Federation of American Hospitals

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President and CEO

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**Via electronic submission at http://www.regulations.gov**

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9873-P
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**RE:** Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification Proposed Rule (CMS-9873-P); 91 Fed. Reg. 67,656 (Oct. 27, 2026)

Dear Dr. Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced *Exchange Pre-Eligibility Verification Proposed Rule (Proposed Rule)*.

FAH appreciates the Administration's continued efforts to strengthen program integrity in the individual market, maintain robust plan participation and keep premiums affordable for consumers. FAH supports appropriate, targeted enforcement of program integrity rules and shares the goal of ensuring that advance payments of the premium tax credit (APTC) are provided only to individuals who are eligible for them, alongside efforts to ensure that consumers receive stable coverage that makes timely and appropriate care affordable. The Proposed Rule implements section 71303 of H.R. 1, the Working Families Tax Cut (WFTC) legislation (Pub. L. 119-21), which requires Exchanges to verify eligibility before an APTC may be paid. FAH supports implementing this requirement in a manner that preserves Congress's program integrity objectives while ensuring that eligible individuals do not lose or forgo the coverage and APTCs for which they qualify.

Affordable premiums and cost-sharing are essential components of a well-functioning insurance market. According to a recent poll, about six in ten (61 percent) Marketplace enrollees report having difficulty affording out-of-pocket costs for medical care, and half report trouble affording health insurance premiums.[1] For these families, a period without an APTC – even a temporary one while paperwork is processed – is effectively a period without coverage. CMS's own analysis confirms this risk and estimates that approximately 332,500 additional consumers *who are eligible* would not enroll in Exchange coverage each year because of the administrative barriers associated with the proposed verification process.[2] CMS further projects that premiums would increase because younger and healthier individuals are more likely to drop out when faced with these barriers.[3] When eligible patients lose coverage, the consequences are directly felt in hospital emergency departments, where patients who have delayed care arrive sicker and require more intensive treatment, driving up costs and uncompensated care across the health care system.

[1] KFF, *Poll: 1 in 3 ACA Marketplace Enrollees Say They Would "Very Likely" Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They "Very Likely" Would Go Without Insurance* (Dec. 4, 2025) (2025 KFF Marketplace Enrollees Survey), https://www.kff.org/affordable-care-act/poll-1-in-3-aca-marketplace-enrollees-say-they-would-very-likely-shop-for-a-cheaper-plan-if-their-premium-payments-doubled-1-in-4-say-they-very-likely-would-go-without-insurance/.
[2] 91 Fed. Reg. 67,709. October 27, 2026.
[3] Id.



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FAH supports the adoption of program integrity measures for Exchange-wide verification requirements that mitigate coverage losses due to administrative barriers for enrollees eligible for APTCs. CMS should ensure the WFTC verification provisions are implemented with clear guidance, education and meaningful communication for consumers along with technical support for State Exchanges to minimize implementation burden. This will ensure that individuals who are eligible for coverage are not unnecessarily burdened and opt out of coverage as a result.

FAH's recommendations below are guided by three principles: (1) maintaining continuous coverage for eligible individuals; (2) reducing consumer burden; and (3) preserving the intent of the WFTC to address program integrity concerns around APTCs. We appreciate CMS's consideration of these recommendations.

**Withholding APTCs and CSRs During Inconsistency Periods (§ 155.315(f)(4)(ii))**

CMS proposes that Exchanges may not authorize payment of APTCs and cost-sharing reductions (CSRs) for applicants with data matching issues (DMIs) related to the applicable enrollment information until those DMIs are adjudicated by the Exchange. Because eligible consumers will receive no financial assistance while a DMI is open, both the number of DMIs that Exchanges generate and the speed with which they resolve them will directly determine how long eligible consumers go without affordable coverage.

**FAH urges CMS to require Exchanges to use every available trusted electronic data source to corroborate the applicant's attested information before generating a DMI,** so that eligible consumers are not unnecessarily pushed into document submission. CMS should expand access to data sources that could resolve inconsistencies without consumer action but are underused today. This includes making the current income Hub service more accessible to State Exchanges, which must pay the full cost to use it and of which only 10 currently do. It also includes enabling Exchanges on the Federal platform to access State quarterly wage data, which CMS acknowledges may be more current than IRS income tax return data.

**When documentation is required, Exchanges should adjudicate information accurately and expeditiously. CMS should establish a performance target for completing documentation reviews, such as appropriately resolving 90 percent of reviews within 10 business days.** Exchanges are already required to determine eligibility "promptly and without undue delay" under § 155.310(e), and CMS has proposed firm timeframes for other administrative processes, including the 72-hour and seven-day deadlines for qualified health plan (QHP) issuers making prior authorization decisions. A comparable target for Exchange documentation reviews is especially important now that eligible consumers will receive no APTC until those reviews are complete. CMS itself acknowledges the potential for Exchange backlogs and delays in processing documents that could leave DMIs unresolved for reasons beyond the consumer's control, and its own illustrative example assumes 15 days for an Exchange to resolve a single DMI.[4] Under the proposed coverage effective date rules, a delay of only a few days can push back a consumer's coverage start date by a full month. CMS should monitor both Exchange processing times and the frequency of avoidable appeals, and act as a convener to bring technology solutions, such as automated document review and real-time verification, to bear on these processes, so that administrative delays do not cost eligible consumers months of premium assistance or coverage.

**Annual Eligibility Redetermination and Confirmation (§ 155.335) and Verification of Residency (§ 155.315(d))**

CMS proposes that an Exchange may not redetermine an enrollee eligible for APTCs and CSRs for the subsequent plan year unless the enrollee provides or confirms: household income and family size, U.S. citizenship or eligible noncitizen status, eligibility for or enrollment in other minimum essential coverage and place of residence. This verification must occur between August 1 and December 31 of the preceding year. Enrollees who do not confirm such information would be automatically re-enrolled without APTCs or CSRs.

To minimize the burden on enrollees whose circumstances have not changed, **FAH urges CMS to give Exchanges and enrollees adequate flexibility in how the annual confirmation is completed**. CMS notes that the single streamlined application would be one compliant method, but for most returning enrollees, completing a full application is an unnecessary barrier and administrative burden. Specifically, CMS should permit:

- **A short-form confirmation.** Enrollees with no changes to report should be able to confirm their information through a brief form rather than a full application.

[4] Id. at 67,688.



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- **Pre-populated applications.** Filling in prior-year information and current trusted-source data lets enrollees simply review and confirm, reducing errors that could generate avoidable DMIs.
- **One-step confirmation.** Allowing enrollees to confirm and reply to the Exchange's annual notice with a single action online or by mail, email, phone or text minimizes unnecessary barriers and keeps the requirement accessible to those less comfortable with online tools.
- **Confirmation through trusted third-parties.** Allowing navigators, certified application counselors, agents and brokers to help enrollees complete the annual confirmation (e.g., through three-way calls among the assister, the consumer and the Exchange call center, which CMS already uses for agent and broker casework) builds on consumers' existing trusted relationships.
- **Multiple reminders before December 31**. Exchanges should send several reminders, across channels, during the August 1 to December 31 window. Many enrollees are accustomed to automatic re-enrollment with continued APTCs and will not expect a new annual verification requirement, especially in the first years.
- **APTC restored back to January 1 for late confirmations**. Enrollees who confirm after December 31 and are verified for the months back to January should receive APTCs for those months. Otherwise, eligible enrollees would lose months of assistance simply for missing a deadline, even though their eligibility never changed.

Further, additional documentation should not be required in the following circumstances:

- **U.S. citizenship should not require new documentation year-to-year.** Once an Exchange has verified an enrollee's citizenship, that status should not change, and requiring repeated confirmation or documentation for citizens adds burden without any program integrity benefit.
- **Enrollees should be able to attest that their family size is the same, and that attestation should not require verification.** Requiring documentation of an unchanged household size would impose an unnecessary burden on families whose circumstances have not changed.
- **State residency should not require verification.** In response to CMS's request for comment, FAH does not support new residency documentation or identity verification requirements, which would add a barrier for eligible individuals on top of the statutory changes, and urges CMS to retain § 155.315(d) and rely on existing data sources. CMS attributes its concerns about inaccurate residency attestations to unauthorized enrollments by agents, brokers and web-brokers; those concerns, which CMS links to "body broker" schemes involving unlicensed agents, are best addressed through targeted broker enforcement rather than new requirements for all enrollees. CMS has also recently restored and expanded periodic data matching to identify duplicate enrollment, including enrollees in both Medicaid or CHIP and subsidized Exchange coverage. Rather than imposing new requirements on all enrollees, CMS should build on these tools, including by extending data matching to identify individuals enrolled in Exchange coverage in more than one State, which would directly target the residency misrepresentations CMS describes.

**Plan Selection in the Case of Certain DMIs (§ 155.400(i))**

**FAH supports CMS's proposal to require Exchanges to allow applicants and enrollees to pend their plan selection until their DMIs are resolved,** as is allowed today on the Federal platform for new applicants whose special enrollment period (SEP) eligibility is being verified. This avoids forcing eligible consumers to buy full-price coverage while verification is pending or forgo coverage during the DMI review period and return to the Exchange to select a plan option. Given the value of this option to consumers, FAH urges CMS not to allow State Exchanges to delay implementation of this proposal until plan year 2029. Exchanges should explain this option clearly at plan selection and release a pended plan without APTCs only with the consumer's consent.

**Annual Pre-Open Enrollment (Pre-OE) Verification Period (§ 155.410(h))**

**State Exchange Implementation**. FAH is concerned about the operational challenge State Exchanges face in standing up an entirely new pre-OE verification process by August 1, 2027. As CMS acknowledges, there is presently no pre-OE verification process, and all Exchanges would need to develop new system functionality to meet the proposed requirements. State Exchanges will have only a few months to build, test and launch new systems and communicate the changes to consumers. If a State Exchange fails to meet the August 1 deadline, consumer access to premium tax credits will be jeopardized statewide. **FAH urges CMS to finalize the rule as**



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**early as possible in 2027 and to issue any necessary sub-regulatory guidance and technical specifications for State Exchanges concurrently with the final rule.**

**FAH urges CMS to clarify, in coordination with the Department of the Treasury, that an Exchange satisfies section 36B(c)(3)(A)(ii) of the Code if, by August 1, 2027, it makes available a process through which any applicant may verify household income and eligibility for enrollment in a QHP, as the statute requires.** CMS should allow State Exchanges to phase in the additional elements CMS proposes, including full eligibility determinations during the pre-OE verification period, no later than the start of open enrollment. Any delay in implementing these requirements beyond the statutory minimum should be addressed through CMS's standard Exchange oversight and technical assistance and should not affect the availability of premium tax credits to consumers in that State.

This approach would give State Exchanges a realistic path to full implementation without putting enrollees' premium tax credits at risk. Such flexibility should not extend to consumer protections, such as pended plan selections, that help eligible consumers maintain coverage.

**Requests for Comment**

***Verification of Family Size (§ 155.320(c)(3))***

**FAH agrees with CMS that the current requirements for verification of family size are sufficient and urges CMS not to pursue stricter verification in the final rule or future rulemaking**. CMS notes that it has seen very limited cases of fraud related to family size. Its own analysis also shows that both broad and risk-based approaches to family size verification would impose significant costs on Exchanges, generate DMIs that consumers would rarely be able to resolve and risk adverse selection as younger and healthier individuals forgo coverage. In addition, the family size SEP waiver authorized under the WFTC ensures that families who gain a dependent through birth, adoption or marriage can receive APTCs based on their attested information at the moment their coverage needs change.

**Further, FAH urges CMS to require all Exchanges to offer the SEP for loss of a dependent** through divorce, legal separation or death, which Exchanges on the Federal platform do not currently offer, so that this protection reaches those families as well. New family size verification requirements would undercut these protections without addressing a demonstrated program integrity problem.

***Medicaid/CHIP Denial SEP (§ 155.420(d)(11))***

**FAH supports expanding the Medicaid/CHIP denial SEP to include individuals who apply for Medicaid or CHIP during the pre-OE verification period.** Depending on how long a State takes to process an application, consumers who apply early may not receive a Medicaid or CHIP determination before open enrollment ends. Extending the SEP closes a gap for people moving between Medicaid and Marketplace coverage, particularly as Medicaid eligibility tightens, and it ensures they can move to Exchange coverage without interruption.

FAH appreciates the opportunity to address these critical issues and looks forward to collaborating with the Administration and CMS to implement the WFTC legislation in a manner that strengthens program integrity while ensuring a robust market for affordable, high-quality private insurance coverage through the Marketplace. If you have any questions or would like to discuss further, please do not hesitate to contact me or Paul Eiting, VP, Policy, at peiting@fah.org.

Sincerely,
/s/
Charlene K. MacDonald
President and CEO



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