Part II - Navigator, Producer, Non-Navigator Assistance Personnel and Issuer Fraud

The Health Insurance and Managed Care (B) Committee has developed the following two white papers on the roles of Navigators and Producers and Marketing issues:

- **The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?** (June 22, 2011)
- **Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage** (June 27, 2012)

Since the adoption of these white papers, the U.S. Department of Health and Human Services (HHS) has issued additional guidance, and the states have taken additional steps surrounding the certification and oversight of navigators, producers and non-navigator assistance personnel. In addition, the states are considering how to protect consumers from fraudulent and/or misleading practices and to help ensure consumers receive accurate information.

With this, there is a need to build upon the prior work of the Committee through the respective subject matter experts discussing the following topics: 1) certification and training standards for navigators, non-navigator assistance personnel, Certified Application Counselors and Producers; 2) potential fraud issues related to the activities of navigators, producers non-navigator assistance personnel, and persons who do not fit into any of these categories; and 3) the functions of navigators and non-navigator assistance personnel and how these functions vary from the functions of licensed producers.

The white paper is not intended to be used as a “best practices” guide, but, rather, as a paper that outlines issues and options states should evaluate for their respective marketplace.

I. Overview of Issues

A. Introduction

While the rollout of the Affordable Care Act (ACA) presents all Americans the ability to purchase health insurance, it is important to recognize that the implementation of a health care system unlike anything the nation has ever seen further presents an opportunity for fraud.

In order to take a proactive approach to the investigation of fraud schemes associated with ACA enrollment in private coverage, state fraud directors analyzed the ACA as well as the role specific individuals and entities will play in the implementation of America’s new health insurance delivery system. They identified three specific areas at risk of fraud. While it is anticipated that a significant number of the fraud schemes identified and highlighted below will primarily be committed by professional con artists and thieves looking to capitalize on the confusion surrounding the rollout of the ACA, state and federal agencies need to be open to the fact that navigators, non-navigator assistance personnel, certified application counselors, “Champions of Coverage,” producers and insurers may too engage in such activities.
While state enforcement laws are not preempted so long as state law does not prevent the “application of the ACA”, there is variation from state to state in the ability of state departments of insurance to take action against navigators, non-navigator assistance personnel, certified application counselors, in-person assisters and “Champions of Coverage”. State fraud directors analyzed the enforcement authority of a number of state and federal agencies so as to facilitate the prompt exchange of fraud-related information and the coordination of investigations.

B. Areas Of Fraud Identified

In analyzing specific portions of the ACA, and the role various categories of licensees and unlicensed individuals and entities will have in the health marketplace, state fraud directors identified three specific categories of fraud: 1) Predatory Marketing / Sales Practices; 2) Enrollment Fraud and 3) Identity Theft.

1) Predatory Marketing & Sales Practices

Based upon trends identified from 2005 – 2009 with the rollout of Medicare prescription drug and Medicare Advantage plans, the predominant category of complaints state departments of insurance anticipate receiving are those related to predatory marketing and sales practices. Predatory marketing and sales schemes anticipated or already identified to date include:

- The creation of misleading websites specifically designed to lure consumers into believing they are visiting an official state or federal exchange. (“Marketplace”).
- The deceptive use of ACA buzzwords, such as navigator and “exchange.”
- Individuals and entities misrepresenting themselves as “Navigators,” “Certified Application Counselors,” “In-Person Assisters,” or producers, when they have never been approved to act in any such capacity.
- The use of fictitious titles or designations in order to gain the trust of consumers.
- Deceptive and/or misleading correspondence to consumers.
- Individuals and entities posing as a government official or organization (e.g. Medicare, Medicaid, Health & Human Services, a state exchange.) to solicit personal and financial information from consumers and/or insurance business.
- The use of high pressure sales tactics to persuade or scare consumers into purchasing insurance.
- The selling of insurance policies by saying that premiums next year will go up considerably to persuade small businesses or individuals to renew an existing policy without actual comparative cost information. This is mostly a problem during the transition year as insurers can still sell non-compliant policies.
- The charging of an “application” or “consultation” fee to assist consumers with the selection of a health plan.
- Selling other insurance products or goods under the guise that they are mandated by law.
- Misrepresenting the price, terms or classification of a policy / product, or an individual’s ability to sell exchange products, in order to secure a sale.
• The “churning” of products whereby a consumer is encouraged to change from one plan to another when it may not be in the consumer’s best interest.

• Utilizing a consumer’s personal information or forging their signature in order to submit an application for insurance without their knowledge or consent.

2) **Enrollment Fraud**

The second category of ACA fraud state regulators identified is enrollment fraud.

While it is expected that most insurers and authorized consumer assistance personnel and entities will perform their duties responsibly and abide by the law, it is likely that state fraud bureaus will nevertheless receive allegations that an insurer, producer, navigator, certified application counselor, in-person assister or “Champion of Coverage”:

• Encouraged consumers and/or business entities to misrepresent specific information (e.g. address, income, dependents, citizenship, and number of employees) on a subsidy application or application for insurance in order to qualify for government assistance and/or lower insurance premiums.

• Recommended a policy or product to a consumer without having the proper authority, license to do so.

• Intentionally steered business to a specific producer or insurer for personal gain, without regard to the best interests of the consumer.

• Established a business relationship that resulted in a conflict of interest, a kickback or the payment of unlawful compensation.

• Selling other insurance products or goods under the false guise they are mandated by law.

• Selling insurance products or goods such as short-term limited duration or fixed-indemnity products, without fully informing consumers that these products do not meet Affordable Care Act insurance requirements and that consumers who buy these products only will have to pay the individual responsibility penalty.

• Marketed a particular policy or product to a consumer in the individual or small group market without informing the consumer that additional policies or products may be available through the marketplace.

• Failed to encourage an eligibility determination for consumers who appear eligible for lower cost coverage via premium tax credits or Medicaid.

3) **Identity Theft**

As part of the education and enrollment process, consumers will be required to provide a significant amount of personal, medical and financial information to producers, insurers, navigators, certified application counselors and in-person assisters. The predominant concern this raises for state regulators is the risk of identity theft, meaning the fraudulent appropriation and use of someone’s personal information.
Some of the ways that a consumer’s personal, financial or medical information could be misused for financial gain include:

- Enrolling the consumer into a health plan or other insurance product he or she did not select.
- Making unauthorized withdrawals or purchases using the consumer’s bank account or credit card.
- Filing fictitious tax returns to recoup tax credits owed to the consumer.
- Compiling lists to sell to lead generation firms or on the black market.
- Assuming the consumer’s identity in order to seek medical treatment, make purchases, or enter into other transactions (e.g. credit cards, loans) for personal gain.

State regulators are particularly concerned about identity theft because it is a crime that often takes weeks, months and even years to detect. Victims of identity theft face financial problems, credit issues, the loss of benefits, and even civil or criminal prosecution for actions committed in their name by someone else. Remedying the damage caused by an identity theft incident could cost a consumer a significant amount of time and money.

II. Enforcement Authority

The regulation of insurance is an administrative responsibility of the states. The Affordable Care Act has added new actors who will play a role in the health insurance marketplace as navigators and non-navigator assistance personnel. Each state will handle them differently as state laws vary. Despite the differences in control and the level of coordination with the federal government of exchanges from state to state, collaboration is crucial to achieve an appropriate regulatory response to regulate navigators, producers, non-navigator assistance personnel and insurers.

A. HHS Authority

The Department of Health and Human Services is the United States government’s principal agency for protecting the health of all Americans and providing essential human services. HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. CMS a division of HHS regulates navigators and CACs through its certification process. CMS also works with the states that will regulate those navigators, producers, non-navigator-assistance personnel, and insurers. The ACA recognizes that licensing and regulating insurers and producers is a state responsibility, and expressly assigns the states primary authority to enforce insurers’ compliance with the ACA within their borders. The procedures and requirements, imposed by CMS on participants in the state exchanges discussed in Part I, will largely be left to the states to enforce with CMS assisting as needed and then responding appropriately to actions taken by the state.

B. Examples of State Authority

The regulation of insurance fraud through administrative actions is vital to state enforcement authority. Many states have dedicated fraud units to investigate insurance fraud. Both administrative and criminal investigations focus on determining whether an insurance agent, agency or unlicensed individual/entity violated a state insurance law. Many fraud units are housed within their states DOI’s while others are housed within the AG’s office. All fraud units have administrative power conduct investigations and initiate regulatory actions to by issuing cease and desist orders, summary suspension, revocations, and fines. However, not all state insurance fraud bureaus have law enforcement authority, meaning their personnel are
not sworn peace officers. Especially in these states, DOI’s must work with local, state and federal law enforcement and prosecutors to investigate and prosecute insurance fraud.

C. Authority of other Federal Agencies.

Other federal agencies also play a major role in identifying and prosecuting fraud under the Affordable Care Act. These include the Federal Trade Commission, which has general authority to deal with consumer fraud, and the Department of Justice, which can investigate fraud through the Federal Bureau of Investigation and prosecute fraud under mail fraud, wire fraud, conspiracy, and other federal criminal laws.

III. Coordination of Investigations

A. Coordination Between State Insurance Departments

As discussed, most state departments of insurance have established fraud bureaus to investigate potential violations of state insurance laws and allegations of insurance fraud. In addition to investigating complaints received directly from consumers, state fraud bureaus often receive allegations of suspected fraud from insurance companies, law enforcement agencies and other government entities. As part of the investigation process, it is common for state fraud bureaus to work with local, state and federal law enforcement and prosecutorial agencies to bring charges against those who commit fraud.

As the sharing of information and the coordination of investigations is crucial to providing consumer protection, state fraud directors, through the National Association of Insurance Commissioners (NAIC) Anti-Fraud Task Force, communicate regularly with one another to discuss fraud schemes that have been observed. As the NAIC holds three national meetings per year, regulator only meetings provide an excellent forum for discussing and coordinating major insurance fraud issues and investigations.

In addition to communicating with state counterparts, the Anti-Fraud Task Force and its members have fostered working relationships with other state and federal regulatory and law enforcement agencies as well as a number of antifraud organizations. A few such organizations include the Department of Justice, FinCEN, HHS, (in particular, CMS and CCIIO), the Coalition Against Insurance Fraud, the National Healthcare Anti-Fraud Association, the National Insurance Crime Bureau and the National Fraud Prevention Partnership.

B. Coordination Between State Insurance Departments and the U.S. Center for Consumer Information and Insurance Oversight (CCIIO)

As the oversight of the new healthcare framework will involve compliance with both state and federal laws, ongoing communication and coordination with the Center for Consumer Information and Insurance Oversight (CCIIO), a division of the Department of Health & Human Services, will be key in the fight against ACA fraud.

In order to facilitate consumer protection, the Consumer Protection Division of the US Department of Justice and the Federal Trade Commission (FTC), as part of the implementation process for health insurance exchanges, has taken steps to open up the lines of communication between state insurance regulators and State Attorneys General by hosting weekly calls in which fraud issues can be discussed and coordinated.
In September of 2013, a meeting involving the US Attorney General, White House Staff, the Secretary of Health and Human Services (HHS), members of the Federal Trade Commission (FTC) and NAIC representatives was held so a comprehensive interagency initiative, using the legal infrastructure that currently exists, could be developed to prevent and protect consumers from fraud and privacy violations during the implementation of the Health Insurance Marketplace. The FTC additionally hosted a roundtable discussion consisting of experts on the health care law, federal and state consumer protection officials, consumer advocates, representatives of legal services and community organizations. The focus of the discussion centered on key features of the law, state approaches to implementation, and how agencies could assist consumers in avoiding potential scams.

The Department of Justice also followed suit by hosting a law enforcement meeting with state and local officials with the purpose of urging State Attorneys General to work with HHS and federal, state, and local law enforcement in educating consumers about fraud in the marketplace and the importance of protecting their personal information.

Because state and federal authorities having joint regulatory authority over the fraud issues that have been identified, ongoing communication between state fraud bureaus and CCIIO will be a must.

C.  Coordination Between State Insurance Departments and State Attorneys General

As Attorneys General are the chief legal officers of the states, commonwealths and territories of the United States, state fraud bureaus recognize that partnering with State Attorneys General will assist tremendously in providing added consumer protection during the rollout of the ACA. As Attorneys General represent the public interest and are called to protect consumers who would be susceptible to fraud schemes similar to those outlined in Part I, Attorneys General may be able to institute civil suits for deceptive advertising, unlawful consumer sales practices, unfair trade practices and fraud. As Attorneys General are able to share enforcement authority with federal agencies, a relationship with their organization, the NAAG, could serve as a vital link between local and federal partners.

States without a state prosecutor are encouraged to strengthen their partnership with local district attorneys and if available, their state district attorney associations.