



March 30, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) (RIN 0938-AV97)

Dear Administrator Oz,

Covered California appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information regarding the potential regulatory and programmatic changes to strengthen program integrity and address fraud, waste, and abuse across federal health programs, including health insurance Marketplaces.

Covered California is the nation's largest State-Based Marketplace (SBM), serving over 1.9 million consumers, and has long maintained a strong operational focus on program integrity, consumer protection, and accountability across all aspects of eligibility, enrollment, and ongoing oversight. As such, Covered California is well positioned to provide practical, experience-based feedback on approaches that effectively mitigate fraud risk while preserving a seamless, accessible consumer experience. Our experience demonstrates that appropriately designed safeguards can strengthen program integrity while simultaneously reducing consumer burden and improving enrollment outcomes.

We note that, although the RFI does not explicitly reference the recently published Government Accountability Office (GAO) report,¹ the issues raised throughout the RFI — including unauthorized enrollments, misuse of Social Security numbers, and gaps in fraud risk management — closely track the findings identified by the GAO with respect to vulnerabilities in the Federally-Facilitated Marketplace (FFM). In particular, the GAO's findings regarding unauthorized enrollment activity and weaknesses in front-end controls underscore the need for stronger-front-end controls, particularly related to agent and broker access, identity verification, and enrollment authorization.

At the same time, we further note that the GAO's review was limited to the FFM and did not include an assessment of SBMs. Covered California's experience indicates that the patterns identified by GAO—such as unauthorized enrollment activity and widespread consumer complaints—have not been observed in our Marketplace, due to the presence of specific front-end controls, enrollment safeguards, and continuous monitoring practices described below. This distinction is particularly important as CMS considers potential regulatory changes, as the GAO report indicates that the vulnerabilities identified are associated with the FFM's structure and program integrity controls, rather than reflecting issues inherent to all Marketplaces. In fact, Covered California has been able to implement strong controls and robust anti-fraud measures

¹ U.S. Government Accountability Office, [Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist](#), GAO-26-108742 (Dec. 2025).

while also prioritizing consumer experience and minimizing barriers to enrolling eligible consumers.

Across the following responses, several common themes emerge from Covered California's operational experience. Absent this targeted approach, program integrity policies risk imposing broad administrative burdens on consumers without addressing the primary drivers of fraud identified in the FFM.

First, program integrity efforts are most effective when they are targeted to the primary sources of risk, particularly enrollment pathways and intermediary activity, rather than broadly applied to consumers. As reflected in the issues identified in the FFM, including unauthorized enrollments and plan changes, vulnerabilities are often associated with the actions of agents, brokers, and enrollment platforms. Covered California has addressed these risks through operational controls that limit access to consumer accounts and require affirmative consumer involvement in enrollment actions. This targeted approach has enabled Covered California to mitigate risk without introducing unnecessary barriers for eligible consumers.

Second, preventing fraud at the point of enrollment through front-end controls is more effective and less disruptive than post-enrollment recovery approaches. Covered California has implemented safeguards that identify and address potential fraud before coverage is effectuated, including required consumer consent prior to case access and modern identity verification processes. These controls reduce the need for retroactive corrections, which can create administrative burden, disrupt coverage, and confuse consumers. A prevention-focused model supports both program integrity and continuity of coverage.

Third, well-designed, risk-based safeguards can strengthen both program integrity and consumer experience. Covered California's experience demonstrates that modern verification tools and streamlined processes can reduce friction while improving accuracy and oversight. By moving away from more burdensome verification approaches and adopting risk-based methodologies, Covered California has improved enrollment completion rates while maintaining strong protections against fraud. This approach reflects the principle that program integrity and consumer access can be advanced simultaneously when controls are appropriately calibrated.

Fourth, it is important to distinguish between fraud and consumer error, and to preserve state flexibility for SBMs where effective controls are already in place. Covered California's experience with duplicate enrollment and similar issues indicates that many such cases are attributable to consumer confusion rather than intentional misuse. These situations are addressed through structured resolution processes and coordination with partner programs, rather than punitive measures. At the same time, because the vulnerabilities identified by GAO were specific to the FFM, CMS should avoid one-size-fits-all approaches and instead allow SBMs to continue operating under models that have demonstrated strong program integrity outcomes.

Accordingly, as CMS considers future rulemaking, Covered California provides the following response to the questions posted in the RFI, informed by its operational experience and demonstrated outcomes. Detailed responses to each question are set forth in the attached table.

Covered California appreciates CMS's consideration of these comments and the opportunity to inform future policy development in this area. We look forward to continued collaboration with CMS to share best practices and support the development of effective program integrity efforts that address fraud risks while maintaining a seamless and accessible experience for consumers.

Sincerely,



Jessica Altman
Executive Director

RFI Question	Covered California Response
<p>1. How could CMS strengthen program integrity, including fraud prevention and consumer protection, in both the FFE and SBEs by better leveraging existing regulatory oversight authority and identifying areas where additional regulatory authority may be needed?</p>	<p>The GAO report highlights persistent vulnerabilities in the FFM, including weaknesses in enrollment controls, identity verification, and oversight of enrollment activity. These gaps have allowed fictitious applicants to receive subsidized coverage and revealed shortcomings in fraud risk management, with CMS’s fraud risk assessment remaining outdated since 2018. While the GAO’s findings focus on the FFM, Covered California’s operational experience as the nation’s largest SBM demonstrates that targeted safeguards and proactive fraud monitoring can prevent similar vulnerabilities and maintain program integrity.</p> <p>To strengthen program integrity across both FFEs and SBMs, CMS should implement measures that prioritize prevention at the point of enrollment and leverage proven practices from successful SBMs. Covered California’s approach offers key recommendations:</p> <ul style="list-style-type: none"> • Require affirmative, verifiable consumer consent prior to any case access or enrollment activity. Covered California mandates secure consumer involvement through delegation processes, including portal management, call center authentication, and passcode verification, ensuring that enrollment actions reflect consumer intent. • Implement modern, risk-based identity verification tools, such as Artificial Intelligence (AI)-driven remote identity proofing. Covered California’s system detects nearly 100% of fraudulent attempts while maintaining a 95–98% success rate for identity verification, significantly reducing fraud and consumer friction. • Establish active duplicate enrollment monitoring and resolution processes to address overlapping coverage and protect financial assistance integrity. Covered California’s duplicate enrollment framework effectively flags improper cases, ensuring swift corrective action while maintaining consumer-centered communication. • Maintain a centralized fraud management team to coordinate monitoring, investigation, and enforcement. Covered California operates a dedicated fraud team that tracks complaint trends, investigates suspicious activity, and collaborates with internal and external stakeholders to uphold program integrity. <p>Covered California’s experience demonstrates that SBMs can effectively mitigate fraud risks through proactive, prevention-focused controls, which stand in contrast to the systemic vulnerabilities identified in the FFM. These measures are scalable and replicable across both FFEs and SBMs, ensuring that program integrity is strengthened without imposing unnecessary burdens on consumers. CMS should also recognize that SBMs with effective controls in place may not require identical interventions as the FFM, allowing for tailored approaches that reflect the operational strengths of SBMs.</p>

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<p>2. How could CMS improve regulations to strengthen oversight of agents, brokers, web-brokers, and direct enrollment entities including compliance standards, training, and fraud prevention in both the FFE and SBEs?</p>	<p>The GAO report identified significant misconduct among agents and brokers in the FFM, including unauthorized enrollments and plan changes made without consumer consent. CMS received approximately 275,000 complaints related to unauthorized enrollment activity and plan changes during the review period. These findings highlight the need for stronger oversight of agents, brokers, and other enrollment entities in the FFM.</p> <p>However, the GAO report did not include an assessment of SBMs, and Covered California’s experience demonstrates that the vulnerabilities identified in the FFM are not reflective of SBMs. Covered California has not observed widespread issues with agent or broker misconduct. This is largely due to its distinct business model, which relies on in-person brick-and-mortar agents rather than large web-based broker platforms. This approach inherently reduces exposure to the types of systemic risks highlighted in the GAO report, even while over 50% of Covered California’s enrollments are assisted by certified agents.</p> <p>Covered California’s oversight model provides valuable insights into effective safeguards that could strengthen agent and broker oversight in FFEs:</p> <ul style="list-style-type: none"> • Require consumer authorization for all enrollment actions: Covered California mandates that agents and brokers obtain formal delegation before accessing or modifying a consumer’s case. Delegation requires direct consumer participation and is confirmed through secure channels, including portal authorization, call center verification, three-way calls, or one-time passcode authentication. These measures ensure that enrollment actions reflect consumer intent and prevent unauthorized access or changes. • Establish clear standards of conduct and enforceable requirements: Covered California subjects all agents to an Agent Agreement and Code of Conduct that requires accurate representation of consumer information and prohibits unauthorized or misleading activity. Violations of these standards may result in graduated enforcement actions, including coaching, suspension, termination, and referral to the California Department of Insurance for licensing enforcement. • Continuously monitor agent activity and market behavior: Covered California actively tracks complaint trends, reviews enrollment activity for anomalies, and conducts regular oversight of agent marketing practices, including website reviews to prevent misrepresentation or improper use of Covered California branding. This allows for early detection and resolution of suspicious activity or misconduct. • Adopt a structured enforcement and corrective action framework: Covered California employs a proportional enforcement model tailored to the severity of the issue. Enforcement actions include coaching, warning notices, suspension, termination, and referral to regulatory authorities, allowing Covered California to address misconduct effectively and prevent repeat violations.

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	<p>Covered California’s approach has produced measurable results. In recent years, the Marketplace has received no complaints of consumers being enrolled without their knowledge, and only one agent has been decertified in the past two years. These outcomes reflect both low incidence of misconduct and the effectiveness of Covered California’s oversight mechanisms.</p> <p>As CMS considers regulatory changes, it should recognize that the vulnerabilities identified by the GAO report are specific to the FFM and not inherent to all Marketplaces. While FFEs may benefit from adopting proven safeguards like those used by Covered California, SBMs with effective oversight systems should retain flexibility to continue operating under their established frameworks.</p>
<p>3. How could CMS expand its regulatory authority to incentivize insurance agencies to thoroughly vet assigned agents, brokers, and web-brokers assisting consumers with enrollment in FFE plans and hold agencies accountable for activities relating to these individuals?</p>	<p>Covered California’s experience demonstrates that agency-level accountability can play a vital role in preventing misconduct. Since 2017, Covered California has implemented an agency contracting model that requires agencies to assume responsibility for the actions of agents operating within their organization. This approach provides a framework that CMS could adopt to incentivize thorough vetting and improve accountability. Specific recommendations include:</p> <ul style="list-style-type: none"> • Agency-level contracting structure: Covered California utilizes an agency-based contracting model, under which individual agent agreements are tied to an agency’s organizational structure. This enables oversight at both the individual and organizational level. • Pattern identification across affiliated agents: Linking agents to agencies allows Covered California to identify trends in enrollment behavior that may not be visible at the individual level, supporting earlier detection of potential misconduct. • Direct engagement of agency leadership in compliance actions: Coaching and corrective actions are more effective when agency managers are involved in addressing issues, reinforcing accountability across the organization. <p>Covered California’s agency contracting model has strengthened oversight and accountability, allowing the Marketplace to track and address issues at both the individual agent and organizational levels. By adopting similar measures, CMS can incentivize agencies to thoroughly vet assigned agents, improve visibility into enrollment activity, and ensure compliance across the FFM.</p>

RFI Question	Covered California Response
<p>4. What specific measures could CMS implement to better curtail the ability of fraudulent agents, brokers, and web-brokers to enroll or change the enrollment of consumers without their knowledge or consent</p>	<p>Covered California has developed a robust framework to ensure that enrollment actions reflect consumer intent and prevent unauthorized activity by agents, brokers, or web-brokers. These measures focus on secure consumer authorization, proactive monitoring, and structured enforcement, offering a replicable model for CMS to strengthen oversight in the FFM. Key components of Covered California’s approach include:</p> <ul style="list-style-type: none"> • Mandatory consumer authorization for all enrollment actions: Covered California’s delegation framework ensures that enrollment partners cannot access or modify a consumer’s case without explicit authorization. This process requires direct consumer participation and uses secure pathways to verify identity and intent. Authorization methods include: <ul style="list-style-type: none"> ○ Consumer-managed delegation via the online portal: Consumers can directly add, change, or remove enrollment partners through their account, maintaining control over their case access. ○ Authenticated service center requests: Consumers can authorize case access by calling Covered California’s service center, where identity verification is conducted before delegation is granted. ○ Three-way calls: Consumers can participate in a real-time call involving the enrollment partner and Covered California’s agent service center to authorize delegation. ○ One-time passcode verification: Enrollment partners initiate delegation, but the process cannot be completed without the consumer entering a one-time passcode sent directly to them, ensuring the consumer’s active involvement. • Prohibition of unilateral enrollment actions by agents or brokers: Covered California strictly prohibits enrollment partners from independently initiating or completing enrollment actions without secure consumer authorization. This safeguard ensures that consumers retain full control over their coverage decisions, preventing unauthorized activity. • Active monitoring of enrollment activity and complaint trends: Covered California continuously tracks consumer complaints and reviews enrollment activity to identify anomalies, such as repeated actions by multiple agents on a single application. Complaint trends are analyzed to flag potential misconduct, allowing for early detection and intervention. • Structured enforcement framework to address misconduct: Covered California employs a graduated enforcement model to respond proportionately to agent or broker misconduct. Enforcement actions include: <ul style="list-style-type: none"> ○ Coaching and corrective action for minor issues

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	<ul style="list-style-type: none"> ○ Warning notices for repeated or concerning behavior ○ Suspension or termination of certification for egregious violations ○ Referral to external regulatory authorities, such as the California Department of Insurance for licensing enforcement or law enforcement for criminal investigations <ul style="list-style-type: none"> ● Oversight of agent marketing practices: Covered California actively monitors agent websites and advertising materials to ensure compliance with branding guidelines and prevent misleading or deceptive practices. This includes reviewing the use of Covered California logos and disclaimers to ensure agents do not misrepresent themselves or engage in deceptive marketing. <p>These measures have proven highly effective in preventing unauthorized enrollment activity. Covered California has received no complaints in recent years of consumers being enrolled without their knowledge or consent, and only one agent has been decertified in the past two years. These results reflect both low incidence of misconduct and the strength of Covered California’s oversight mechanisms.</p>
<p>5. How can CMS strengthen its enforcement activities to better address fraud, waste and abuse in the FFE and SBEs?</p>	<p>Covered California believes that instances of fraud, waste, and abuse within SBMs are significantly mitigated through the implementation of robust program integrity controls and distinct operational models. While the GAO report highlighted vulnerabilities specific to the FFM, Covered California’s experience demonstrates that SBMS effectively address these challenges through proactive and targeted measures. Covered California’s enforcement framework provides valuable insights that CMS could adapt to improve oversight in the FFM.</p> <p>Covered California’s enforcement approach is structured around a centralized, proactive fraud management program supported by coordinated oversight and clear escalation pathways. Key components include:</p> <ul style="list-style-type: none"> ● Centralized fraud management team: Covered California operates a dedicated fraud management team that serves as the centralized hub for all fraud-related issues. The team receives complaints through multiple intake channels—phone, email, and written submissions—and conducts thorough investigations into all reported cases. ● Cross-functional coordination: The fraud management team collaborates closely with other divisions to address complaints and ensure compliance. This coordination enables swift and effective resolution of issues. ● External partnerships: Covered California actively engages with external regulatory authorities and enforcement agencies to address cases that require escalation. Key partnerships include: <ul style="list-style-type: none"> ○ California Department of Insurance (CDI): Covered California refers agent misconduct cases for licensing enforcement to CDI.

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	<ul style="list-style-type: none"> ○ Department of Health Care Services (DHCS): Collaboration with DHCS (California’s Medicaid agency) allows Covered California to address Medi-Cal fraud investigations and ensure eligibility accuracy. ○ Department of Managed Health Care (DMHC): Covered California coordinates with DMHC to resolve consumer complaints related to health plan operations. ○ Law enforcement agencies: Covered California works with local, state, and federal law enforcement to address criminal investigations involving fraud or identity theft. ● Graduated enforcement framework: Covered California employs a proportional enforcement model designed to address misconduct effectively while preventing repeat violations. Enforcement actions include: <ul style="list-style-type: none"> ○ Coaching and corrective action for minor infractions. ○ Warning notices for repeated or concerning behavior. ○ Suspension or termination of agent certification for serious violations. ○ Referral to licensing authorities or law enforcement for egregious cases. ● Ongoing monitoring and trend analysis: Covered California continuously monitors complaint trends, consumer data, and suspicious enrollment patterns to identify potential misconduct early. Agents with performance issues are placed on watch lists for ongoing evaluation, allowing Covered California to proactively address emerging risks. ● Fraud awareness and training: Covered California fosters an organizational culture mindful of fraud through enterprise-wide mandatory fraud training for all team members. The training equips staff to identify, prevent, and report suspicious activity. Covered California also hosts annual Fraud Summits with internal and external stakeholders to share best practices, monitor trends, and exchange knowledge. <p>Covered California’s approach has proven effective in maintaining program integrity. In recent years, the Marketplace has received no complaints of systemic fraud, waste, or abuse, and enforcement actions have been limited to isolated incidents. For example, only one agent has been decertified in the past two years, reflecting both low incidence of misconduct and strong oversight.</p> <p>As CMS considers strengthening enforcement activities, it is critical to distinguish between the challenges facing the FFM and the demonstrated outcomes of SBMs. While Covered California’s framework provides a replicable model for proactive fraud management and enforcement, it is important to recognize that SBMs have distinct operational structures and controls that have successfully mitigated fraud risks. There is no evidence of systemic fraud, waste, or abuse in SBMs, and regulatory changes should avoid imposing one-size-fits-all approaches that could disrupt proven</p>

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	<p>practices. Instead, CMS should focus its enforcement efforts on addressing the vulnerabilities identified in the FFM while allowing SBMs the flexibility to continue operating under their effective and established models. Any enforcement strategy should strike a balance between strengthening program integrity and maintaining a seamless, accessible consumer experience—ensuring eligible individuals can enroll in coverage without facing unnecessary barriers.</p>
<p>6. How could CMS strengthen its standards for corrective action and for suspension or termination of agents', brokers', and web brokers' Exchange Agreements and what circumstances should trigger each type of action? Should CMS consider additional use of civil money penalties? If so, under what circumstances?</p>	<p>Covered California's enforcement framework provides a clear and structured approach to addressing agent, broker, and web broker misconduct. By utilizing a graduated corrective action model, Covered California ensures proportionate responses to issues while maintaining accountability and protecting consumers. CMS could adopt similar practices to strengthen standards for corrective action, suspension, and termination in the FFM.</p> <p>Covered California's operational experience suggests the following circumstances as appropriate triggers for enforcement actions:</p> <ul style="list-style-type: none"> • Unauthorized enrollment or case modification • Submission of inaccurate or misleading consumer information • Plan steerage, including enrolling consumers in plans inconsistent with their needs • Program steerage, such as enrolling consumers in Marketplace coverage when they may be eligible for Medicaid • Misleading or non-compliant marketing practices, including improper use of branding or deceptive websites • Bundling practices, such as requiring consumers to purchase unrelated insurance products <p>Covered California's graduated enforcement framework, described in response to Question 2, outlines proportionate actions to address misconduct effectively. These actions range from coaching and corrective measures for minor infractions to suspension, termination, and referral to external authorities for egregious violations. CMS could adopt similar graduated enforcement practices to ensure proportionate responses to issues while protecting consumers and maintaining program integrity.</p> <p>Covered California does not currently impose civil money penalties (CMPs) and does not have a specific position on whether CMS should adopt them. While CMPs could be one option for addressing systemic misconduct, CMS should carefully assess whether their use is appropriate and consider the potential impact on agents, brokers, and web-brokers, particularly those serving vulnerable populations. The decision of whether to implement CMPs and the circumstances under which they might apply should be determined by CMS based on its analysis of enforcement needs and program integrity goals.</p>

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<p>7. How could CMS improve the accuracy, timeliness, fraud prevention, and other aspects of program integrity in income verification for FFE enrollees?</p>	<p>Income verification is a critical component of determining eligibility for Marketplace subsidies, and ensuring its accuracy and timeliness is vital to maintaining program integrity. The GAO report highlighted weaknesses in the FFM income verification processes, including cases where income inconsistencies were not adequately resolved, allowing applicants to receive subsidies without proper verification. Covered California’s experience demonstrates that modern, automated, and risk-based verification processes can enhance accuracy and efficiency while reducing fraud risks and minimizing consumer burden.</p> <p>Covered California has implemented several measures to ensure the accuracy and timeliness of income verification while balancing program integrity with the consumer experience. CMS could adopt similar practices to address the gaps identified in the FFM:</p> <ul style="list-style-type: none"> • Integration of intelligent document processing (IDP): Covered California uses a technology-driven solution to validate income documentation submitted by consumers. This approach includes: <ul style="list-style-type: none"> ○ Automated document processing: IDP supports verification for over 25 document types, such as pay stubs, tax returns, and benefit letters. ○ Fraud detection: The system uses machine learning to identify inconsistencies, flagging suspicious or fraudulent documents for further review. ○ Efficiency improvements: Automation accelerates eligibility determinations, reducing delays during peak enrollment periods while maintaining accuracy. • Risk-based verification models: Covered California employs a tiered approach to verification that prioritizes higher-risk cases for enhanced review while processing lower-risk cases efficiently. This methodology reduces unnecessary barriers for consumers while ensuring that potential fraud risks are addressed. • Seamless integration of identity verification and income validation: Covered California leverages its AI-driven remote identity proofing solution to ensure that income verification aligns with accurate consumer identity data. By validating identity and income information simultaneously, Covered California strengthens program integrity and minimizes the risk of fraudulent enrollments. • Improved consumer experience: Covered California’s income verification processes are designed to reduce friction and support enrollment completion. For example, transitioning from credit-based identity verification to AI-driven remote identity proofing significantly reduced application abandonment rates—previously as high as 34 percent—while maintaining robust fraud detection capabilities. This principle of balancing fraud prevention with consumer access can similarly improve the accuracy and timeliness of income verification.

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	<p>Covered California’s experience demonstrates that modern technology, risk-based methodologies, and a focus on consumer experience can simultaneously improve accuracy, timeliness, and fraud prevention in income verification processes. By adopting similar measures, CMS can address the vulnerabilities identified in the FFM and enhance its income verification standards while reducing barriers for consumers.</p>
<p>8. What successful anti-fraud measures already implemented in SBEs should be adopted in the FFE and vice versa?</p>	<p>Covered California appreciates the recognition that SBMs can be looked to as a source of best practice for anti-fraud measures. Covered California’s experience as the nation’s largest SBM demonstrates that effective anti-fraud measures can prevent systemic issues while preserving a seamless and accessible consumer experience.</p> <p>Anti-fraud measures from SBMs that could be adopted in the FFM</p> <p>Covered California has implemented a comprehensive framework to address fraud risks, combining front-end controls, continuous monitoring, and collaborative enforcement. Successful measures include:</p> <ul style="list-style-type: none"> • Consumer-consent-based access controls: Covered California requires enrollment partners to obtain formal delegation before accessing or modifying a consumer’s case. Delegation pathways involve secure, consumer-involved processes, such as portal-based authorization, authenticated service center requests, three-way calls, or one-time passcode verification. These controls ensure that all enrollment actions reflect consumer intent and prevent unauthorized access. • Active duplicate enrollment monitoring and resolution: Covered California proactively identifies overlapping coverage and addresses duplicate enrollment issues through a structured framework: <ul style="list-style-type: none"> ○ Multiple Advanced Premium Tax Credit (APTC) cases: Consumers are notified and given 30 days to act; non-responsive cases are corrected to retain only one active subsidized enrollment. ○ APTC + Medi-Cal overlap: Cases are flagged through coordination with Medi-Cal partners, and tax credit eligibility is removed once Medi-Cal eligibility is confirmed. ○ Non-APTC duplicates: Consumers are notified of overlapping plans but corrective action is only taken if requested. <p>These measures ensure program eligibility accuracy while protecting financial assistance integrity.</p> <ul style="list-style-type: none"> • Advanced identity verification: Covered California has deployed an AI-driven remote identity proofing solution that strengthens fraud prevention while improving consumer experience. The system detects nearly 100% of fraudulent identity attempts and achieves a 95–98% success rate for identity verification. By reducing reliance on

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	<p>burdensome credit-based verification, Covered California has simultaneously enhanced fraud detection and enrollment completion rates.</p> <ul style="list-style-type: none"> • Integrated fraud management program: Covered California operates a dedicated fraud team that serves as the centralized hub for all fraud-related issues. The team actively monitors complaint trends, investigates suspicious activity, and collaborates with internal and external stakeholders to ensure program integrity. Key features include: <ul style="list-style-type: none"> ○ Cross-functional coordination: Collaboration with Outreach and Sales, the Service Center, and the Office of Legal Affairs ensures swift resolution of issues. ○ External partnerships: Covered California engages with regulatory authorities, such as the California Department of Insurance and Department of Health Care Services, to address escalated cases. ○ Enterprise-wide fraud awareness: Mandatory fraud training for Covered California staff equips team members to identify, prevent, and report suspicious activity, reinforcing a culture of fraud prevention. • Ongoing monitoring and continuous improvement: Covered California analyzes consumer complaint data, enrollment patterns, and agent activity trends to identify emerging risks and improve processes. Fraud summits with internal and external stakeholders provide opportunities to share best practices and enhance oversight across the program. <p>The success of SBMs like Covered California demonstrates that program integrity and consumer access can be advanced simultaneously when fraud prevention measures are carefully designed and implemented.</p>
<p>9. How could CMS enhance HealthCare.gov to prevent fraud at the point of enrollment and reduce reliance on post-payment recovery (“pay-and-chase”), and how could</p>	<p>Covered California’s experience demonstrates that fraud prevention is most effective when implemented at the point of enrollment, rather than relying on post-payment recovery mechanisms. By prioritizing front-end controls, such as secure identity verification, consumer authorization processes, and continuous monitoring, Covered California has successfully minimized fraud risks while maintaining a seamless enrollment experience. These approaches ensure program integrity and reduce the administrative burden associated with retrospective corrections.</p> <ul style="list-style-type: none"> • AI-driven remote identity proofing: Covered California’s AI-powered identity verification system ensures that applicants are who they claim to be, preventing fraudulent enrollments before coverage is effectuated. This modern solution replaced a credit-based identity proofing system that previously caused high abandonment rates, making it both more secure and consumer-friendly. Key features include: <ul style="list-style-type: none"> ○ Passive verification: Approximately 85% of consumers are verified passively using primary contact data and cross-industry intelligence, eliminating additional steps for most enrollees.

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<p>CMS most effectively encourage SBEs to adopt best practices for such fraud prevention within their legal and other authority?</p>	<ul style="list-style-type: none"> ○ Document and biometric verification: Higher-risk cases (~15%) are routed to a secure workflow requiring a selfie and upload of identity documents, ensuring accurate validation of identity. ○ Fraud detection success: Nearly 100% of fraudulent identity attempts are detected, while 95–98% of applicants successfully complete verification, reducing fraud without adding barriers for legitimate consumers. ● Consumer-consent-based access controls: Covered California requires enrollment partners to obtain formal delegation before accessing or modifying a consumer’s case. Delegation involves secure, consumer-involved processes, such as portal-based authorization, authenticated service center requests, three-way calls, or one-time passcode verification. These controls ensure that enrollment actions reflect consumer intent and prevent unauthorized access. ● Proactive monitoring of enrollment activity: Covered California continuously monitors enrollment patterns and complaint data to detect anomalies, such as unauthorized plan changes or duplicate enrollments. This monitoring allows for early identification of suspicious activity, reducing the need for post-enrollment corrections. ● Structured resolution of duplicate enrollments: Duplicate coverage involving financial assistance represents less than 1 percent of Covered California’s enrollment, reflecting the effectiveness of its proactive monitoring framework. Covered California categorizes duplicate enrollment cases into distinct scenarios, ensuring tailored corrective actions: <ul style="list-style-type: none"> ○ More than one case with APTC: Consumers are notified and given 30 days to act, after which duplicate financial assistance is removed if unresolved. ○ APTC + Medi-Cal overlap: Cases are flagged through coordination with Medi-Cal partners, and APTC eligibility is removed once Medi-Cal eligibility is confirmed. ○ Non-APTC duplicates: Consumers are notified of overlapping plans, but corrective action is only taken if requested. ● Technology-driven fraud detection: Covered California uses machine learning and automation to validate eligibility documentation, flag enrollment anomalies, and analyze complaint trends. These tools improve accuracy while minimizing administrative burden. <p>Covered California’s experience demonstrates that fraud prevention is most effective when front-end controls are prioritized. CMS could benefit from adopting tools and frameworks proven to prevent fraud before coverage is effectuated, including AI-driven identity verification, consumer consent processes, and automated monitoring systems.</p>

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	<p>These measures help reduce reliance on post-payment recovery while ensuring program integrity and preserving a seamless consumer experience.</p>
<p>10. How could CMS expand its regulatory authority to enhance oversight of enhanced direct enrollment (EDE) partners?</p> <p>11. How could CMS expand its authority to monitor the activity of agents/brokers on EDE platforms?</p>	<p>Covered California does not utilize EDE platforms as part of its operational model and suggests CMS carefully weigh the benefits of EDE platforms against additional program integrity vulnerabilities associated with allowing third parties this level of system access. Instead, Covered California relies on in-person, brick-and-mortar agents and brokers, which limits exposure to some of the risks associated with large-scale web-based broker platforms and automated EDE systems. However, Covered California’s oversight framework for agents and brokers offers valuable insights into best practices for monitoring enrollment activity and ensuring accountability, which CMS could adapt to strengthen oversight of EDE partners and agent/broker activity on these platforms.</p> <p>Oversight best practices from Covered California</p> <ul style="list-style-type: none"> • Secure consumer authorization: Covered California requires enrollment partners, including agents and brokers, to obtain formal delegation before accessing or modifying a consumer’s case. Delegation involves secure, consumer-involved processes such as portal-based authorization, authenticated service center requests, three-way calls, or one-time passcode verification. These controls prevent unauthorized access and ensure that enrollment actions reflect consumer intent. Applying similar consumer authorization requirements to EDE platforms would help mitigate risks associated with unauthorized enrollment actions. • Attribution and traceability of enrollment actions: Covered California tracks enrollment actions to specific agents or entities, ensuring clear attribution and accountability for enrollment activity. This level of traceability is critical for investigating complaints, addressing misconduct, and preventing fraudulent actions. CMS could require EDE platforms to implement systems that enable auditable attribution of enrollment actions to individual agents or brokers. • Continuous monitoring of enrollment activity and complaint trends: Covered California continuously monitors enrollment patterns and complaint data to detect anomalies, such as unauthorized plan changes, repeated actions by multiple agents on the same application, or misleading marketing practices. This monitoring allows for early detection of systemic issues and provides a basis for corrective action. Enhanced monitoring of EDE platforms could help CMS identify agent or broker misconduct and address patterns of unauthorized activity. • Enforceable agreements and compliance standards: Covered California requires enrollment partners to adhere to an Agent Agreement and Code of Conduct, which establish clear compliance standards and prohibit unauthorized or misleading actions. Violations trigger graduated enforcement actions, ranging from coaching and warning notices

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	<p>to suspension, termination, and referral to external regulatory authorities. CMS could expand its regulatory authority to require EDE platforms to operate under similar enforceable agreements and compliance frameworks.</p> <ul style="list-style-type: none"> Graduated enforcement framework: Covered California employs a proportional enforcement model to address misconduct effectively. Enforcement actions include coaching, warning notices, suspension, termination, and referral to external regulatory authorities. This approach allows for scalable resolution of issues based on severity, ensuring prompt corrective action while maintaining program integrity. CMS could apply a similar graduated enforcement framework for EDE platforms and agent/broker activity. <p>While Covered California does not utilize EDE platforms, its oversight framework for enrollment partners provides valuable insights into scalable, effective fraud prevention measures. By expanding its regulatory authority to include secure consumer authorization, traceable enrollment actions, monitoring systems, enforceable compliance standards, and proportional enforcement mechanisms, CMS can enhance oversight of EDE partners and agent/broker activity on these platforms to strengthen program integrity and prevent fraud, waste, and abuse.</p>
<p>12. How could CMS better detect and mitigate improper dual enrollment in Medicaid/CHIP and subsidized Exchange plans?</p>	<p>Dual enrollment involving financial assistance represents less than 1 percent of Covered California enrollment, and Covered California’s experience indicates that many such cases result from consumer confusion rather than intentional misuse. Covered California addresses these situations through targeted resolution processes rather than punitive enforcement, while maintaining program integrity and protecting consumers from unintended consequences.</p> <p>Covered California actively monitors enrollment data and coordinates with the California Department of Health Care Services (DHCS) to flag and resolve cases where consumers may be enrolled in both Medicaid (Medi-Cal in California) and subsidized Marketplace coverage. These measures include:</p> <ul style="list-style-type: none"> Coordination with Medicaid partners: Covered California maintains a close partnership with DHCS, sharing enrollment data and collaborating to identify overlapping coverage. This coordinated approach ensures that dual enrollment cases are flagged early and resolved efficiently. When Medi-Cal eligibility is confirmed, Covered California removes APTC eligibility from the consumer’s Marketplace plan, preventing improper financial assistance while maintaining coverage continuity. Proactive monitoring and resolution framework: Covered California categorizes dual enrollment cases into three distinct scenarios, each with tailored corrective actions: <ul style="list-style-type: none"> More than one case with APTC: Covered California identifies overlapping cases where consumers are enrolled in multiple plans with financial assistance. Consumers are notified and given 30 days to act, either by

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	<p>confirming the correct case or ending the duplicate coverage. If no action is taken, Covered California removes the duplicate plan, ensuring only one subsidized enrollment remains active.</p> <ul style="list-style-type: none"> ○ APTC + Medi-Cal overlap: Dual enrollments in both Medi-Cal and Covered California are flagged through coordination with DHCS. Consumers are notified and given an opportunity to clarify their eligibility. Once Medi-Cal eligibility is confirmed, tax credit eligibility is removed from the Marketplace case. This prevents improper financial assistance while ensuring alignment with eligibility requirements. ○ More than one case but only one with financial assistance: These cases involve consumers enrolled in multiple plans, but only one plan includes financial assistance. Because these scenarios do not represent improper use of federal funds, corrective action is not required. Covered California sends annual notices to inform consumers of overlapping plans and provides them the option to end one of the plans if desired. <p>Covered California’s monitoring process ensures program integrity while protecting consumers from unintended consequences. By focusing on clear resolution pathways and avoiding punitive enforcement, Covered California addresses dual enrollment issues effectively while minimizing consumer burden. This collaborative and consumer-centered approach has helped reduce dual enrollment to less than 1 percent of overall enrollment, providing CMS with a proven model for improving oversight of dual enrollment in the FFM.</p>
<p>13. How could CMS leverage advanced technologies, such as AI, to prevent, detect, and address fraud, waste, and abuse in both the FFE and SBEs?</p>	<p>Covered California’s experience demonstrates the power of advanced technologies, such as AI, machine learning, and automation, to significantly strengthen program integrity while improving the consumer experience. These tools have enabled Covered California to reduce fraud risks and enhance oversight across critical program areas while improving consumer experience and mitigating barriers to enrollment. The following highlights Covered California’s use of these technologies:</p> <ul style="list-style-type: none"> ● AI-driven remote identity proofing: Covered California transitioned to an AI-powered identity verification solution that validates applicants’ identities while detecting fraudulent activity. This modern approach replaced a credit-based identity verification system, which previously caused high application abandonment rates (approximately 34%). Key features include: <ul style="list-style-type: none"> ○ Passive verification: Roughly 85% of applicants are verified passively using primary contact data and cross-industry intelligence, without requiring additional steps from the consumer. ○ Document and biometric verification: Higher-risk cases (~15%) require consumers to upload a selfie and identity documents (e.g., driver’s license, passport) for validation. The system uses AI to confirm document authenticity and match biometrics against official records.

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	<ul style="list-style-type: none"> ○ Fraud detection and success rate: This solution detects nearly 100% of fraudulent identity attempts and achieves a 95–98% success rate for identity verification overall. It simultaneously reduces fraud risks while improving enrollment completion rates. ● IDP: Covered California uses machine learning and automation to validate eligibility documentation submitted by consumers. This system supports over 25 document types, including pay stubs, tax returns, and benefit letters. By automating document processing, Covered California has improved the speed and accuracy of eligibility determinations, particularly during peak enrollment periods. IDP also reduces exposure to identity- and document-based fraud by detecting inconsistencies and flagging suspicious submissions for manual review. ● Multifactor authentication (MFA): Covered California implemented MFA to strengthen consumer account security. MFA requires consumers to verify their identity using “something they know” (e.g., username/password) and “something they have” (e.g., a registered phone number or email address). This system reduces the risk of unauthorized account access and aligns with federal security expectations. ● Automated duplicate enrollment detection: Covered California leverages automation to flag overlapping enrollments across programs, such as duplicate cases involving APTCs and Medi-Cal. This technology enables cross-program enrollment checks and routes flagged cases for manual review or corrective action, ensuring program integrity and preventing improper financial assistance. ● Trend analysis and fraud monitoring: Covered California uses AI and machine learning to analyze consumer complaint data, enrollment trends, and agent activity patterns. This proactive monitoring helps identify emerging risks, such as fraudulent agent activity or enrollment anomalies, and informs continuous process improvement. Fraud summits with internal and external stakeholders provide opportunities to share best practices and strengthen oversight. <p>Covered California’s experience demonstrates that advanced technologies can simultaneously improve fraud prevention and streamline operations, benefiting both program integrity and the consumer experience. By leveraging scalable solutions, CMS can modernize its fraud detection efforts while reducing unnecessary barriers for eligible enrollees.</p>