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Submitted via Regulations.gov

November 23, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: **RIN 0938-AW03; CMS-9873-P**
Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification

Dear Administrator Oz:

For over 57 years, the National Health Law Program (NHeLP) has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations. We appreciate the opportunity to comment on the Department of Health and Human Services' notice of proposed rulemaking, *Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification* (Proposed Rule).[1]

The Proposed Rule would implement § 71303 of the so-called "One Big Beautiful Bill Act" (OBBBA), a far-reaching provision that mandates new pre-verification requirements that will upend longstanding enrollment processes on the Affordable Care (ACA) Marketplaces and jeopardize access to affordable health coverage for millions of low- and middle-income people. Unfortunately, the Proposed Rule fails to provide an implementation framework that will protect consumers from avoidable coverage losses.[2]

We object to the 30-day comment period, which is insufficient for a highly technical proposed rule with such far-reaching and potentially harmful effects. The comment period also coincides

[1] Dept. of Health and Human Svcs., *Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification*, 91 Fed. Reg. 67656 (Oct. 27, 2026), hereinafter "Proposed Rule".
[2] Pub. L. No. 119-21 (2025).

with the first month of the annual Open Enrollment Period, during which interested parties – including State Based Marketplaces, Navigators, agents and brokers, and consumers – have limited capacity to review and provide public comments. The Department should provide at least a 60-day comment period for the Proposed Rule.

The Proposed Rule Would Create an Inequitable, Two-Tiered Enrollment System

Under the Proposed Rule, households with incomes between 100-400% of the Federal Poverty Level (FPL) would be subject to a raft of new administrative requirements to maintain access to affordable coverage, while wealthier households could continue to leverage longstanding mechanisms such as automatic re-enrollment and provisional eligibility during a data matching issue (DMI) inconsistency period. The Department estimates that if the Proposed Rule were finalized, 5.4 million individuals would ultimately be unable to complete verification and would forgo coverage for all or part of a plan year due to the high cost of unsubsidized coverage.[3]

This inequitable approach is deeply problematic given documented challenges with the rising cost of health care in the United States, particularly for people with Marketplace coverage.[4] Further, given that the most common DMIs are related to income, citizenship, and immigration, the burdens associated with delayed or denied APTCs and CSRs will fall disproportionately on people with lower incomes, who are more likely to generate a DMI because of a relatively small income fluctuation; and people who have more complex documentation related to citizenship or lawful presence.[5] The negative impacts of pre-verification requirements would therefore be borne by the most vulnerable consumers in ways that will deepen existing health disparities.[6]

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[3] Proposed Rule at 67708. We note that the Department's estimate of full-year coverage losses (332,500, or roughly 1.7% of February 2026 effectuated enrollments) is improbably low given that independent analysis of the effects of § 71303 of OBBBA estimate coverage losses ranging from 8-33% across Federal and State Marketplaces, or between 1.5 and 6.3 million people. *See* CMS, Health Insurance Exchanges Monthly Effectuated Enrollment (Accessed Nov. 23, 2026), https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/health-insurance-marketplace/health-insurance-exchanges-monthly-effectuated-enrollment; *see also,* Michele Anderson, et al., Wakely, *Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market* (June 23, 2025), https://www.wakely.com/wp-content/uploads/2025/06/Reconcilliation-Bill-Impacts_6_23_25_FINAL.pdf.

[4] KFF, *Americans' Challenges With the Cost of Health Care* (Oct. 23, 2026), https://www.kff.org/health-costs/americans-challenges-with-health-care-costs (finding that 26% of Americans are "very worried" about affording health care costs; four in ten U.S. adults carry some form of medical debt; and a disproportionate number of Marketplace enrollees rating premium and out-of-pocket costs as "fair" or "poor" compared to adults with other forms of insurance).

[5] CMS, Resolving Data Matching Issues at 2, https://www.cms.gov/files/document/resolving-dmis-job-aid.pdf; Lauren Bauer, et al., *Low-income workers experience — by far — the most earnings and work hours instability* (Jan. 9, 2025), https://www.hamiltonproject.org/publication/post/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability; Judith Solomon, Ctr. on Budget and Pol'y Priorities, *Limiting Data Matching Issues Could Help Stabilize Federal Marketplace Coverage* (Feb. 16, 2016), https://www.cbpp.org/limiting-data-matching-issues-could-help-stabilize-federal-marketplace-coverage;

[6] Herd, et al., *Administrative Burden as a Mechanism of Inequality in Policy Implementation* (Sept. 2023), https://www.rsfjournal.org/content/9/4/1.full; Latoya Hill, et al., KFF, *Health Coverage by Race and Ethnicity, 2010-2024*, https://www.kff.org/racial-equity-and-health-policy/health-coverage-by-race-and-ethnicity.

To that end, we recommend the Department withdraw the current Proposed Rule and incorporate the following consumer protections into a revised Proposed Rule:

1. Delay the Implementation Date of the Pre-Enrollment Verification Requirements

Even with a shortened, 30-day public comment period, the Proposed Rule is unlikely to be finalized until early 2027. This timeline would provide Marketplaces with mere months to design, test, and operationalize systems changes necessary to implement a first-ever pre-OEP by the proposed implementation date of August 1, 2027. Marketplaces will not have adequate time to develop and implement a communications strategy that ensures that all consumers — including those with disabilities, limited English proficiency, or low health insurance literacy — are aware of the fundamental shift in enrollment requirements for the 2028 plan year.

Rather than proposing a more reasonable timeframe, the Department repeatedly prioritizes an unrealistic start date over clear communications, streamlined enrollment processes, and consumer protections.[7] Forcing Marketplaces to rush systems development and communications will result in technical errors, consumer confusion, and unnecessary and costly coverage losses. Not only are confusing or burdensome administrative processes shown to deter eligible individuals from accessing benefits to which they are entitled, coverage losses driven by pre-enrollment verification requirements could worsen the risk pool overall, increasing costs for those who remain covered.[8]

Therefore, we urge the Department to delay the effective date of the pre-enrollment verification requirements, holding consumers entirely harmless, until plan year 2029 at the earliest. There is extensive precedent for enforcement discretion of this kind, ranging from early implementation of certain ACA requirements to the Department's recent announcement of a six-month hold harmless period for states implementing OBBBA's Medicaid work requirements.[9]

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[7] For example, the Department indicates that it considered establishing a separate notice requirement for the pre-OEP, but ultimately proposes to allow Marketplaces to issue a single, combined notice for both pre-OEP and the annual OEP, up to six months prior to the next plan year. *See* Proposed Rule at 67688-67689. Similarly, the Department "considered proposing … a requirement for Exchanges to provide a streamlined electronic re-enrollment form for existing enrollees," but opted against it, "given the short timeframe for implementation." *See* Proposed Rule at 67711.

[8] *See, e.g.*, Adrianna McIntyre, et al., *Policy Brief: Automatic Health Insurance Policies and Coverage Outcomes: Evidence from Massachusetts and Implications for ACA Reforms* (Feb. 2022), https://www.hks.harvard.edu/sites/default/files/Automatic%20Health%20Insurance%20Policies%20Publication_02-03-2022.pdf; Yue Li and Mansai Deschpande, *Who Is Screened Out? Application Costs and the Targeting of Disability Programs*, Amer. Econ. J., Vol. 11, No. 4 (Nov. 2019), https://www.aeaweb.org/articles?id=10.1257/pol.20180076. https://scholarsarchive.library.albany.edu/economics_fac_scholar/1.

[9] *See, e.g.,* U.S. Treasury, Notice 2013-45, *Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)*, https://www.irs.gov/pub/irs-drop/n-13-45.PDF (delaying enforcement of the employer responsibility provision of the ACA); Ctrs. for Medicare & Medicaid Svcs., SMD# 26-006, *RE: Optional Hold Harmless Period for Community Engagement Implementation,* Nov. 13, 2026, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd26006.pdf.

2. Give Consumers Choices During DMI Inconsistency Periods

Under the Proposed Rule, consumers who are unable to resolve a DMI prior to the scheduled enrollment start date would be required to choose whether to enroll in coverage at full cost or "pend" enrollment until the DMI is resolved. Pended coverage protects the consumer's ability to enroll in the plan when DMIs are resolved, but provides no coverage during the inconsistency itself. For many households with incomes between 100-400% FPL, however, absorbing the full cost of coverage for an inconsistency period of unknown length is unaffordable and unrealistic.

The Department previously estimated that up to one-half of all successful income DMI resolutions required more than 90 days to resolve.[10] Given that the pre-verification requirements will require millions of additional consumers to engage with Marketplaces, generating nearly 2 million additional DMIs on the Federal Marketplace alone, the Department should anticipate that resolution times will only lengthen.[11] Moreover, the Department and other experts within and outside of government have raised concerns about the accuracy of "trusted" data sources that Marketplaces use to verify applicant and enrollee information.[12] Consumers should not be penalized for the failures of an overloaded system or flawed data sources.

First, State Based Marketplaces should have the flexibility to determine when it is appropriate to accept self-attestation to the greatest extent permitted under statute, including but not limited to residency. In response to the specific request for comments on residency verification requirements at 45 C.F.R. § 155.315(d), we urge the Department to maintain an approach that permits Marketplaces to accept an applicant's self-attestation of residency without additional verification.[13] The longstanding acceptance of self-attestation is particularly important for individuals who are more likely to experience frequent changes of residence, such as migrant workers, people who experience homelessness, and young adults.[14] However, the U.S. Census Bureau estimated that about 15% of the U.S. population experienced a change in living arrangements in 2017, suggesting a high level of

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[10] 90 Fed. Reg. 12942, 12963 (Mar. 19, 2025).
[11] Proposed Rule at 67699 (estimating that the Proposed Rule would result in 1,749,325 DMIs on the Federal Marketplace and noting that the Department is "unable to estimate the potential impacts on State Exchange consumers or State Exchanges.")
[12] *See* 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023) (acknowledging significant delays in tax return processing); Dep't of the Treasury, *The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002)*, https://www.oversight.gov/sites/default/files/documents/reports/2026-01/2026400002_Readiness%20Memo_Final.pdf (identifying risks to tax return processing related to IRS staffing reductions); Sarah Grusin, Nat'L Health L. Program, *CMS' Burdensome New Policy to Re-Verify Immigration Status Is The True Waste of Medicaid Funds* (Aug. 21, 2026), https://healthlaw.org/cms-burdensome-new-policy-to-re-verify-immigration-status-is-the-true-waste-of-medicaid-funds; *see also*, Jasleen Singh, Brennan Ctr. for Justice, *Homeland Security's "SAVE" Program Exacerbates Risks to Voters* (July 21, 2025), https://www.brennancenter.org/our-work/research-reports/ homeland-securitys-save-program-exacerbates-risks-voters.
[13] Proposed Rule at 67660-67661.
[14] Zachary Scherer, U.S. Census Bureau, *Young Adults Most Likely to Change Living Arrangements* (Aug. 31, 2020), https://www.census.gov/library/stories/2020/08/young-adults-most-likely-to-change-living-arrangements.html.

mobility across the population.[15] The Department admits that it has not identified a single, reliable source of residency data. The status quo therefore avoids triggering a deluge of residency DMIs, which under the Proposed Rule could place consumers' access to affordable coverage at significant risk.

Second, consumers in a DMI inconsistency period should be given a choice to either pend coverage or enroll with APTCs and CSRs based on their application information, provided they are clearly notified of any potential tax liability. Such an approach is entirely consistent with language at § 71303(a) that permits verification "using applicable enrollment information that shall be provided or verified by the applicant," and would allow individuals to access affordable coverage while they are working with the Marketplaces to resolve an outstanding DMI.

3. Establish a SEP for Individuals Who Lose Access to Automatic Re-Enrollment

In 2026, nearly 40% of all Marketplace enrollees were automatically re-enrolled in coverage; in 13 states, this rate exceeded half of all enrollees.[16] However, the Proposed Rule would effectively end automatic re-enrollment for individuals with incomes between 100-400% FPL. Given the historically widespread use of automatic re-enrollments, insufficient implementation timeline, and limited notice requirements proposed by the Department, it is likely that a significant number of otherwise-eligible Marketplace enrollees will fail to realize that they must complete pre-enrollment verification until it is too late to avoid losing APTCs and CSRs.

In order to prevent coverage loss stemming from entirely predictable administrative confusion, we recommend the Department require Marketplaces to provide a Special Enrollment Period (SEP) that would allow an eligible individual who was enrolled in a QHP in the prior coverage year to verify eligibility and enroll in coverage after the end of the annual OEP. While it remains necessary to delay implementation of the pre-verification requirements for at least one year, as explained above, a targeted SEP will provide additional consumer protections, particularly in early years of pre-enrollment verification implementation. To prevent adverse selection, we recommend this SEP be available once per 12-month period and limited to individuals residing in households that received APTCs and/or CSRs during the prior coverage year but lost subsidies due to a failure to complete pre-verification requirements.

4. Expand the Timeframe for the Medicaid/CHIP Denial SEP

The Department requests comment on whether to expand the timeframe of the Medicaid/CHIP denial SEP.[17] We agree that consumers who apply for Medicaid or CHIP coverage during the pre-OE period may not receive an eligibility determination prior to the end of the annual OEP. Longstanding Medicaid application processing issues are likely to

[15] *Id*.
[16] KFF, *Marketplace Plan Selections by Enrollment Type, Timeframe: Open Enrollment 2026*, https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-enrollment-type-2.
[17] Proposed Rule at 67695-67696.

be exacerbated by confusion over the distinction between pre-OE and the annual OEP, as well as anticipated operational delays related to distinct but equally burdensome OBBBA Medicaid changes, such as work requirements.[18] Therefore, we recommend that the Department amend 45 C.F.R. § 155.420(d)(11) to extend the Medicaid denial SEP to individuals who submit applications during pre-OE. Granting these consumers an SEP based on the date of their Medicaid denial date would enable them to gain access to timely, affordable Marketplace coverage.

5. Fully Fund the Navigator Program

Under the Proposed Rule, millions of consumers will be confronted with convoluted, high-stakes pre-enrollment verification requirements on a rushed timeline. There is little financial incentive for agents and brokers to support consumers with these requirements, which are distinct from commission-generating enrollment processes. In many communities, Navigators will provide the sole source of well-informed and unbiased pre-enrollment verification support. The Department must fully restore Navigator funding prior to the implementation of any Final Rule.[19]

Conclusion

Thank you for considering our comments. We have included citations to supporting research, including direct links. We direct the Department to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If the Department does not plan to consider these materials part of the record, we request you notify us and provide an opportunity to submit copies into the record.

Sincerely,



Geraldine M. Doetzer
Senior Attorney

[18] Ltr. from 19 State Medicaid gencies to the Hon. Mehmet Oz, M.D., *Re: Request for a Good Faith Effort Exemption from Medicaid Work and Community Engagement Implementation* (Nov. 19, 2026) (detailing challenges to implementation of Medicaid work requirements).
[19] U.S. Dept. of Health and Human Servs., *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025), https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.