

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
CRIMINAL INVESTIGATIONS DIVISION

ANTI-FRAUD DATABASE SERVICES



GAA 2024 – 2596 Anti-Fraud Database Services

The nonrecurring funds in Specific Appropriation 2596 are provided to the Department of Financial Services to obtain access to an anti-fraud database. The department shall create metrics that demonstrate efficiencies and/or the increase of fraud detection based on access to the anti-fraud database and provide a report to the President of the Senate, the Speaker of the House of Representatives, and the Governor's Office of Policy and Budget by November 15, 2024.

ABSTRACT

As the law enforcement branch of Florida's Department of Financial Services, the Criminal Investigations Division (CID) is tasked with serving Florida's citizens by investigating and preventing financial crimes across the state of Florida, including but not limited to insurance fraud, workers' compensation fraud, and misuse of state funds, as well as arson.

CID has a responsibility to protect Florida's citizens and be a national leader in detecting, preventing, and investigating insurance fraud. There are over 4,500 insurance related entities in Florida and approximately 7.43 million residential insurance policies currently in force alone, in addition to all workers' compensation, automobile, healthcare, and other types of policies offered by insurance companies doing business in Florida. For the state to monitor and review this level of activity, in 2021 we initiated a pilot program and partnered with Verisk to deploy the most expansive anti-fraud databases available.

Verisk is an anti-fraud database with over 1.7 billion aggregate industry-wide claim files collected during the past 50 years, representing 97% of all Property & Casualty (P & C) carriers and all 27 workers' compensation insurance companies nationwide.

Access to the records kept by Verisk, along with their data mining and predictive modeling software, provides CID with real time information showing possible criminal activity occurring in, or connected to, the State of Florida. Currently, there is no other database available with a similar repository of information related to claims filed that may affect Florida. Any attempt by the state to create such a data source would take years and require a significant investment up front, along with recurring maintenance costs. In addition, such a system would be limited to information filed in Florida and would not include external data associated with, or having an impact on the state, especially during natural disasters.

INTRODUCTION

The complex nature of financial crimes under the Division's jurisdiction, which include premium fraud, misappropriation of state funds, money laundering, and racketeering, require the use of sophisticated resources capable of conducting data analytics, predictive modeling, and establishing connections between organized groups operating in multiple jurisdictions.

Nationally, Florida has a history of being a leader in fighting fraud. Florida was the first state to create an electronic gateway for the submission of suspected fraud referrals, a method which has now been adopted by many states around the country. Maintaining usage of Verisk's databases (claims, compliance and reporting, data and statistical services, property estimating solutions, underwriting and predictive modeling) would continue that trend.

Using Verisk's third-party data, CID is now capable of leveraging the intelligence gathered from over 1.7 billion existing claims, in addition to an estimated 80 million new claims expected to be added on a yearly basis, to help conduct criminal investigations.

With implementation of the software now complete, CID has begun widespread usage in the field. Because Verisk's database and features apply to many different types of fraud, including but not limited to auto, fire, workers' compensation, and property & casualty, the software provides benefits across all bureaus and allows for greater collaboration Division-wide.

CLAIMSEARCH / CLAIMDIRECTOR SIU TRIAGE

While the Division has had basic access to Verisk's ClaimSearch database, the addition of the ClaimDirector SIU (Special Investigative Unit) Triage module provides greater access to data. CID supervisors can now enter a claim number and receive information not only on that claim, but also on links to other claims, persons, phone numbers, addresses, etc. This greatly reduces the amount of time conducting research and ensures accurate connection to the millions of available claims data points.

ClaimDirector allows for the implementation of a scoring ("rule tuning" or data filtering) system to determine which referrals should receive top priority. This feature is designed to continually improve based on the outcome of cases worked by CID investigators. As new trends emerge, the Division can edit scores for individual rules so that priority is given to referrals having the highest probability of being investigated and prosecuted. To date, the Division has scored over twelve thousand claims. The chart below illustrates an example of how an individual referral is scored.

0120 [REDACTED] has ClaimDirector Score **564**



Personal Auto | Date of Loss: 02/08/2023

Alerts

100	A service provider for this involved party appears to match an entity on the NICB Forewarn Alert SA-2020-163. The match was made on the service provider's TIN	Rule 503
	View Details	
90	Including this loss, this involved party's SSN [REDACTED] is linked to 2 or more involved parties in the ClaimSearch database	Rule 24
80	The first notice of loss was delayed by greater than 30 days	Rule 69
40	No police report exists for this loss	Rule 67
40	The involved party has a total of 4 or more claims in the database	Rule 120
40	There was no witness to this loss	Rule 515
10	This involved party appears to match an entity associated with a loss that was referred to the NICB	Rule 116
10	This involved party also appears on another loss(es) with the same date of loss reported by 1 or more other insurers	Rule 121

NETMAP

The NetMap feature combines geography, third party statistics, and an overview of prior claim history to find “areas of suspicion” between all parties in a claim. This feature is especially useful in identifying crime rings and organizations. It provides immediate identification between law firms, businesses, individuals, insurance companies, and more, presented as a series of links for investigators to follow and investigate further.

It utilizes information provided by Verisk’s database and offers repository features that will allow the Division to utilize internal databases along with the ClaimSearch data.

NetMap can be used as both an organizational and visualization tool, drastically reducing the time investigators spend on a case by identifying links and putting them into easily understandable graphics that may not be immediately recognizable during baseline analysis.

MEDSENTRY

MedSentry is an Artificial Intelligence driven model that leverages analytics and expert analysis to provide actionable intelligence to identify provider fraud, waste, and abuse. The system analyzes data from over 500,000 providers and 6 million patients through more than 100 analytical models to find potential instances of criminal activity in a timely and correct manner.

PROCUREMENT AND IMPLEMENTATION

After legislative approval of this pilot in the 2022-23 budget cycle, a procurement instrument was developed and deployed which resulted in the hiring of Verisk. This procurement document was complex because of the need to ensure appropriate use and protect the confidentiality of this massive claims database. Contract negotiations between CID and Verisk were started July 4th, 2022, and finalized October 28th, 2022.

CID and Verisk IT personnel have finalized the required data sharing processes, one of which enabled a more seamless transfer of information received by the National Insurance Crime Bureau (NICB). Past practices involved the need for personnel to manually enter claim and subject information received from each referral. Through ongoing collaboration with Verisk, this process has become automated and is expected to save hundreds of hours each year. The NICB portal now communicates directly with our internal database allowing for a more effective and efficient method for processing referrals.

Since implementation, the Division has identified specific performance metrics to further track and monitor the effectiveness of the database to enhance the following measures:

1. Percentage of fraud referrals that result in opened cases.

The anti-fraud database provides access to prior claim histories with supporting documents and/or submitted images. The database also allows the Division to create rules or selection processes based on prior case outcomes. These rules quickly identify referrals containing elements associated with successful prosecutions.

The Division received 20,011 insurance fraud referrals during FY 2023/2024. This was an increase of 1% over the previous year. Of these, approximately 1,342, or 7%, were opened as cases for further investigation.

The use of screening rules has been activated and is currently being adjusted to capture their proper value. This fiscal year, several rules were put in place to close out referrals at the analyst level that scored low, allowing supervisors to place more emphasis on higher impact referrals.

2. Percentage of fraud referrals that result in opened major cases.

Investigations involving multiple jurisdictions, multiple subjects, organized schemes to defraud or aggravated white-collar crime are considered major cases given their greater complexity.

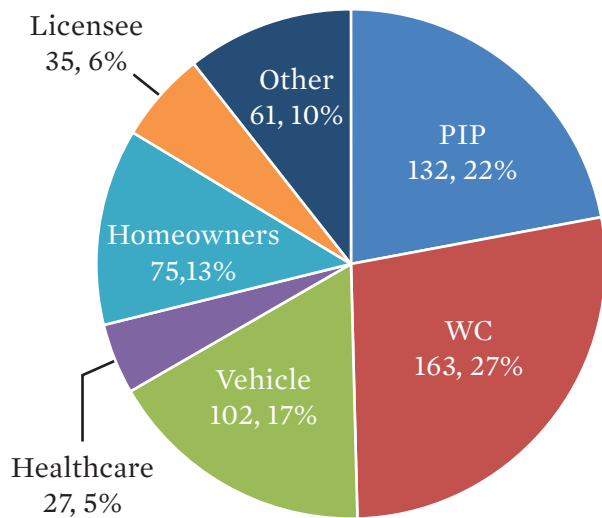
The Division opened 303 major cases during FY 2023/2024 as compared to 285 the previous FY.

The anti-fraud database has claim scoring features that assist in the triage of claim information designed to identify links between different individuals, businesses, properties, parties, and locations along with prior claims, referrals, and investigations. This process was initially activated and continues to be adjusted for proper use.

3. Percentage of opened cases that result in presentations.

For FY 2023/2024, the Division opened 1,342 cases and submitted 749 presentations for criminal prosecution compared to 1,281 cases opened and 662 presentations in FY 2022/2023, representing a 4% increase in the number of cases opened and presented for prosecution. Many of the cases that were presented for prosecution include Homeowners, Vehicle and PIP fraud in which Verisk was used to run previous claim history.

**FY 2023/2024
SUCCESSFUL PROSECUTIONS**



4. Percentage of successful prosecutions.

The Division obtained 595 successful prosecutions during FY 2023/2024 compared to 580 in FY 2022/2023. Of those 595 prosecutions, the three largest portions of cases were Workers' Compensation Fraud (27%), PIP (22%), and Vehicle Fraud (17%). Other types of fraud cases prosecuted by the Division were Homeowners, Healthcare, Licensee and Other.

5. Number of subjects and business records entered into the Division's case management system.

The anti-fraud database provides access to over 1.7 billion claim files in the U.S., with over 80 million claims anticipated to be added annually. Utilizing this database, the Division is now capable of instantly gathering and collecting information on subjects and businesses associated with suspicious claims. The system is now automatically creating subject, business, vehicle, telephone and address profile records in the Division's case management system. Because of these enhancements, the Division can quickly see the connections, or links, between previous fraud referrals made to the Division.

In October 2023, Verisk began creating subject records for CID in its case management system for all NICB referrals. All subjects and businesses in an NICB referral were automatically created

by Verisk and entered into the case management system, where in previous years CID's word processors would only be able to enter the main subject of the referral into the case management system. In FY 22/23 (prior to Verisk), CID word processors entered 17,177 subjects and 4,522 businesses into the case management system. In FY 23/24, 26,324 subjects and 7,299 business were entered into the case management system automatically by Verisk, a 53% increase and a 61% increase respectively. This automation not only led to a much larger data pool for investigators to utilize when linking and associating cases but also allowed CID word processors to reallocate their time to preparing more cases for referral to investigators.

6. Percentage of Insurance Services Office (ISO) database checks to increase.

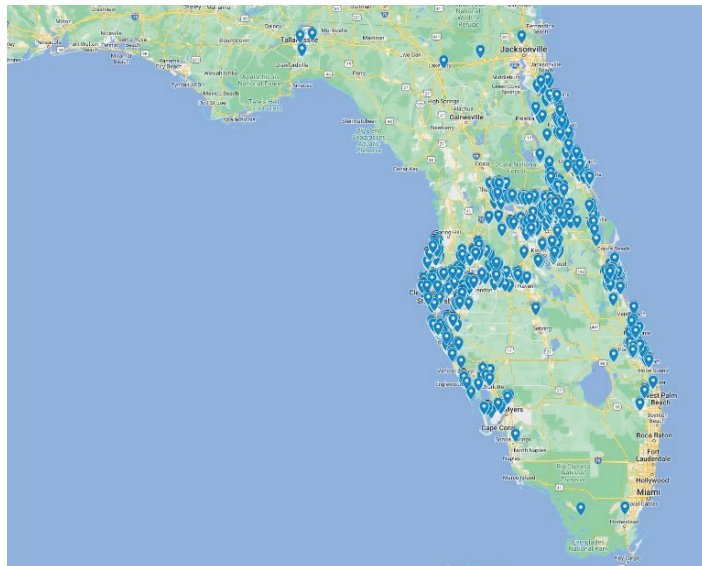
The anti-fraud database combines multiple search functions into one task, allowing Division analysts to conduct more searches within a fraction of the time and gain access to a greater number of claims filed throughout the country. The database also allows analysts and supervisors to quickly view previous claim history for insured and claimants. CID's current policy is to query all NICB referrals through the ISO database to obtain additional information to include claim scoring and a Verisk report that shows previous claims for the various subjects listed in the referral. In FY 23/24, CID queried 13,550 NICB referrals through Verisk.

CONCLUSION

As with any predictive modeling software, the volume of stored data is proportional to the capability of its ability to accurately forecast future occurrences. While it is still too early to provide long-term statistics regarding the benefits of Verisk, the Division is taking the steps necessary to compile vital data points and can project efficiency improvements in several sections going forward.

Complaint screening and processing – CID received over 20,000 suspected fraud referrals for FY 23/24. Each referral takes approximately 15 minutes to process. Due to the voluminous number of referrals, CID does not have the available resources to conduct detailed claim searches for each fraud referral; however, the new system automates data entry and with the hundreds of hours saved, staff can conduct data mining and track emerging trends. The development and implementation of a scoring system for red flags and solvability factors will assist supervisors in their review of referrals and likewise increase effectiveness during the triage process.

Disaster Response – Verisk’s tracking of weather event occurrence and location will aid in the discovery of fraudulent claims and help develop a coordinated response. For several years, CID has deployed trained law enforcement investigators with specialized knowledge of property & casualty and workers’ compensation fraud to affected areas after landfall of a named hurricane or other significant weather event. These teams investigate active fraud schemes or claims that take advantage of the conditions occurring after a disaster. Previously, CID’s teams primarily relied on anecdotal evidence from local law enforcement or officials to determine where to deploy. Obtaining evidence from previous claims involving homeowners or contractors while in the field was difficult, as well as maintaining near real-time information about claims already reviewed by the teams. During hurricanes Helene and Milton in September and October of 2024, CID was able to coordinate a response to potential fraudulent claims by using the data contained within Verisk to develop tasking lists for each team and create a visual map of all responses.



Hurricane Milton Response Map

Investigations – The ability to quickly recognize organized schemes to defraud will ensure CID can direct its limited resources toward the investigation of individuals and organizations having the greatest impact on the citizens, businesses, and the insurance industry in the State.

Now that the database is fully deployed, we are seeing significant benefits in our ability to process information and dedicate resources. The automation of the referral process is more thorough and includes associated claims data previously not received. This reduces the amount of time required to process and evaluate complaints, while greatly increasing the amount of intelligence being developed. The additional data is accurately classified and reduces research by criminal analysts and investigators. This is critical in making connections between parties involved regardless of the location in the country they are operating from.

Successful Implementation and Use Case Study – Between February and April of 2024, CID received multiple referrals from several insurance carriers alleging that one individual had filed multiple kitchen fire claims for the same address shortly after policy inception.

Using Verisk's NetMap features, the Division was able to not only tie the subject's claims at the single address but also to link the same subject to several claims across several states, including Indiana and Florida.

Utilizing the data available from Verisk and from the NICB, CID was able to identify several false claims submitted by the same subject in which she utilized false identities and aliases to submit renter's insurance claims as well as automobile claims. CID's investigation of the Florida claims has led to an arrest warrant for six counts of insurance fraud, two counts of application fraud, and 1 count of scheme to defraud. The subject is currently detained in Clark County, IN on six counts related to insurance fraud and racketeering. The NICB has indicated that the prosecutor in the Indiana case has filed a notice to seek a habitual offender enhancement which, if convicted, will add an additional six years to any sentences received.

As with any new software implementation, there is always a need for personnel to attain comfort in working with the system and its available features. As CID's comfort with Verisk grows, our ability to utilize the system to assist not only with fraud investigations based on referrals but also as a proactive tool to identify emerging trends as insurance fraud expands. As the previous case study illustrates, the Verisk software has become an essential tool to identify fraudulent practices occurring not only in Florida but throughout the United States. We are therefore requesting that this procurement be supported with a permanent recurring funding allocation.

