Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

November 24, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-9873-P

Re: Patient Protection and Affordable Care Act, Exchange Pre-Eligibility Verification Proposed Rule (91 Fed. Reg. 67656)

Dear Dr. Oz,

The Catholic Health Association of the United States, the national leadership organization of the Catholic health ministry, representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organizations across the continuum of care, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule on Affordable Care Act (ACA) pre-eligibility verification, implementing provisions of H.R. 1. We are concerned about the coverage losses that may occur and urge CMS to delay implementation for one year to ensure that the changes are effectively communicated to consumers so they can maintain their coverage.

CHA and our members firmly believe that health care is a fundamental human right that is essential to human flourishing, and we remain committed to our goal of providing quality, affordable, and accessible health care for all. Rooted in our faith, we affirm that every individual is created in the image of God, possesses inalienable worth, and deserves care that upholds their inherent dignity.

Prior to the passage of H.R. 1, we expressed our concerns that, rather than moving our nation closer to these goals, it would harm critical health and social safety-net programs, including the Medicaid program and the ACA marketplace insurance framework. We appreciated the extended implementation dates and attempts to mitigate the impact on rural hospitals in the final bill. However, we are deeply concerned that the Congressional Budget Office projected that H.R. 1's provisions would lead to 10 million people losing health coverage over 10 years, including 700,000 coverage losses due to the mandatory ACA pre-eligibility verification requirement. And we anticipate that the overall effect of H.R. 1 will be to threaten the viability of many rural hospitals and long-term care facilities, add financial stress on already overburdened health

providers and state budgets, and take away vital assistance from low-income and vulnerable individuals, families and children.

As health care providers who directly serve patients with ACA Marketplace (Marketplace) coverage, we know that coverage is essential for people to be able to receive the medical care they need and to protect patients around the country. CHA and our members strongly support ensuring that patients can navigate Marketplace programs as effectively as possible, so eligible people can get and stay covered, just as Congress intended.

CHA is deeply concerned that Marketplace-related provisions of H.R. 1 will raise premiums and keep eligible people from getting and keeping insurance coverage. Under the statute and the proposed rule, consumers can no longer be automatically re-enrolled with financial assistance, and advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) are withheld until eligibility is verified. CMS itself projects that 332,500 fewer people will enroll in Marketplace coverage each year beginning in plan year (PY) 2028 as a result of these provisions. CMS also projects that premiums will increase and roughly five million consumers, about 30 percent of enrollees, will have a data matching issue (DMI) that delays their verification, resulting in coverage loss and gaps. APTC are projected to fall by an estimated $7.6 billion a year because of verification delays and denials.

Most of these coverage losses will not be because people are ineligible, but because they cannot complete new administrative steps on time. When patients lose coverage or financial assistance, they delay care, enter the hospital with more advanced illness, and add to the uncompensated care that hospitals, particularly safety-net and rural providers, must absorb.

CHA remains concerned that H.R. 1's verification requirements will keep eligible people from obtaining and keeping the coverage they need. Due to the implementing rulemaking's release so close to the effective date and the complexity of updating systems for Marketplaces, CHA urges CMS to delay implementation or offer transitional relief for one year to allow adequate time for new enrollment systems to be built and tested and for effective consumer communication about new requirements. Additionally, CHA urges CMS to adopt protections to promote continuity of care and coverage, including the provision of additional allowances for retroactive coverage and refraining from adding unnecessary verification requirements. Finally, CHA urges CMS to ensure Marketplaces meet minimum consumer outreach and enrollment facilitation requirements so that eligible patients can obtain and retain critical coverage.

- **Implementation Timeline and Marketplace Readiness**

CMS should delay the effective date so that Marketplaces have adequate time to build and test their systems and communicate with consumers. While the law was passed in July 2025, the proposed rule was published over a year later, on October 27, 2026, and Marketplaces must open the pre-open enrollment verification period by August 1, 2027. With a final rule unlikely before spring 2027, Marketplaces would have only a few months to implement some of the most

significant eligibility and enrollment changes since the Affordable Care Act took effect. Starting the requirements before Marketplaces are ready increases the likelihood that eligible patients lose coverage or financial assistance because of system problems rather than ineligibility.

The proposed rule acknowledges that Marketplaces may not be able to implement many of these requirements in time and gives State-based Marketplaces (SBMs) some flexibility, which we support. It offers no comparable relief for consumers, however. To the extent CMS has discretion under the statute, **CHA urges CMS to exercise enforcement discretion and adopt transitional relief for consumers in PY 2028.**

- **Prioritizing Coverage Continuity and Clarifying Retroactive Tax Credits for Verified Enrollees**

Beginning in PY 2028, consumers with an unresolved DMI cannot receive APTC or CSRs until verification is complete. The proposed rule requires Marketplaces to let consumers enroll and then "pend" their enrollment while the DMI is resolved. Coverage would then begin the first day of the month if the DMI is resolved by the 15th, and the first day of the following month if resolved after the 15th. Consumers who pend would be required to pay premiums for retroactive coverage (i.e., if resolution occurs before the 15th of the month) plus the first prospective month in order to get retroactive coverage. If resolution occurs after the 15th of the month, retroactive coverage is not available and the consumer must pay the premium for the first prospective month to activate coverage.

Those who pay less than the full amount would receive prospective coverage only. If consumers choose not to pend and instead enroll and pay the full premium, they could receive APTC and CSRs retroactively once the DMI is resolved, but the proposed rule does not explain how retroactive APTC would be applied.

Any gap in coverage means delayed care for patients and uncompensated care for providers. **CMS should finalize the proposed policies allowing for pended enrollment and retroactive APTC and CSRs but should strengthen these policies to promote continuity of coverage for eligible consumers**. Specifically, CMS should:

- Maximize the period of retroactive coverage available upon DMI resolution;
- Clarify how retroactive APTC will be applied for consumers who pay the full premium, including any required premium and CSR refunds; and
- Give consumers a clear and affordable path to retroactive coverage when they cannot pay several months of premiums at once.

Consumers have no control over how quickly the Marketplace processes their documents, making retroactive coverage essential. The proposed rule limits retroactive coverage to 15 days. **CHA urges CMS to extend this so that consumers have the option of coverage retroactive to January 1 (or to the date the DMI was issued, if later).** CMS should also give consumers a

clear and affordable path to pay for retroactive months, such as installments or a longer payment window, so that a consumer who cannot pay several months of premiums at once does not lose coverage for care already received. CHA recognizes CMS's concern about adverse selection, but that concern should be weighed against the harm to patients who delay care or incur medical bills after they have submitted their documentation but before the Marketplace has acted. When care is received during these gaps, the cost falls on patients and the hospitals that serve them, particularly safety-net and rural providers.

CHA also supports retroactive CSRs. Deductibles and cost-sharing are often unaffordable, especially for lower-income consumers who are later verified as CSR-eligible. High out-of-pocket costs lead patients to forgo needed care and increase bad debt for providers. CMS should also clarify how retroactive APTC and CSRs will be applied, so that consumers receive the assistance for which they qualify and patients and providers avoid billing confusion.

- **Promoting More Consumer-Friendly Verification by Cutting Red Tape**

Under the law and proposed rule, beginning in PY 2028, consumers seeking APTC and CSRs must provide or actively confirm their income, family size, citizenship or lawful presence, other coverage, and residence each year. The proposed rule sets forth rules for how such eligibility elements are verified. Additionally, starting August 1, 2027, Marketplaces would be required to give applicants and enrollees the option to pre-verify their PY 2028 information before open enrollment (OE) begins, generally on November 1, 2027. Participation in this pre-OE period is optional.

CMS should make verification as simple as possible, so patients do not lose coverage due to administrative red tape.

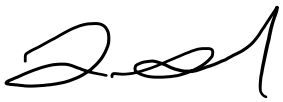
- **Trusted data and "one-touch" confirmation.** CHA supports requiring Marketplaces to verify pre-open enrollment information against trusted data sources. CMS should also require Marketplaces to pre-populate renewal applications and attempt verification using electronic data sources before any document is required. This would reduce consumer burden while preserving the statutory requirement for active verification.
- **Outreach and assistance.** CMS should require plain-language notices and at least two outreach methods, consistent with Medicaid renewal requirements. It should also support funding and earlier training for Navigators, assisters, and hospital financial counselors.

Verification data sources. CMS should not finalize the proposed heightened verification requirements for residency or family size. The pilot data show that reliable sources are not available: residency data could not be found for roughly half of the pilot population, and family size data could not be returned for 44 percent of applications. Where reliable data are unavailable, CMS should continue to accept self-attestation.

- **DMI resolution and special enrollment periods.** CHA supports DMI extensions for consumers making good-faith efforts. CHA also supports continuing APTC and CSRs during verification for family size special enrollment periods (SEPs), without delay for SBMs, given the importance of newborn and postpartum coverage. CHA further supports expanding the Medicaid denial SEP as states implement H.R. 1's Medicaid requirements.
- **Mid-year income changes.** CMS should exempt consumers whose income falls because of job loss or other hardship from the proposed ceiling on assistance while changes are verified.

Thank you for the opportunity to provide these comments. We look forward to continued engagement with CMS as implementation proceeds. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,



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