

October 9, 2026

Mehmet Oz, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

*Via electronic mail*

Dear Dr. Oz:

The National Association of Insurance Commissioners (NAIC) represents the chief insurance regulators of the states, the District of Columbia, and U.S. territories. State insurance regulators appreciate the Centers for Medicare & Medicaid Services' (CMS) ongoing efforts to identify and combat fraud and abuse. We write to request enhanced coordination among CMS, state insurance regulators, state-based Marketplaces, health insurance issuers, and, importantly, law enforcement to address fraud schemes targeting individuals in need of mental health and substance use disorder treatment.

In particular, we urge greater collaboration to disrupt schemes in which individuals are improperly enrolled in Marketplace coverage, transported across state lines for purported treatment, and used to generate fraudulent claims. These practices cause significant harm to vulnerable consumers, impose substantial financial costs on insurers and government programs, and threaten the stability of individual insurance markets.

### **Fraudulent Marketplace Enrollment and Sham Treatment Schemes**

We ask CMS to place greater focus on a fraud scheme affecting insurance markets in multiple states. Perpetrators frequently target American Indians and Alaska Natives, who are eligible for monthly Special Enrollment Periods (SEPs) for Marketplace coverage. Other SEP-qualifying events, such as adoption, may also be exploited to obtain coverage outside of the annual Open Enrollment Period. In other cases, perpetrators use the annual Open Enrollment Period to facilitate fraudulent enrollments.

Consumers are often misled, pressured, or otherwise induced to enroll in Marketplace coverage, frequently using false or inaccurate information. Once enrolled, individuals may be transported to another state—or even across the country—for purported treatment. Sham treatment centers may then submit claims to Marketplace insurers for services that were never provided or were not medically necessary. In some cases, consumers are left without the resources or ability to return to their state of residence. Most concerning, these practices can exacerbate or encourage substance use disorders rather than provide legitimate treatment.

Consumers who ultimately return home may continue to experience significant consequences, including persistent debt-collection efforts associated with claims resulting from fraudulent or improperly obtained coverage, even after coverage is appropriately rescinded.

Beyond the substantial harm to consumers, these schemes impose extraordinary financial costs on the insurance market. Sham treatment centers have submitted hundreds of millions of dollars in claims associated with individuals enrolled in Marketplace plans. Even after improper claims are identified and coverage is rescinded, the same individual may be reenrolled during the same plan year, allowing additional fraudulent claims to be generated.

The scope of the problem is significant. Alaska alone has identified more than \$100 million in suspected fraudulent claims associated with these schemes. In Pennsylvania, the state-based Marketplace, Pennie, rescinded more than 1,600 policies, preventing the payment of more than \$480 million in fraudulently billed claims this year. Fraud at this scale threatens the stability and integrity of the individual insurance market in affected states. Alaska and Pennsylvania are not alone; an increasing number of states have identified similar patterns of fraud and abuse affecting both the federally facilitated Marketplace and state-based Marketplaces.

We recognize and appreciate CMS' ongoing efforts to address these schemes. Through the work of CMS, insurers, and state regulators, significant amounts of improper claims have been identified and stopped before payment. However, the continued emergence of these schemes demonstrates the need for additional measures and stronger coordination among federal and state partners.

## **Recommended CMS Actions**

As potential fraud is investigated and identified, we respectfully request that CMS take the following actions to prevent continued exploitation of consumers and facilitate state investigations:

### **1. Provide state insurance regulators with access to Marketplace application information for suspected fraudulent enrollments.**

CMS should provide state departments of insurance with appropriate access to the complete Marketplace applications of individuals whose eligibility or enrollment is suspected of being fraudulent or otherwise improper. Access to this information would allow state regulators to identify potential perpetrators and evaluate whether applications contain false statements or other inaccurate information.

Where legally permissible and appropriate, application information should include identifying information and relevant metadata, such as IP addresses associated with application submissions and payment information used to pay premiums. States are prepared to work with CMS to establish the appropriate agreements, safeguards, and procedures necessary to facilitate access to this information while protecting consumer privacy.

### **2. Establish an expedited pathway for rescission when there is substantial evidence of fraud.**

CMS should establish an expedited rescission process when evidence establishes probable cause or otherwise provides a substantial basis to conclude that coverage was obtained through fraud.

Improper claims can begin accumulating as soon as the first month of coverage. When the current rescission process takes several months, substantial additional exposure can accrue before coverage is terminated. An expedited process would reduce the opportunity for fraudulent claims to accumulate while preserving appropriate due-process protections and an opportunity for legitimately eligible consumers to demonstrate their eligibility and maintain coverage.

### **3. Consider income, enrollment patterns, and other indicators as part of the overall fraud analysis.**

CMS should consider reported income and income sources, as well as enrollment and disenrollment behavior, as components of the overall fact pattern when evaluating potential fraudulent enrollment.

States and insurers have identified instances involving fraudulent income information on Marketplace applications, as well as Medicaid disenrollment occurring immediately before enrollment in Marketplace coverage. States and insurers have also documented repeated Marketplace plan changes, or “plan hopping,” which may indicate that perpetrators are moving individuals between insurers after encountering barriers related to prior authorization or claims for out-of-state treatment.

These factors, considered collectively with other available information, may provide important indicators of fraudulent activity and should be incorporated into CMS’ evaluation of potential rescission cases.

### **4. Establish additional pre-enrollment verification for individuals previously associated with fraudulent coverage.**

CMS should permit Marketplaces and insurers to conduct additional pre-enrollment verification for individuals whose prior Marketplace coverage was rescinded for fraud.

Additional safeguards could help prevent the repeated use of the same individual to generate fraudulent claims. SEPs—including the SEP available to American Indians and Alaska Natives—serve an important purpose by providing meaningful access to health coverage. However, when an SEP has previously been exploited in connection with a fraudulent enrollment, additional verification measures should be considered before subsequent enrollment is finalized.

### **5. Strengthen information sharing between Medicaid agencies and Marketplaces.**

CMS should facilitate more timely and comprehensive information sharing between state Medicaid agencies and the federal and state-based Marketplaces to prevent Medicaid-eligible individuals from improperly enrolling in subsidized Marketplace coverage.

Both the federally facilitated Marketplace and state-based Marketplaces would benefit from more robust and timely access to Medicaid enrollment information during the application and eligibility process. We encourage CMS to issue guidance or pursue regulatory changes, as appropriate, to facilitate the timely availability of Medicaid enrollment data to Marketplaces as Marketplace applications are processed.

### **6. Collaborate with states while encouraging prosecutors to pursue cases in federal court.**

Within the broader federal fraud task force effort, CMS should encourage federal investigators and prosecutors to collaborate with states’ anti-insurance fraud teams to indict and prosecute perpetrators in federal court.

Bringing cases in federal court related to public and private plan fraud associated with sham treatment centers and the body brokers who work with them may result in more effective prosecutions since these cases involve multiple states and payers that include Medicare and Medicaid.

## Strengthening Federal, State, and Law Enforcement Coordination

Together, CMS, state regulators, insurers, and law enforcement have made meaningful progress in identifying and disrupting fraudulent treatment center schemes and the individuals who facilitate them. We urge CMS to build on that progress through stronger and more systematic information sharing and coordination.

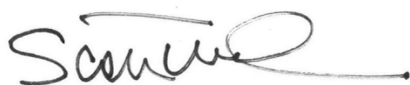
Greater collaboration among CMS, state insurance regulators, state-based Marketplaces, insurers, and law enforcement can help identify, investigate, and disrupt fraudulent activity regardless of the particular scheme or business model involved. Fraud schemes frequently extend beyond treatment centers, cross state lines, and involve multiple participants and jurisdictions. They are also rarely isolated to a single market.

Accordingly, we request that CMS establish a regular process for sharing information with investigative teams within state insurance departments regarding identified fraud schemes. To the extent permitted by law, this information should include the characteristics and indicators associated with a scheme, how the activity was identified, and relevant case information that would assist states in recognizing similar activity in their own markets.

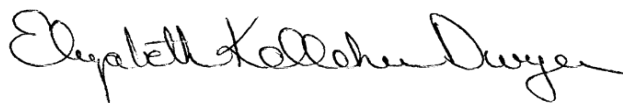
Timely information sharing would enable state regulators to identify emerging schemes earlier, coordinate with federal and state partners, and implement appropriate measures to prevent improper claims from being paid. Early intervention, coupled with meaningful involvement from law enforcement, increases the opportunity to disrupt fraudulent activity before it becomes widespread. Coordinated and timely regulatory and law enforcement action can also help deter the replication of successful fraud schemes in other jurisdictions.

State insurance regulators stand ready to work collaboratively with CMS and our federal and state partners to protect consumers, safeguard the integrity of Marketplace coverage, and preserve the stability of the individual insurance market. We appreciate CMS' continued attention to this issue and respectfully request consideration of the actions outlined above.

Sincerely,



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NAIC President  
Commissioner  
Virginia Bureau of Insurance



Elizabeth Kelleher Dwyer  
NAIC President-Elect  
Director  
Rhode Island Department of Business  
Regulation



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