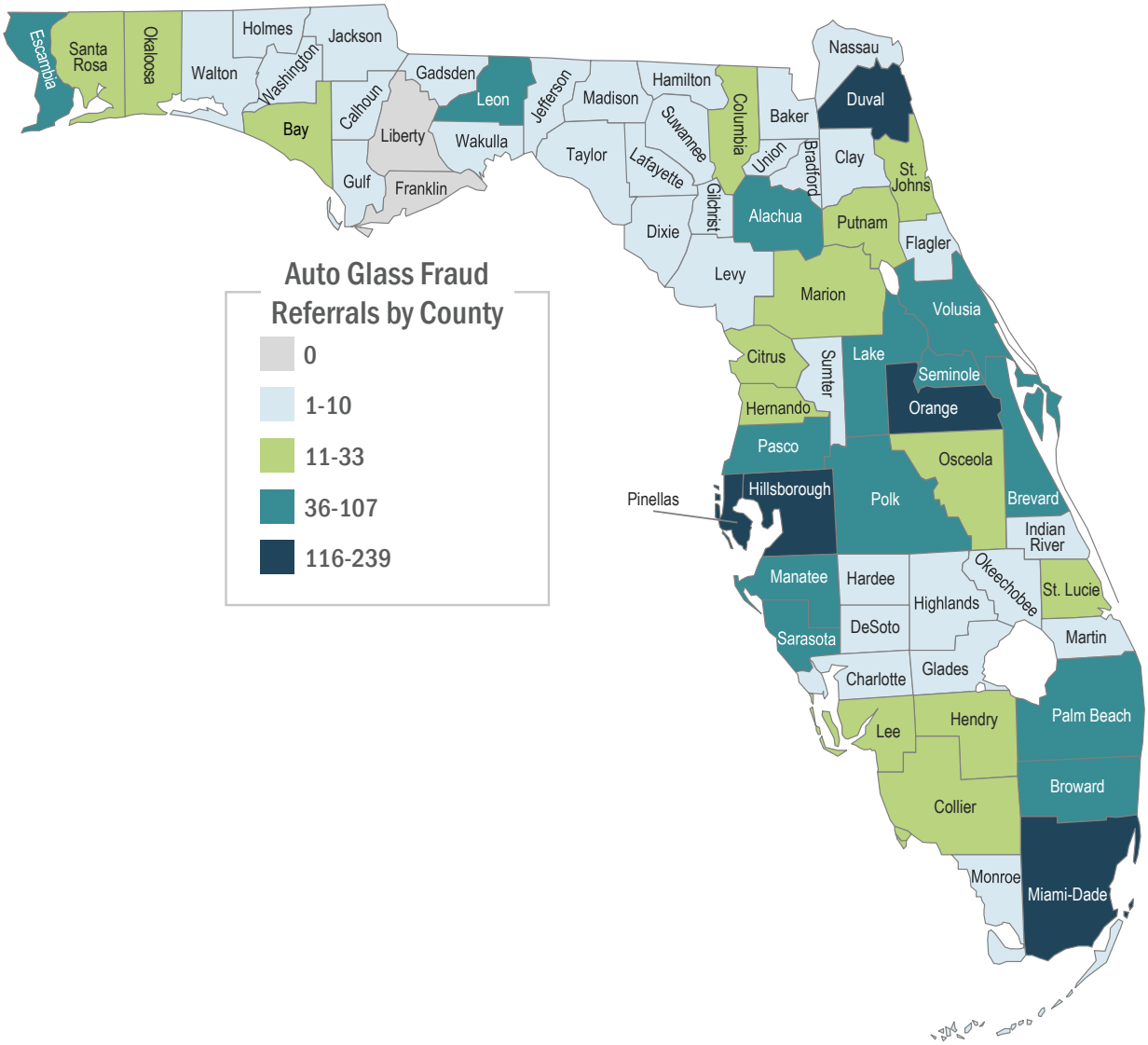
While the incidence of referrals for all types of homeowner fraud appeared to follow county population patterns, the incidence of fictitious damage and roofing claim subtypes of homeowner fraud referrals did not show the same consistent pattern, particularly with regard to Florida's most populous counties. For example, Miami-Dade County, with Florida's highest population, had the fourth highest number of fraud referrals for fictitious damage. For roofing fraud referrals, Orange County, the 5th largest county, had the highest number of fraud referrals, while Volusia, the 11th highest in population, ranked 3rd for this type of referral. (See Appendix B for more information on geographic distribution of these referrals.)

Auto glass fraud occurred in almost all Florida counties but is primarily concentrated in five counties. Over the six-year review period, 65 counties reported at least one referral of auto glass fraud; only two counties had no referrals for auto glass fraud. Though referrals are concentrated in

populous counties, two of the most populous counties, Broward and Palm Beach, were not among the top five for auto glass referrals. Thirty-four counties had fewer than 10 referrals, two of which had no referrals of this type. (See Exhibit 6.) The top five counties (Duval, Hillsborough, Miami-Dade, Orange, and Pinellas) accounted for over 45% of all referrals. OPPAGA found that a relatively small number of companies were the basis for auto glass solicitation referrals. As stated above, nearly half of the referrals in Fiscal Year 2019-20 (367) were for only 10 companies.[16]

Exhibit 6

During the Review Period, Auto Glass Referrals Were Primarily Concentrated in Duval, Hillsborough, Miami-Dade, and Orange Counties



[1] Numbers in legend represent actual number of referrals. OPPAGA categories illustrate county variation, thus, categories show zero and low incidents of fraud, midrange incidents, and the top five counties for fraud incidents.
Source: OPPAGA analysis of DIFS/ACISS data.

[16] We treat companies with the same names and referrals in more than one county as the same company.

Stakeholders reported a variety of issues that may affect trends in fraudulent homeowner and auto glass insurance referrals

Organized homeowner and auto glass fraud may follow common patterns. Stakeholders that OPPAGA interviewed noted that insurance fraud may occur in patterns over time. These stakeholders, including the Division of Investigative and Forensic Services, state attorneys, and insurance companies, described typical scenarios for both homeowner and auto glass fraud, including arson for hire, non-storm water damage, and dropped object claims.

Homeowner Insurance Fraud

Homeowner insurance fraud commonly involves non-weather water or roof-windstorm damage claims. Teams engage in marketing, offering free inspections, such as examining a roof for wind damage. Unlicensed activity may play a part in homeowner fraud teams. The Division of Investigative and Forensic Services and other stakeholders report concerns about individuals who are not licensed as adjusters soliciting claims.

The team representative has the homeowner sign a contingency contract and makes referrals to other team members, such as a water mitigation company or roofer, depending on the damage. The contractor(s) then submits an inflated claim to the insurance company.

When the insurance company does not acquiesce to the estimate, the attorney on the team files suit, and may represent both the contractor and the policyholder. What is typically not transparent to policyholders is that, should the claim go to court, these contracts can assign as much as 40% of any settlement to the attorney and other third parties.

Auto Glass Insurance Fraud

Auto glass insurance fraud typically involves solicitation of vehicle owners by companies offering to conduct free windshield inspections. Some fraudulent companies approach consumers in public places, such as car washes and grocery store parking lots, and offer to provide free inspections. The company tells the owner the windshield is damaged and their insurance will cover the entirety of the cost of a repair/replacement because in Florida, a consumer with comprehensive or combined additional coverage does not have to pay a deductible for windshield glass repair or replacement.

Company representatives may offer free steak dinners or gift cards to entice the person to sign an assignment of benefits contract, giving the auto glass company the right to file a claim, replace the windshield, and collect insurance payments.

Typically, these companies complete repairs in a short amount of time and the insurance company is only notified after repairs have been made. The fees charged to insurers are generally much higher than the industry standard. In some instances where claims are not paid, a repair company will sue and has the ability to then collect attorney fees.

Stakeholders described third-party motivated claims as creating a large volume of non-meritorious claims on behalf of policyholders. Specifically, stakeholders reported that teams of consumer representatives, which can include attorneys, adjusters, loss consultants, and contractors, generate fraudulent claims, collect substantial fees, and often fail to complete necessary home repairs for the policyholder or do not leave the consumer with sufficient resources to complete repairs.

Stakeholders reported that current statutory provisions may facilitate fraudulent behavior. For example, Florida's one-way attorney fee provision and fee multiplier allow the policyholder's attorney fees to be paid by their insurance company, if the policyholder is the prevailing party in a dispute.[17,18] These awarded fees may also be bolstered by a fee multiplier, which could create an additional

[17] S. 627.428, *F.S*, specifies the awarding of attorney fees that pertain to assignees in a residential and commercial property insurance policy.
[18] See *Joyce v. Federated Nat'l Ins. Co*., 228 So. 3d 1122 (Fla. 2017)

financial incentive for attorneys to pursue litigation.[19] For example, Citizens Property Insurance Corporation provided information about cases in which Citizens was ordered to pay fees, with multipliers that reached 2.5.[20] These cases originated in Broward, Hernando, Hillsborough, Miami-Dade, and Pasco counties.[21] The primary reported causes of loss in these cases included sinkhole, water, wind, and fire.[22] The largest percent increase in the indemnity amount after the fee multiplier was applied was 2036%. Between 2018 and 2020, Citizens' paid over $4.6 million in multiplier fees to attorneys. [23] The financial impact of the multiplier statewide for all insurance companies is unknown.

In addition, a similar incentive to commit fraud may occur under existing assignment of benefits (AOB) law as it applies to auto glass insurance claims. Stakeholders reported that auto glass fraud referrals could be driven by third-party representatives and that such referrals commonly occur under AOB to a vendor. Auto glass damage coverage is typically part of a consumer's comprehensive vehicle insurance coverage. Some auto insurance companies have a network of auto glass repair shops that provide repairs at negotiated rates. If consumers use a network shop, insurance companies will pay these shops directly. However, if a consumer uses a company that is out of the network, the company will often obtain an AOB from the consumer. Some companies use their AOB status to charge fees that are higher than an insurance company would normally cover.

Moreover, DIFS and insurance companies reported that fraudulent homeowner claims increase towards the end of the three-year time frame for filing claims for hurricane/windstorm events. Florida law allows an insured policyholder up to three years to file such claims. When asked about the claims timeline process, Citizens Property Insurance reported that many claims filed toward the end of the three-year window tend to have a high level of third-party representation, which can be associated with non-meritorious claims on behalf of policyholders. Additionally, DIFS indicated that insurance companies were more likely to submit suspected fraud referrals near the end of the three-year claim limit for hurricane/windstorm events. Insurers told OPPAGA that these claims can be costly, because of both the fee multiplier and one-way attorney fee provisions noted above.

Finally, stakeholders reported that the economy influences fraud scheme trends. People find themselves without money, so they decide to pursue compensation or the needed service by filing fraudulent claims.

Stakeholders reported that insurance fraud patterns may be disrupted by insurance company policy changes and prosecution. Insurance companies reported that cycles that occur when fraudsters learn to exploit loopholes in homeowner policies can be addressed by companies revising their product language, thus closing the exploitable loophole. For example, one insurance company described a spate of dropped object claims related to broken tiles in South Florida, where it is common to have ceramic tile throughout a home. After the company adjusted their contract language, they stopped seeing these types of claims.

Insurance fraud cycles may also be affected by successful investigation and prosecution of fraud. For example, one state attorney reported a significant downward trend in arson related homeowners insurance fraud cases in their circuit. Their opinion was that this reduction in "arson for hire"

[19] In Florida, the size of the multiplier varies from 1 to 2.5 times the fee amount based on the likelihood of success at the start of a case. Other state courts, such as the New Jersey and Hawaii Supreme Courts, have imposed a maximum multiplier of 2 under their state fee shifting statutes.
[20] The range of the fee multiplier on these cases was 0 to 2.5.
[21] The majority of cases originated in Miami-Dade County, with 11.
[22] Of the 18 lawsuits, the most common primary reported cause of loss was water damage (6), followed by sinkhole damage (5).
[23] This amount may change, pending the resolution of appeals. As of June 30, 2020, Citizens reported it held 7% of the state's estimated 6.9 million residential property policies, which at the time was the second largest individual company market share in Florida.

insurance fraud was likely due to their successful prosecutions of these type of cases. As arson cases have waned, the circuit has seen an upward trend in water damage in homeowners insurance fraud cases.

DIFS fraud processing was hindered by insufficient evidence, delays, and staffing challenges

During our review period, most suspected fraud referrals were closed without resulting in a case investigation because they lack sufficient evidence to proceed. Further, most fraud case investigations do not result in successful prosecutions for similar reasons. Regardless of their outcome, fraud referral evaluations and investigations can take months to complete. Processing suspected fraud referrals and investigating fraud cases takes substantial work, time, and experience. Division of Investigative and Forensic Services staffing issues affect its ability to investigate complex insurance fraud cases.

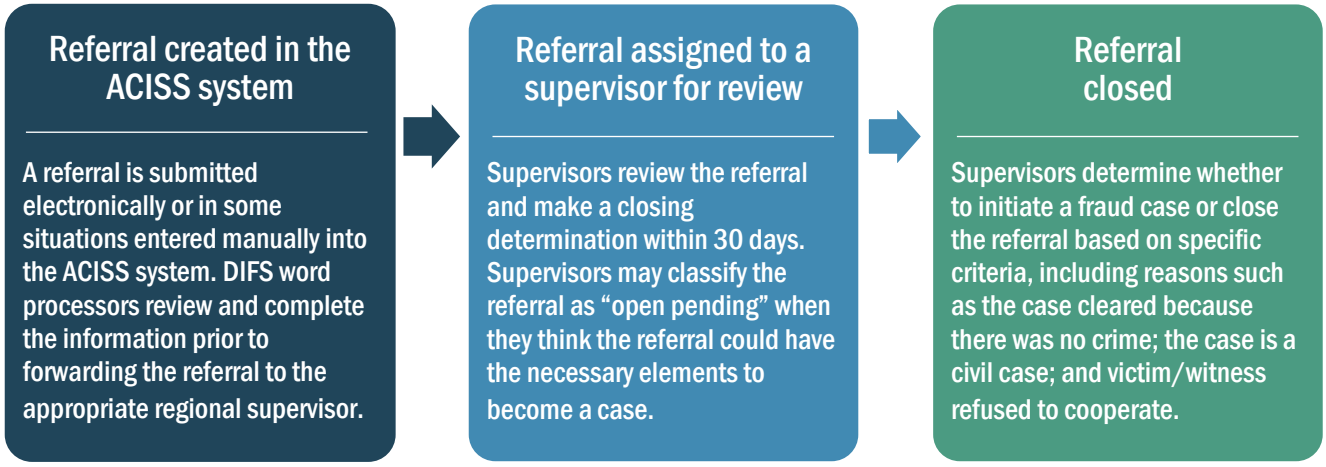
During the review period, the DIFS referral evaluation process did not meet internal deadlines

DIFS has established protocols for processing fraud referrals. The division's work begins when an entity reports suspected fraud information via its website or hotline. Three full time and two part time staff conduct the intake and processing of referrals before assigning them to a supervisor. At this time, staff also look for associated referrals or trends that should be included. As supervisors review referrals, they look for articulated elements supporting a crime and possible trends requiring attention. This supervisor will also contact the complainants to obtain additional information or clarify facts. After review, supervisors either close referrals and document the reason that no case is warranted or initiate a fraud case investigation.

The DIFS referral process exceeded timeline policies because supervisors extended the review to gather information or allow for staffing availability. According to DIFS policy, a referral closing determination should be made within 30 days of receiving the referral, including providing a specified reason. The referral may then be designated as an "open pending" referral (still not a case), and policy suggests that there should be a final determination for closing an "open pending" referral or initiating a fraud case within 180 days.[24] (See Exhibit 7.)

[24] DIFS/ACISS guidance recommends that supervisors indicate the status and priority of referrals in the brief description of the referral. This referral status shows whether it has been reviewed or an information request was sent to or received from the SIU. Additionally, the priority of a referral is ranked from high to low on a 3-point scale. OPPAGA found that fewer than 5% of referrals included priority or status information.

Exhibit 7
The Fraud Referral Evaluation Process Has Several Stages



Source: OPPAGA analysis.

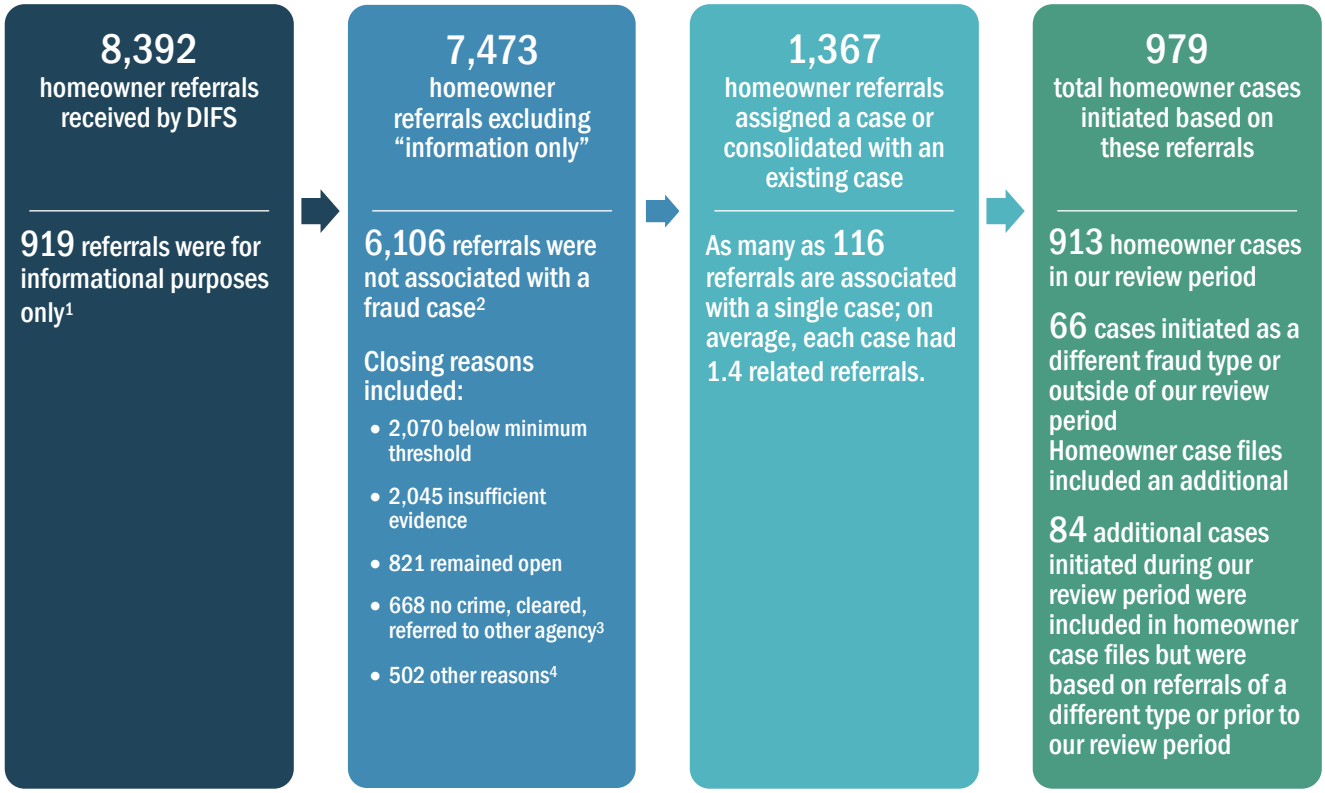
However, for many referrals, the time between assignment to a supervisor for review and closing was longer than expected. OPPAGA reviewed open referrals to determine current referral process timeliness. At the time we received data from DIFS, 821 homeowner referrals had a status of open or open pending (9.7% of all referrals), and 48% of those had been assigned for review in the data system more than 180 days prior. Similarly, 87 referrals involving auto glass had a status of open or open pending (6% of all referrals), 30% of which had been assigned for review more than 180 days prior. DIFS explained that some supervisors may leave referrals open in the hopes of creating a case if additional evidence or staffing resources become available.[25] Given the relatively large proportion of open cases that have not been closed or have a case initiation within 180 days, DFS may wish to consider whether the 180-day metric should be adjusted to be more useful.

During the review period, DIFS dismissed most referrals and investigations, primarily because they lacked sufficient evidence or did not meet minimum thresholds for further investigation or prosecution

Homeowner and auto glass referrals were commonly closed without being classified as fraud cases because of insufficient evidence or because DFS was not able to address all the factors needed to pursue a case. Of the 8,392 homeowner referrals submitted during the review period, only 1,367 resulted in a subsequent case. Exhibit 8 shows the attrition of homeowner referrals submitted during the period. Because multiple referrals may be associated with the same case, the resulting number of cases was smaller—979. The average number of referrals associated with a single case was 1.4, but as many as 116 referrals were associated with a single case.[26] Auto glass referrals during the review period exhibited similar trends—2,079 referrals, 152 of which were associated with a total of 115 cases.[27]

[25] This pattern occurred previously as well, with closed referrals showing similar delays. We report results for open referrals because the dates associated with these results are more reliable.
[26] Cases resulting from these referrals were not all initiated as homeowner cases during our review period; 66 of them were initiated either as another type of fraud case or were initiated as a case after our review period ended. Additionally, homeowner case files included 84 cases that resulted from referrals either of another fraud type or prior to our review period.
[27] Eight of these auto glass cases were opened as a case type other than vehicle fraud.

Exhibit 8
During the Six Year Review Period, Many Homeowner Insurance Fraud Referrals Did Not Proceed to a Case Investigation



[1] We exclude one additional information only referral from this count because it was assigned to a case.
[2] Although 6,106 referrals had no direct relationship with fraud cases, 11% (671) were associated with a company or person under investigation based on a separate referral.
[3] This captures the following referral closing reasons: exceptionally cleared/no crime; exceptionally cleared/civil case; exceptionally cleared/duplicate entry; and exceptionally cleared /referred to other agency.
[4] All other referral closing reasons include lack of cooperation by reporting party; no action; statute of limitation expired; and victim/witness refused to cooperate. A small number of referrals indicated being associated with a case (32), but records indicated no associated fraud case number.
Source: OPPAGA analysis of DIFS/ACISS data.

Referrals may be closed without leading to a case for a number of reasons. First, a substantial number of referrals to DIFS were never meant to be investigated; 12% of all referrals submitted to DIFS during the review period were "information only" referrals, meaning they are submitted for reference. In addition, during the review period, 49% of all homeowner referrals and 58% of all auto glass referrals were closed for either having insufficient evidence or being below the minimum investigative threshold.[28]

Limited investigative information provided by SIUs may be one reason fraud referrals are closed for insufficient evidence. Section 626.989, *Florida Statutes*, requires insurance companies to report to DIFS when there is a "belief" that fraud has occurred and when such belief is accompanied by a limited amount of evidence.[29] However, it appears that the evidence that SIUs are currently required to provide may not always facilitate opening a case. OPPAGA analyzed the "Information" and "Reply Comments" sections of closed referrals DIFS categorized as "Below minimum threshold"

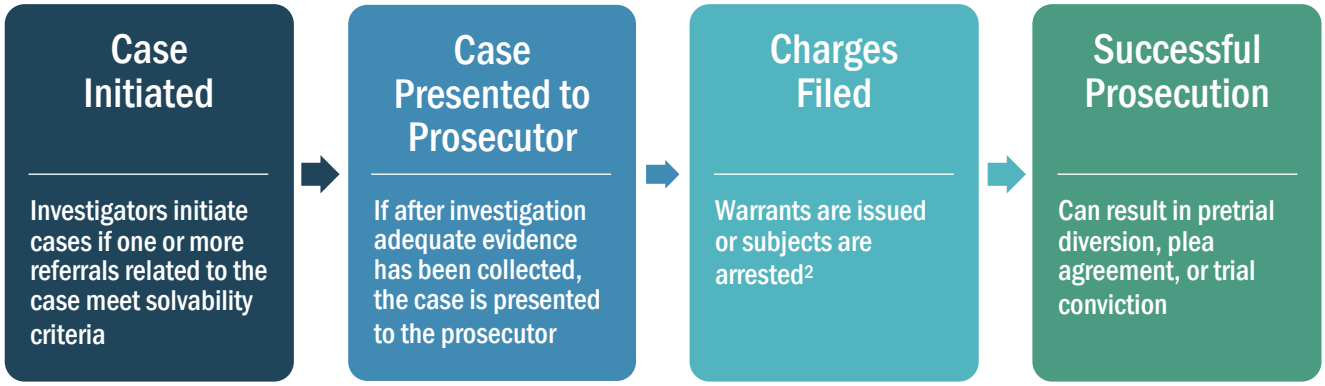
[28] Other referrals either remained open or they were closed for other reasons, such as being cleared and not associated with a crime or the "victim/witness refused to cooperate," among others.
[29] Section 626.989(6), *F.S.*

(168 homeowner and auto glass referrals) or having "Insufficient evidence" (151 homeowner and auto glass referrals).[30] Most comments (67%) did not provide a specific explanation for the lack of evidence. For referrals that did provide statements beyond minimal information for closure or a definition of the closure type, the most common theme was an issue with SIUs that provided inadequate investigation information (21%). While SIUs are not responsible for determining or generating information that is sufficient for criminal charges, requiring them to provide information that is currently optional could assist DIFS and other law enforcement.

Similarly, during the review period, DIFS dismissed most case investigations because they lacked sufficient evidence to present to prosecutors. Referrals that become cases are assigned to DIFS investigators. Investigators are responsible for establishing whether a crime was committed, identifying responsible individuals and supporting evidence, and executing arrest(s) based on developed probable cause or arrest warrant(s). Investigators develop the case by following up on leads, collecting and documenting evidence, executing search warrants, and conducting interviews. Investigators pursue cases for several months prior to closing them. During our review, the median completion time for investigations of cases that had not been presented for prosecution was four months. DFS reports that the length of time to complete a case depends on its complexity and the evidence available.

If the investigator is able to gather sufficient evidence to prosecute a case, the case is presented to the appropriate prosecuting authority and charges are filed.[31] Prosecutors may accept or decline the case, and if the case proceeds, one fraud case may result in multiple arrests and prosecutions, as each person involved is charged and prosecuted. (See Exhibit 9.)

Exhibit 9
During the Six Year Review Period, Many Homeowner Insurance Fraud Referrals Did Not Proceed to a Case Investigation

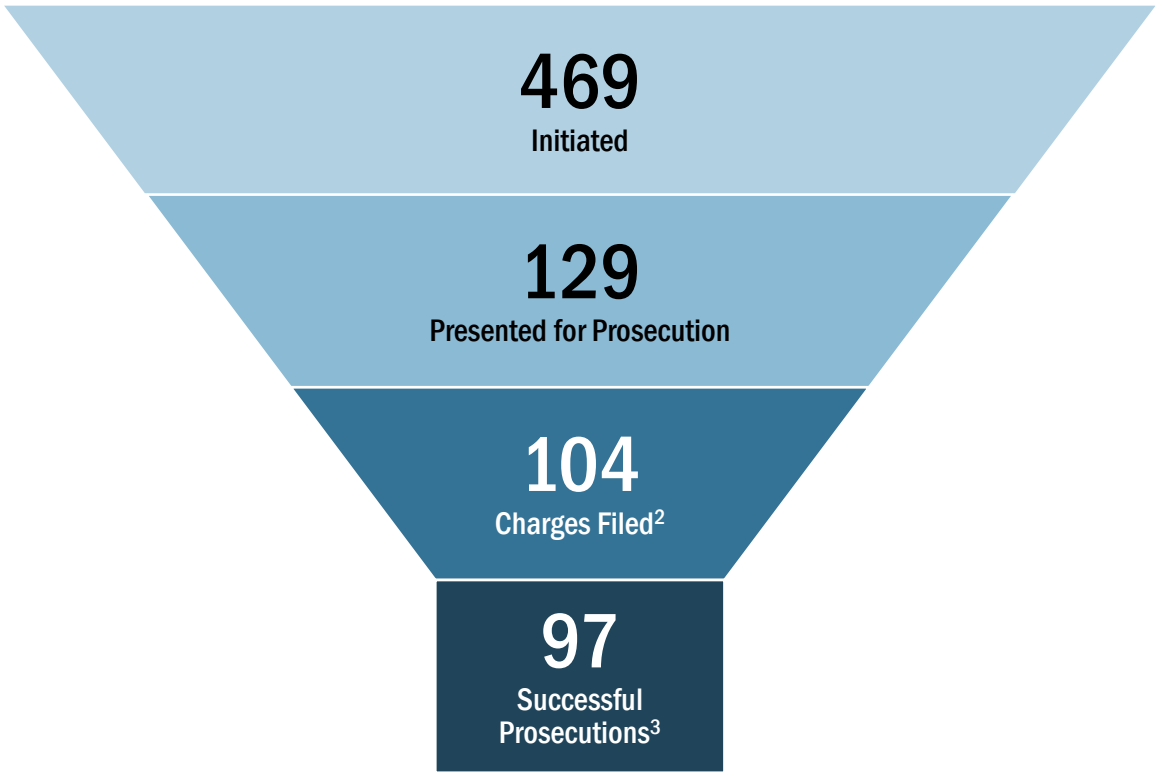


[1] Charges may be filed prior to or after cases are presented to the appropriate prosecutorial entity.
[2] Arrests may occur based on warrants or probable cause.

[30] DIFS policy and procedures specified that after reviewing a referral, DIFS personnel were to record the reason for closure in ACISS and were to provide the necessary documentation and explanations to support the decision to close the referral. However, existing documentation in this field was limited during our review period.
[31] DIFS investigators are sworn law enforcement officers and have the power to arrest. If probable cause exists, arrests may be made or warrants issued prior to the presentation of a case to the prosecuting authority.

The primary reason most cases initiated from Fiscal Year 2014-15 through 2016-17 were not presented for prosecution was that they lacked sufficient evidence.[32] The main reason that most cases did not result in a presentation for prosecution was that the cases lacked sufficient evidence or had no further leads (43% of cases that were not presented lacked sufficient evidence). Of the 469 homeowner case investigations initiated between Fiscal Year 2014-15 and Fiscal Year 2016-17, only 129 were presented for prosecution. (See Exhibit 10.) The percentage of cases presented to prosecutors fluctuated by year—48% of cases initiated in 2014-15 were eventually presented to prosecutors, compared to only 18% of cases initiated in 2016-17.[33,34]

Exhibit 10
Few Homeowner Fraud Cases Initiated From Fiscal Year 2014-15 Through Fiscal Year 2016-17 Resulted in Presentations to Prosecutors



[1] We show cases initiated in these years because 87 cases initiated in later years remain open. Five cases initiated from Fiscal Year 2014-15 through Fiscal Year 2016-17 were still open at the time of our review.
[2] This means a warrant has been issued or a subject has been arrested. Arrests may occur based on warrants or probable cause.
[3] Three cases are reported as having a successful prosecution based on the final case disposition, although these cases had no supporting reports for presentations, arrests or warrants, or successful prosecutions during the time frame. One case counted here as a successful prosecution had both a successful prosecution and a declination report on record.
Source: OPPAGA analysis of DIFS/ACISS data.

[32] We exclude cases initiated after 2016-17 from this analysis because the final result of the substantial number of open cases may distort case outcome reports.
[33] Fluctuations from year to year do not necessarily reflect long-term trends in the number of cases presented for prosecution. Five cases initiated in the three fiscal years remained open at the time of our review. Although it is possible that those cases may result in eventual presentation to prosecutors, they would not dramatically alter this trend.
[34] Each case can include more than one occurrence of each outcome, since more than one suspect per case can be charged and prosecuted. Outcomes presented above represent only the first (chronological by date) outcome of each type per fraud case investigation, thus may not match DFS publications that report multiple outcomes for each case investigation. This method counts each case only one time to prevent the appearance that more cases resulted in a specific outcome (e.g., presentations).

DIFS reported that staffing issues affect its ability to investigate complex cases like insurance fraud

DIFS and state attorneys suggested that recruitment and retention of skilled investigators as well as retention of dedicated prosecutors are essential to fighting insurance fraud because of the complexity of cases. State attorneys report that homeowners fraud, as well as most auto glass fraud, are not "one-off" crimes committed by individuals but are perpetrated by organized crime teams. They report these organized crime cases are complex and require expertise, time, and effort to properly prosecute them, specifically in a manner where the crime ring is broken and individuals at the top of the organization can be prosecuted for their involvement. State attorneys expressed the benefits of employing dedicated prosecutors with experience in insurance fraud. These prosecutors can work repeatedly with the same DIFS investigators, which builds professional relationships, allows for increased professional development of DIFS investigators, and results in better quality investigations.

DIFS reported that personnel resources to investigate complex case referrals are limited due to staffing challenges. DIFS and state attorneys reported that investigators who are new to insurance fraud require extensive training and mentoring to be effective in investigating and assisting prosecutors with insurance fraud cases. However, DIFS is unable to hire or maintain such experienced staff. DIFS reported the average tenure for BIF investigators is 3.4 years. The current vacancy rate for BIF investigators is just under 19% statewide.

DIFS indicated this is primarily because the division's salaries are not competitive with other law enforcement agencies or the private sector. Officers with the specialized skill set necessary for financial investigations are in demand across the state. While the division invests significant staff time in training, supervising, and mentoring new hires, they often lose them to local police departments and the private sector, which offer better pay, raises, and opportunities for advancement. This issue particularly affects the division in metropolitan areas where vacancies and lack of experienced investigators can result in an inability to effectively pursue complex cases. To manage this issue, DIFS reported that, when necessary, they assign additional personnel from other offices to assist with significant cases. DIFS additionally reported that its Miami, Orlando, and West Palm Beach offices have the highest number of vacancies on average. These areas are also in counties with some of the highest number of fraud referrals in the state.

Because of difficulty recruiting and retaining qualified individuals, DIFS reported they recently began hiring new graduates from the police academy. This is a contrast with their previous hiring criteria, which required three years of related experience. DIFS reported that lack of experience results in staff with a lower-level skill set who require additional supervision, thereby continuing to limit the division's capacity to investigate complex cases.

State attorneys reported a number of barriers to prosecuting insurance fraud cases

Florida insurance fraud cases presented to prosecutors are mostly under the jurisdiction of state attorneys. State attorneys reported that homeowner and auto glass insurance fraud is only a small portion of the insurance cases they receive. State attorneys described multiple barriers that affect their decision to prosecute insurance fraud cases, including limited evidence and lack of independent witnesses. When prosecutors decide to pursue an insurance fraud case, they report that the process may be prolonged due to unique features of such cases, including the number of defendants.

State attorneys reported that homeowner and auto glass cases are a small proportion of insurance fraud cases they prosecute

Division of Investigative and Forensic Services officials reported that while they do present cases to the statewide prosecutor and federal prosecutors, most of the cases presented to prosecutors are under the jurisdiction of state attorneys. All state attorney offices may prosecute insurance fraud. However, the Dedicated Prosecutor Program funds the salaries of prosecutors, paralegals, and investigators at state attorney offices that are dedicated solely to prosecuting fraud and related cases.

Similar to DIFS insurance fraud referrals, state attorneys reported that homeowner and auto glass make up a small portion of their insurance fraud cases. For example, in Fiscal Year 2019-20, DIFS presented 308 cases to dedicated prosecutors in state attorney offices, of which 25 were vehicle insurance fraud and 12 were homeowner insurance fraud cases. In addition, OPPAGA conducted an email survey of the 20 state prosecutors via the Florida Prosecutors Association.[35] Twelve state attorneys responding to the survey reported that in the last five years, homeowner and auto glass cases have been infrequent and make up a small portion of the insurance fraud presentations they receive from DIFS. Three of these 12 attorneys reported their circuits did not receive any referrals of these types. More common referral types include staged accidents, workers' compensation, unemployment benefits, and medical and dental billing.

Once homeowner cases were presented to prosecutors, the majority resulted in successful prosecution. The outcome of the 469 homeowner case investigations noted in Exhibit 10 above, initiated between Fiscal Year 2014-15 and Fiscal Year 2016-17, showed that 97 of the 129 cases with a presentation for prosecution also had at least one successful prosecution. For the few cases that did not result in successful prosecution, the main reason was that the prosecution of the case was declined (22 cases were declined after presentation), although an additional 5 cases with arrests or warrants had a case disposition indicating the prosecutor decided not to prosecute.[36]

State attorneys reported multiple barriers to prosecuting insurance fraud cases

Quality of evidence is the key feature that helped state attorneys determine whether to prosecute cases. When asked how their office determines which cases to prosecute and how they are prioritized, state attorneys described evaluating each case to determine if the evidence is sufficient to

[35] Nineteen responded, including all seven offices with Dedicated Prosecutor Program staff.

[36] Prosecutors may decide not to prosecute after charges have been filed and prior to a trial in several circumstances, such as the realization that insufficient evidence supports the charges or upon the defendant's completion of a pre-trial diversion program. One case counted as being declined for prosecution was also associated with a successful prosecution. This may occur if a case involves more than one perpetrator or suspect.

convict beyond a reasonable doubt. Such evidence can include the investigative report, statements of the defendant, corroborating documentation of the fraud including video or recorded telephonic communication, and insurance company records. State attorneys further reported that often cases require further investigation and collaboration with the DIFS investigator, after which the case is filed and prosecuted. State attorneys described joint activities with DIFS, including gathering additional evidence, interviewing witnesses, and issuing subpoenas needed to complete the investigation. Some state attorneys reported giving additional priority to cases that involve a repeat offender, have a high dollar restitution, or have a statute of limitations concern. (See Appendix C for information on other states and prosecution of insurance fraud cases)

Some state attorneys reported that when insurance company investigations and evidence are incomplete, prosecution is difficult. In homeowner insurance fraud cases, prosecutors reported that they often rely on information gathered by the insurance company to provide material evidence proving a crime was committed. The completeness of the investigation when presented to the state attorney affects the prosecution timeline, with cases requiring additional investigation taking longer from presentation to final disposition.

State attorneys reported evidence from initial insurance company investigations aids their decision making about who to prosecute, and cited poor documentation or record keeping by the insurance company as a cause for insufficient evidence to prosecute. For example, some state attorneys reported that when insurance company investigators are conducting interviews, which are typically conducted via telephone, they can fail to obtain and document necessary personal information.

In contrast, state attorneys typically characterized DIFS case presentations as complete, accurate, and timely, which corroborated DIFS' report that its practice is to present cases that thoroughly establish whether a crime was in fact committed. On the occasions that a case file is incomplete or more information is necessary, the assigned prosecutor works directly with the DFS/DIFS investigator. Overall, state attorneys described DFS/DIFS staff as professional to work with and responsive to investigative requests and inquiries.

State attorneys noted the difficulty of attributing fraud to a specific person and lack of independent witnesses as barriers to prosecuting an insurance fraud case. To bring charges of insurance fraud, prosecutors must have evidence of a specific person committing a crime. State attorneys reported that it is often difficult to prove who actually committed the fraud. For example, homeowner policies are often issued to two or more persons (e.g., husband and wife), but just because a person is a named policyholder does not necessarily mean they were part of any fraud perpetrated against the insurance company. Similarly, in the case of companies that engage in fraud, proving who knowingly committed an act to defraud can be difficult with multiple employees.

When fraud is being committed by multiple individuals in a single case, such as loss consultants, water mitigation companies, public adjusters, plumbers, and in some cases homeowner(s), the state attorney faces a proof issue. Since all the individuals may have participated in fraudulent activity, there may be no independent witnesses who can testify to the fraud. In these instances, the prosecutor may enter into a plea agreement with the least culpable individual in exchange for their testimony against the more culpable codefendants. In addition to settling cases by plea agreement, state attorneys also described offering pretrial diversion for first time offenders.

To encourage witnesses to report insurance fraud, the Legislature created the Anti-Fraud Reward Program in 1999. Since its inception, the program has not spent most of its allocations. Over the last

19 years, the Legislature has allocated a total of $1.9 million for the program; however, less than $350,000 of these funds have been awarded. The maximum total annual award during the period was $57,500, which occurred in Fiscal Year 2012-13. During four of the years, there were no awards. Over the 19-year period, the Legislature consistently appropriated $100,000 per year, but on average, just over $18,300 per year was awarded. In excess of $1.55 million, or 81.7%, of appropriated funds have reverted to general revenue.

State attorneys reported that homeowner insurance fraud cases can take time because such cases are complex

State attorneys reported that successful prosecution of insurance fraud cases takes a lot of time. Specifically, they noted each case can result in multiple presentations, arrests, warrants, and prosecutions when more than one suspect is involved. Exhibit 11 shows that the timeframe from case initiation to both presentation for prosecution and arrest/warrant was a median of four months.[37] In most years, the longest time between case initiation and successful prosecution was about three years, though the average from Fiscal Years 2014-15 to 2019-20 was 12 months.

Exhibit 11
DIFS Homeowner Fraud Cases Generally Take Four Months From Initiation to Presentation and One Year to Successful Prosecution

	Presentations to Prosecutors			Arrests and Warrants			Successful Prosecutions		
Fiscal Year	Number of Cases[1]	Number of Presentations[2]	Median Months From Case Initiated [3]	Number of Cases	Number of Arrests and Warrants	Median Months From Case Initiated	Number of Cases	Number of Successful Prosecutions	Median Months From Case Initiated
2014-15	48	61	4.0	40	90	5.0	45	51	10.0
2015-16	46	60	2.5	36	79	3.0	26	39	11.5
2016-17	34	41	6.0	29	51	4.0	32	40	11.5
2017-18	58	64	3.5	49	83	4.0	34	37	11.5
2018-19	43	53	4.0	40	74	5.0	29	30	11.0
2019-20	17	20	4.0	15	34	6.0	24	25	15.5
All Years	**246**	**299**	**4.0**	**209**	**411**	**4.0**	**190**	**222**	**12.0**

[1] Presentation and case counts are different than those presented above because they only include cases processed by DFS.
[2] All presentations associated with a single case are counted in the first fiscal year in which they appear (likewise with arrests/warrants and successful prosecutions).
[3] Months reported represent median months between the date the case was initiated and the date of the outcome. Each case can include more than one occurrence of each outcome, since more than one suspect per case can be charged and prosecuted. Outcomes presented above represent all occurrences within a fiscal year and are not tied to cases initiated since Fiscal Year 2014-15; cases with outcomes during this time had been initiated as early as 2004.
Source: OPPAGA analysis of DIFS/ACISS data.

State attorneys reported that the primary factor affecting the timeline of an insurance fraud case is the inherent complexity of such cases. The more complex a case, the longer it takes for DFS/DIFS or law enforcement to conclude the investigation, resulting in a longer timeline for the state attorney to reach a filing decision. As noted above, state attorneys report that most homeowners fraud, as well as most auto glass fraud, are not "one-off" crimes committed by individuals but are perpetrated by organized crime teams. Other factors state attorneys reported that prolong insurance fraud cases include the completeness of the investigation when a case is presented to the state attorney. Cases requiring

[37] To produce the most accurate results about case timing, this analysis includes all case presentations, arrests/warrants, and successful prosecutions that occurred during our review period. Twenty-one cases with presentations, 21 cases with an arrest or warrant, and 43 cases with successful prosecutions during our review period were initiated prior to Fiscal Year 2014-15. Our review used the first outcome in a case to measure the timing of events.

additional investigation take longer from presentation to disposition. In addition, attorneys mentioned the number of defendants, witness availability, and the willingness of a defendant to enter a plea as factors that delay case processing. State attorneys noted that most insurance fraud cases are settled by plea agreement, which resolve relatively sooner than those going to trial.

Investigation and prosecution of insurance fraud can take months or even years; during that time, homeowners may be waiting for full or partial payment. Insurance companies are statutorily required to pay or deny the undisputed amount of property owner claims within 90 days. However, the statute also allows insurance companies to delay payment beyond the 90 days if factors beyond company control reasonably prevent such payment. DFS indicated that suspicion of fraud is one such factor that could allow an insurance company to withhold full or partial payment.

Insurance companies reported paying the undisputed amount of a claim regardless of whether an SIU investigation is underway. DFS and other stakeholders reported that an insurance company's decision to pay or withhold disputed portions of a claim may depend on who is alleged to have potentially committed the fraud. They provided several examples.

- A company may issue a payment to an insured for temporary living expenses related to a fire claim where there is suspicion of arson but withhold payments for structure and personal items while investigating the claim.
- In some cases, notably hurricane or windstorm events, multiple vendors can be involved in a single home repair. For example, to address storm related damage to a roof that results in water entering the home, repairs would require a roofing contractor, a water mitigation company, and possibly a mold remediation company. The insurance company would receive three invoices as part of one claim. If one of the companies was suspected of fraud, only that company would be investigated. The insurance company would pay the other two vendors while its SIU investigated the suspected fraud.
- When a contractor is believed to have perpetrated the fraud as part of an AOB scheme and it is found that the insured was not a party to the suspected fraud, partial or full payments could be released to the homeowner.

Thus, although vendors may do what is required to secure a home from additional damage, when fraud is suspected, consumers may live without complete repairs until their claims are closed.

Stakeholders presented options to reduce the volume of insurance fraud, improve the quality of potential fraud cases referred to DIFS and prosecutors, and encourage reporting

OPPAGA determined that the volume of fraud referrals and the quality of information the Division of Investigative and Forensic Services receives affect the number of cases prosecuted as well as the persistence of fraud in Florida. To address these and other issues, OPPAGA identified options for legislative consideration and grouped them into two categories. First, we present options that reduce individuals' incentive and opportunity to create fraudulent claims. These options present some protections for policyholders, create potential cost reductions for insurance companies, and change allowable activities for third-party representatives. Second, we present options that could improve the quality of data DIFS receives from insurance companies. These options could in turn facilitate more,

higher quality cases being presented to DIFS and prosecutors. (See Appendix D for a table of the considerations associated with each option.)

Options to hold individuals accountable and minimize opportunities to commit fraud

- Modify the one-way attorney fee.
    - Revise s. 627.428, *Florida Statutes*, so that attorney fees or compensation do not apply to lawsuits filed by assignees.[38] This would maintain the consumer as beneficiary and provide less of an incentive for third-party litigation.
- Modify the contingency risk/fee multiplier fee provisions for attorneys.
    - Revise s. 627.428, *Florida Statutes*, to allow a contingency risk/fee multiplier to be applied only in "rare and exceptional" circumstance for insurance fraud cases. In all other instances, the lodestar method to identify a reasonable rate should be applied.[39] This limits the number of bad actors seeking litigation by reducing the potential award amount.
- Extend AOB guidelines for auto glass claims.
    - Amend s. 627.7152, *Florida Statutes*, to apply assignment agreements for commercial and residential property insurance policies to also include auto glass insurance policies. Doing so provides numerous stipulations for assignment agreements, including an equal opportunity of being awarded fees on the part of the insurance company and assignee, and expands the risk associated with litigation to both parties.
    - Amend s. 627.7153, *Florida Statutes*, to expand policies restricting the assignment of post-loss benefits to include auto glass insurance policies. By restricting the insured's right to execute an assignment agreement, this change could limit the solicitation of consumers as well as excessive billing and litigation.
- Reduce the time frame for filing hurricane/windstorm homeowner claims.
    - Revise s. 627.70132, *Florida Statutes*, to reduce the time frame for filing hurricane/windstorm homeowner claims to two years to make it easier for insurance companies and DIFS to properly investigate and collect sufficient evidence of hurricane/windstorm damage. (See Appendix C for information on other states' windstorm claim timeframes)

[38] Assignees can include third parties such as roofers, water mitigation experts, auto glass repair companies, and attorneys.
[39] This method, "the lodestar approach," requires the court to determine the number of hours reasonably expended on the case and multiply that number by the reasonable hourly rate.

Options to improve investigation data provided to DIFS

- Increase the number of required elements insurance companies must include in fraud referrals.
    - Revise the fraud referral form specified in 69D-2.003, *F.A.C.* used by SIUs to include additional specified elements to help resolve issues of insufficient evidence. This would strengthen leads for DFS investigators to pursue and could help investigators present a well-supported case to prosecutors.
- Establish routine audits of insurance company SIUs.
    - Amend s. 626.9891, *Florida Statutes*, to authorize DIFS to conduct audits of SIUs to ensure compliance with statutory requirements and improve the quality of fraud referrals.
- Encourage more witnesses to report fraud via the Anti-Fraud Reward Program.
    - Revise s. 626.9892, *Florida Statutes*, to allow awards for witness reports following an arrest for insurance fraud as opposed to waiting for conviction. This could result in awards being made sooner, thus encouraging more witnesses to report insurance fraud.

APPENDIX A

Referrals by County, Fiscal Years 2014-15 to 2019-20

OPPAGA reviewed Division of Investigative and Forensic Services data on fraud referrals submitted to DIFS for the past six state fiscal years. See Exhibit A-1 for the count of all fraud referrals, from all sources, by county from Fiscal Years 2014-15 to 2019-20.

Exhibit A-1
Referrals by County, Fiscal Years 2014-15 to 2019-20

County	Homeowner Referrals	Auto Glass Referrals
Alachua	39	49
Baker	4	1
Bay	165	18
Bradford	2	1
Brevard	164	44
Broward	1,083	93
Calhoun	8	4
Charlotte	28	7
Citrus	37	13
Clay	44	6
Collier	136	12
Columbia	5	11
Dade	2,028	237
Desoto	0	6
Dixie	0	1
Duval	433	155
Escambia	47	42
Flagler	51	5
Franklin	0	0
Gadsden	19	7
Gilchrist	0	1
Hardee	1	6
Highlands	8	10
Holmes	2	1
Indian River	16	2
Jackson	29	7
Jefferson	5	3
Lafayette	1	1
Lake	110	36
Lee	304	33
Leon	64	37
Levy	0	3
Liberty	3	0
Madison	1	7

County	Homeowner Referrals	Auto Glass Referrals
Manatee	48	64
Marion	56	26
Martin	45	6
Monroe	38	4
Nassau	10	5
Okaloosa	41	14
Okeechobee	5	3
Orange	823	199
Osceola	227	32
Palm Beach	457	61
Pasco	97	66
Pinellas	191	116
Polk	167	107
Putnam	3	18
Santa Rosa	28	12
Sarasota	59	73
Seminole	192	41
St. Johns	45	11
St. Lucie	93	13
Sumter	37	4
Suwannee	6	2
Taylor	0	3
Union	0	1
Volusia	197	61
Wakulla	7	1
Walton	10	2
Washington	10	1
Outside of Florida	9	4
Unknown/Blank	3	2

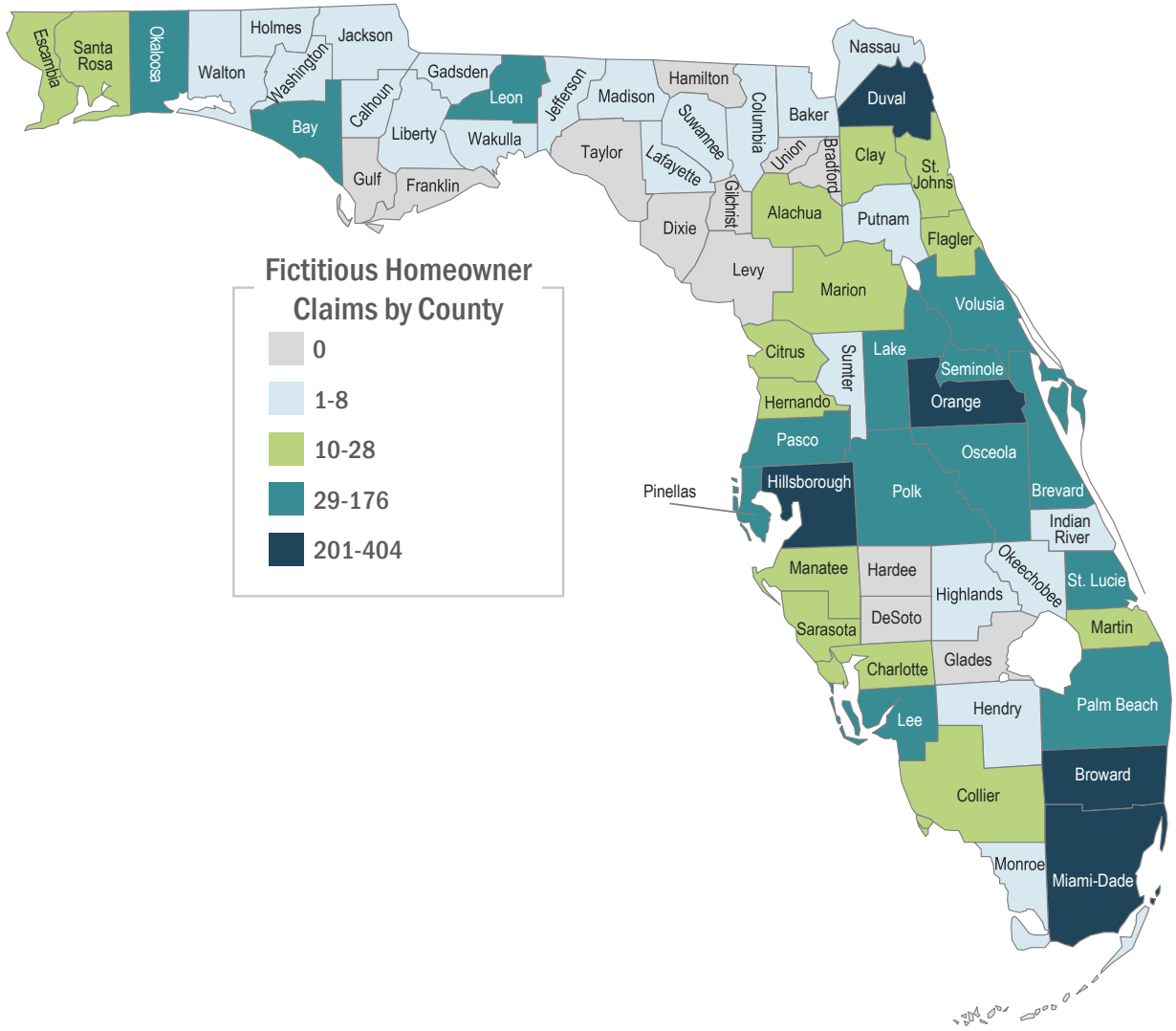
Source: OPPAGA analysis of DIFS/ACISS data

APPENDIX B

Referral Subtypes by County, Fiscal Years 2014-15 to 2019-20

OPPAGA examined the geographic incidence of two of the most common subtypes of homeowner fraud referrals—fictitious damage and roofing claims. The analysis found that homeowner referrals for fictitious damage are concentrated in higher population counties. However, incidence of these types of fraud do not directly to population size in all counties. For example, Miami-Dade, though highest in population, ranked fourth in the number of fictitious damage claims. Palm Beach, which ranks third in population, ranked sixth in fraud referrals. Five counties accounted for over 54% of these types of referrals—Broward, Duval, Hillsborough, Miami-Dade, and Orange. Over the six-year review period, 34 counties had fewer than 10 referrals of this type, 12 of which had no referrals. (See Exhibit B-1.)

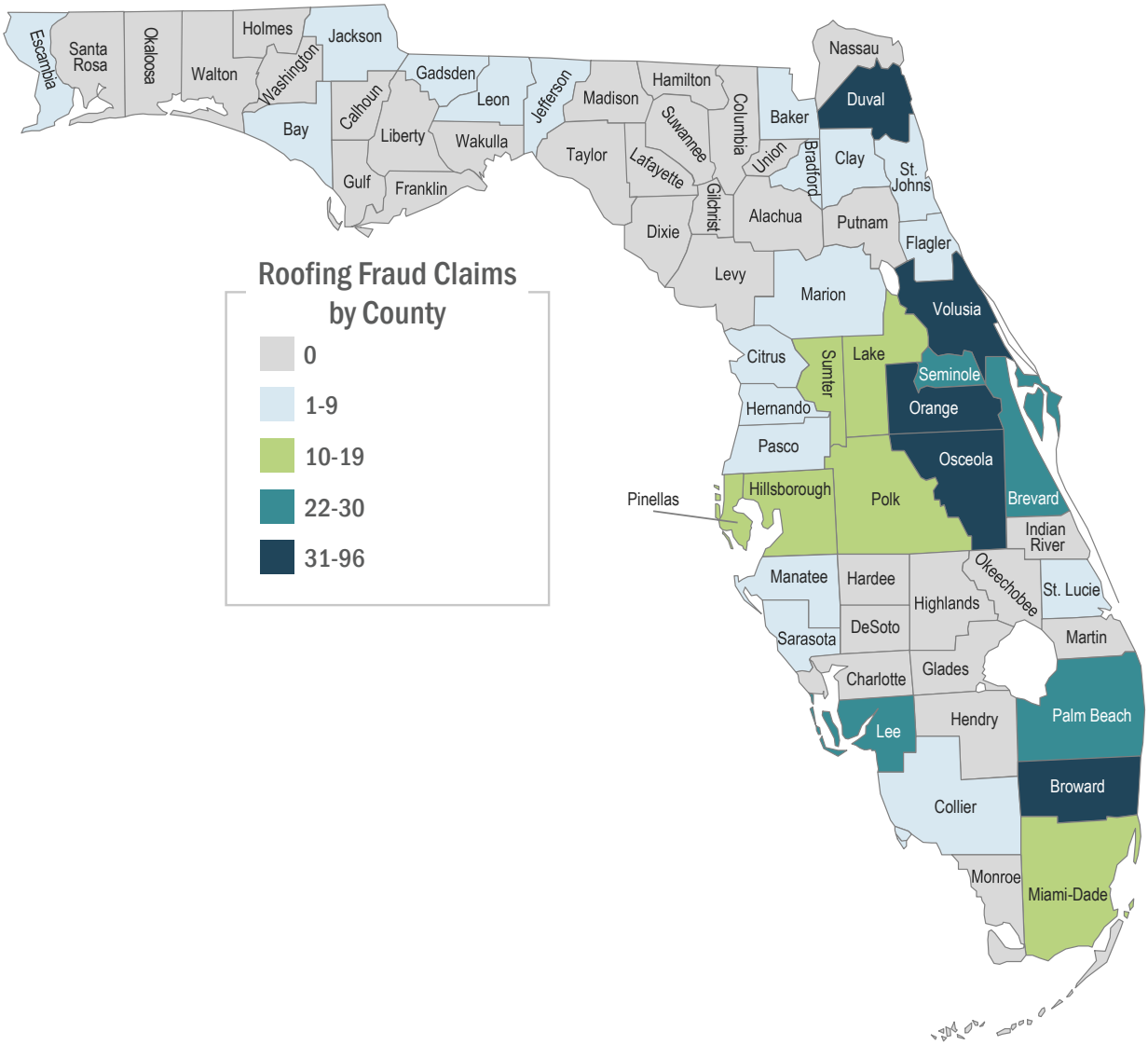
Exhibit B-1
Fictitious Homeowner Fraud Referrals Are Most Common in Broward and Orange Counties



[1] Numbers in legend represent actual number of referrals. OPPAGA categories illustrate county variation, thus, categories show zero and low incidents of fraud, midrange incidents, and the top five counties for fraud incidents.
Source: OPPAGA analysis of DIFS/ACISS data.

OPPAGA's analysis of common homeowner referral types found that referrals for roofing fraud are highly concentrated in the greater Orlando area and neighboring Atlantic coastal counties. Like fictitious damage, roofing fraud is not clearly associated with population size in all counties, Orange County, the 5th largest county in population, had the highest number of roofing fraud referrals, and Volusia, the 11th largest county, ranked 3rd in this type of referral. In contrast, Miami-Dade County, highest in population, ranked 13th in the number of roofing claims. The top five counties (Broward, Duval, Orange, Osceola, and Volusia) accounted for 48.5% of all referrals. Conversely, over the six-year review period, only 15 counties had more than 10 referrals of this type. Thirty-three counties had no roofing related referrals. (See Exhibit B-2.)

Exhibit B-2
Roofing Fraud Referrals Are Highly Concentrated in a Small Number of Counties



[1] Numbers in legend represent actual number of referrals. OPPAGA categories illustrate county variation, thus, categories show zero and low incidents of fraud, midrange incidents, and the top five counties for fraud incidents.
Source: OPPAGA analysis of DIFS/ACISS data.

APPENDIX C

Other States

To evaluate whether other states had promising policies to address insurance fraud, OPPAGA contacted multiple states and received feedback from Georgia, South Carolina, and Texas.[40] Similar to Florida, these states are geographically located in hurricane prone areas. In general, we found that some comparison states have similar caseloads and anti-fraud efforts to Florida's, but states differed in how they prioritize homeowner and auto glass fraud cases. (See Exhibit C-1.)

Exhibit C-1
Fraud Management in Comparison States Varied

Issue	Florida	Georgia	South Carolina	Texas
Investigator case load	15-20	20-30	Maximum of 200	Average of 15 and max of 20
Factors that facilitate insurance fraud prosecution	• Knowledge of prosecutor requirements • Prosecutor education on insurance fraud	• Prosecutor education on insurance fraud	• Obtaining confessions • Arrests shortly after incidents • Witnesses	• Organized crime • High monetary stakes
Investigative considerations	• Impact on community • Dollar amount of loss • Available evidence • Organized crime	• Impact on consumer or business • Dollar amount of loss • Repeat offender • Type of insurance fraud • Time and resources	• Whether the insurance company paid the claim • Repeat offenders	• Deterrence of large-scale claim fraud • Consumer protection
Waive auto glass insurance policy deductible[1]	✓	-	✓	-
Disaster Response Team[2]	✓	Implementing	Not mentioned	✓
Reports of fraud accepted via third party	✓	✓	✓	✓
Natural disasters impact reports of fraud	✓	✓	Not mentioned	✓

1 Per s. 627.7288, F.S., the deductible of any motor vehicle insurance policy with comprehensive or combined additional coverage shall not be applied to the damage of a windshield of a motor vehicle covered under the policy.
2 In Florida, this entity is the DIFS Disaster Fraud Action Strike Team. This entity provides public outreach and education initiatives to mitigate insurance fraud.
Source: OPPAGA analysis of other states' information.

[40] OPPAGA contacted and did not receive feedback from Alabama and Mississippi.

APPENDIX D

Options to Address Insurance Fraud

OPPAGA identified a number of options for legislative consideration. (See Exhibit D-1.) The options are grouped into two categories—options that reduce individuals' incentive and opportunity to create fraudulent claims and options that could improve the quality of data DIFS receives from insurance companies. These options could in turn facilitate more, higher quality cases being presented to DIFS and prosecutors.

Exhibit D-1
The Legislature Could Consider Several Options for Deterring Insurance Fraud and Improving Data Quality

Options	Statute or Code	Implications		Considerations
		Deter Fraud or Reduce Case Volume	Improve Investigation Data	
Modify Florida's one-way attorney fee provision • Statute currently allows one-way attorney fees to apply to assignees as well as the insured. • In modifying the statute, an award of attorney fees would only apply to the policyholder and not assignees or third parties.	s. 627.428, *F.S.*	✓		• Could restrict who is being awarded attorney's fees and ensure the consumer is aware when a lawsuit is filed in their name • Would make the assignment of post-loss benefits a less lucrative opportunity for third-party representatives
Modify the contingency risk/fee multiplier fee provisions for attorneys • Florida law currently allows a fee multiplier to be applied to attorney fees in certain cases.[1] • The modification would only allow a fee multiplier in rare and exceptional circumstances.	s. 627.428, *F.S.*	✓		• Would restrict the number of cases for which a multiplier could be applied and as such, could dissuade the filing of fraudulent claims because litigation would be a less lucrative endeavor • Could make it more difficult for policyholders to obtain legal representation against insurance companies, as there would be less of a reward for attorneys
Extend AOB guidelines for auto glass claims • Statute currently provides AOB restrictions for residential and commercial property insurance policies only. • The suggested amendment would expand AOB restrictions to include auto glass insurance policies.	s. 627.7152, *F.S.* s. 627.7153, *F.S.*	✓		• Could reduce the incidence of consumers being solicited for auto glass repairs • Could restrict excessive charges by repair companies because there is a higher risk of litigation among all parties, not only the insurer • Insurance companies may see a reduction in costs that may result in lower rates for consumers. • Given that litigation is less rewarding for attorneys, consumers may have difficulty obtaining legal representation.

Options	Statute or Code	Implications		Considerations
		Deter Fraud or Reduce Case Volume	Improve Investigation Data	
Reduce the time frame for filing for hurricane/windstorm homeowner claims • Statute currently allows claims to be filed within three years after the hurricane first made landfall or the windstorm caused covered damage. • Revision of statute would reduce time limit for claims after hurricane or windstorm.	s. 627.70132, *F.S.*	✓	✓	• Would reduce loss of evidence from properties after time of impact because investigators would be on the scene sooner, which in turn could lead to investigators gathering more reliable data • May negatively affect policyholders if filing deadline is shortened to a year or less • Could reduce the temporal opportunity to file fictitious claims
Increase the number of required elements insurance companies must include in fraud referrals • *Florida Administrative Code* currently requires insurance companies to report fraud to DIFS via a specific form. • Revision of the referral form would specify additional required elements.	s. 626.9891, *F.S.* 69D-2.003, *F.A.C.*		✓	• Would result in a more thorough report for DIFS to evaluate, leading to a larger volume of cases opened • Could resolve issues of evidence insufficiency and lead to investigators having an easier time examining and evaluating all evidence • Could strengthen leads for detectives to pursue and provide a stronger case for presentation to prosecutors
Establish routine audits of insurance company SIUs • Statute currently requires insurance companies to send acknowledgements of anti-fraud activities to DIFS. • Amendment of statute would give DIFS authority to audit anti-fraud plans and fraud referral submissions.	s. 626.9891, *F.S.*	✓	✓	• Would lead to a comprehensive review of an insurance company's detection, investigation, staffing levels, training, and education processes, which could result in insurance companies providing more consistently reliable information • Would allow for review of referral submissions from insurance companies, possibly improving the quality of their referrals • In-depth audit of anti-fraud plans may ensure insurance companies are raising awareness of fraud within their organization, dedicating adequate resources, enforcing policies, and meeting statutory requirements. DIFS believes that the increase in staffing required to audit insurance companies can be accomplished with non-sworn staff, creating dividends to the division's mission of reducing fraud.

Options	Statute or Code	Implications		Considerations
		Deter Fraud or Reduce Case Volume	Improve Investigation Data	
Encourage more witnesses to report fraud via the Anti-Fraud Reward Program • Statute currently allows reward after arrest and conviction of persons committing crimes that DIFS investigates. • Revision of statute would allow rewards to be made at time of arrest, allowing witness to receive their rewards sooner.	s. 626.9892, *F.S.*		✓	• Could result in awards being made sooner, thus encouraging more witnesses to report insurance fraud

[1] See *Joyce v. Federated Nat'l Ins. Co.*, 228 So. 3d 1122 (Fla. 2017)
Source: Source: OPPAGA analysis.

AGENCY RESPONSE

CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

March 1, 2021

R. Philip Twogood
Coordinator, Office of Program Policy Analysis and Government Accountability
111 West Madison Street
Tallahassee, Florida 32399-1475

Dear Dr. Twogood:

Thank you for the opportunity to respond to your office's report "Several Factors Hinder Homeowner and Auto Glass Insurance Fraud Processing." The Division of Investigative & Forensics Services (DIFS) is an integral part of the Department of Financial Services and is the unit charged with the investigation of fraudulent criminal activity. Based on your report and input from stakeholders from the consumer and insurance industries, we propose a series of interacting solutions to continue the fight against fraudulent activity in Florida.

First, as noted in the report, DIFS has a staffing problem that manifests itself in high vacancies and turnover. The result is a dedicated but less tenured workforce of investigators. Our solution is to propose a recruitment and retention plan to increase hiring and at the same time give investigators a career plan to excellence within the division. The plan allows investigators to train and study to achieve milestones in increments of five years that result in a pay increase. We propose the following hiring stages: Investigator I, Investigator II, Senior Investigator and Master investigator with a new starting pay range at every level. The OPPAGA report makes it clear that a fully functioning work force of experienced investigators is key to working more fraud cases in an expedited manner.

With respect to the suggestion that DIFS consider whether the 180-day metric should be adjusted to be more useful, we agree. We propose a 90-day timeline for the review of initial referrals by analysts and supervisors. Pursuant to the new policy, we will review open referrals every 90 days for new leads and staffing assignment. Referrals will be closed after a year if there is not relevant activity key to assignment or prosecution. The effective date of this policy will be July 1, 2021.

We are in ongoing discussions with the insurance industry about the work of insurance company special investigative unit (SIU) do and how we can work closer with our industry partners. We will be proposing a task force pilot similar in scope to the former workers' compensation task force funded by the carpenters' union. The pilot would be two squads funded by the insurance industry to operate in central Florida focusing on criminal gangs and fraud rings perpetrating large fraud schemes around roofing and property claims. We will request non-recurring spending authority for the pilot.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
Julie Jones, Deputy Chief Financial Officer
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AFFIRMATIVE ACTION • EQUAL OPPORTUNITY EMPLOYER

Concerning the recommendations from the OPPAGA report, we propose the following action:

Increase the number of required elements insurance companies must include in fraud referrals.

- Revise the referral form to include additional specified elements to help resolve issues of insufficient evidence. This would strengthen leads for DFS investigators to pursue and could help investigators present a well-supported case to prosecutors.
- *Action: We would propose making the current fields on our "Information Developed to Confirm Suspicion" section of the Suspected Fraud Report Form mandatory instead of expanding the fields. Working with insurance company SIU groups, we propose making an addendum available to expand information on a case-by case basis. The addendum would be electronic. Our goal is to encourage SIU's to do their due diligence in filling out the complete form and not just populate with data analytics.*

Establish routine audits of insurance company SIUs.

- Amend s. 626.9891, Florida Statutes, to authorize DIFS to conduct audits of SIUs to ensure compliance with statutory requirements and improve the quality of fraud referrals.
- *Action: Currently, three data processor staff review every referral for accuracy and the primary elements required to move a referral forward. The referrals then go to supervisors for review and assignment. In lieu of audits, we will ask for two analysts to triage the information being provided by the industry for thoroughness and fulfillment of established requirements. They will also mine and work as liaisons with the industry SIU's and the Office of Insurance Regulation to ensure compliance. The added analysts will also work to provide SIU's with division training opportunities and provide a feedback loop with the industry. This will make the referrals more robust and increase our ability to build solid cases for prosecutors. The final part of the analyst's job will be to work with OIR if there is a need for an audit of an insurance company's processes.*

Encourage more witnesses to report fraud via the Anti-Fraud Reward Program.

- Revise s. 626.9892, Florida Statutes, to allow awards for witness reports following an arrest for insurance fraud as opposed to waiting for conviction. This could result in awards being made sooner, thus encouraging more witnesses to report insurance fraud.
- *Action: We agree with this OPPAGA report recommendation. We would propose also changing the reward amounts in rule to match a "crime stopper" approach toward arrests, making our own "Fraud Stopper" program. This compliments our Stop Fraud Hotlines and will be marketed accordingly.*

Thank you, again, for the opportunity to formally respond to this report. We look forward to further collaboration on these important topics.

Sincerely,

Julie Jones, Deputy Chief Financial Officer
Department of Financial Services

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OPPAGA

Office of Program Policy Analysis and Government Accountability

OPPAGA provides performance and accountability information about Florida government in several ways.

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