November 21, 2026
The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

Re: CMS-9873-P; RIN 0938-AW03 - Exchange Pre-Eligibility Verification

Dear Administrator Oz:

On behalf of the National Association of Benefits and Insurance Professionals (NABIP), representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists, we submit the following comments on CMS-9873-P, Exchange Pre-Eligibility Verification. Licensed agents and brokers assisted with 76 percent of active plan selections through HealthCare.gov, representing approximately 8.2 million consumers and underscoring their critical role in helping Americans obtain and maintain Marketplace coverage. Section 71303 of Public Law 119-21 establishes new verification requirements for Marketplace financial assistance beginning in plan year 2028. NABIP supports accurate eligibility determinations and targeted measures against fraudulent enrollment while maintaining reliable access to authorized consumer assistance. Our recommendations concern the choices CMS is making in the proposed rule and specific implementation issues created by related 2026 CMS guidance.

**1. Require a streamlined annual confirmation and an actionable warning before financial assistance ends (45 CFR 155.335, 155.410(d)(2), and 155.410(h))**

CMS solicits comment on whether current enrollees should reconfirm their information through a full application or through a shorter, prepopulated process. The proposed rule would retain automatic QHP re-enrollment but generally discontinue automatic renewal of APTC and income-based CSRs without required confirmation and verification. NABIP recommends that the final rule expressly recognize one secure, prepopulated confirmation of the specified eligibility information as satisfying the enrollee's obligation to "provide or confirm" that information. Enrollees should be able to affirm unchanged information and correct only changed fields; Exchanges should preserve a record of the confirmation, its date, and any authorized application filer. This approach would require actual consumer confirmation and subsequent verification, not passive subsidy renewal.

CMS proposes to allow the annual open enrollment notice to be sent earlier, but does not require a separate notice when the August pre-open enrollment verification window begins. That is insufficient for a newly mandatory annual action. CMS should require a personalized notice when the verification window opens, followed by a reminder at least 30 days before the last date to confirm information for January 1 assistance. Each notice should identify the unfinished action, explain that the QHP may automatically renew without APTC/CSRs, show the anticipated full premium once available, and provide an immediate way to complete confirmation

or discontinue coverage. The same confirmation and status functionality should be available through authorized EDE enrollment pathways and Exchange-operated channels.

For the August 1, 2027 launch, CMS should publish Exchange and EDE technical specifications, test scenarios, and consumer-notice templates early enough for end-to-end testing and agent/broker training.

**2. Make DMI requirements precise, usable, and consistent across enrollment channels (45 CFR 155.315(f)(4) and 155.410(h)(3))**

The proposed rule applies the statutory verification condition by withholding APTC and income-based CSRs during specified unresolved data matching issues (DMIs); NABIP is not asking CMS to pay assistance before the required verification. NABIP has previously urged CMS to attempt verification using trusted federal data before requiring manual documents, to standardize document-submission processes, and to show clear verification status through EDE and Exchange systems. CMS should now specify a minimum set of data for every open DMI visible to the consumer and their licensed guiding professional: the eligibility item at issue, a complete, issue-specific list of acceptable documents or other evidence that can resolve the inconsistency, including alternative documentation options where available, submission deadline, date of receipt, whether a document is under review or rejected, and the reason further action is required. A generic "verification pending" message does not tell anyone how to resolve a specific problem.

As State Exchanges implement the new verification requirements, CMS should establish consistent security, eligibility verification, and operational standards across Exchange-operated and approved third-party enrollment platforms. NABIP recommends that qualified EDE partners have a clear pathway to integrate with State Exchange systems and support the same verification and DMI-resolution functions available through Exchange-operated channels. This approach would preserve program integrity while ensuring that consumers and their licensed agents and brokers can continue using established enrollment tools.

CMS's proposed verification requirements will operate alongside its separate October 2026 Marketplace Enrollment Pathways guidance governing SSN and immigration-document verification for certain agent-assisted enrollments. While NABIP supports stronger identity verification, we remain concerned that unsuccessful real-time matches may disrupt legitimate agent assistance or result in the loss of NPN attribution when consumers must move between EDE, HealthCare.gov, and the Marketplace Call Center. CMS should establish a limited correction process for documented technical or administrative errors while preserving safeguards against unauthorized agent changes.

An unsuccessful electronic match also does not necessarily mean a consumer is ineligible for coverage or financial assistance. NABIP requests that CMS identify specific information that could not be verified, provide acceptable alternative documentation options, and establish a straightforward process for resolving mismatches. Information successfully verified during pre-open enrollment should carry forward into open enrollment to avoid duplicative verification requirements.

CMS also recommends that Exchanges generally avoid extending pre-OE inconsistency periods beyond December 15, although existing rules permit extensions in appropriate cases. NABIP opposes a categorical December 15 cutoff when a consumer submitted requested evidence within the applicable deadline and the Exchange has not completed its review. CMS should permit available extensions, maintain the consumer's pended plan selection, and provide a prompt escalation pathway for those cases. Financial assistance would still begin only when the statutory verification conditions are satisfied.

Under proposed § 155.315(f)(4)(iii), consumers who report an income decrease that would qualify them for additional financial assistance would generally continue receiving their previously verified APTC and CSR amounts while the new information is verified. This could create affordability challenges for consumers who have lost employment or experienced a significant reduction in income but must continue paying premiums based on their previous earnings. NABIP recommends that CMS establish an expedited verification process for these circumstances and ensure that any additional APTC or CSR assistance available retroactively is applied promptly once eligibility is confirmed.

**3. Preserve pended selections without enrolling consumers in unaffordable coverage by default (45 CFR 155.400(i))**

The proposed pended-plan option would let applicants select a QHP while resolving qualifying DMIs rather than pay the unsubsidized premium or lose their enrollment window. CMS specifically asks whether an unresolved selection should be released at full price after an inconsistency period expires and whether the consumer should make that choice at the outset. NABIP recommends an affirmative, separate consumer election at plan selection: "If I am ultimately found ineligible for financial assistance, release this plan at the full premium" or "Do not enroll me at the full premium without a new decision." Absent that election, the Exchange should not transmit a previously pended plan as full-price enrollment merely because the DMI period ended. The anticipated unsubsidized premium and cancellation consequences should be disclosed before the election.

**4. Use timely document submission, not agency processing speed, to protect coverage dates (45 CFR 155.410(f)(5), 155.420(b)(6), and 155.400(e))**

For pended SEP selections, CMS proposes that resolution by the 15th of a month can produce a first-of-that-month effective date, while resolution after the 15th generally produces a first-of-the-following-month date. CMS's own example involves a consumer submitting DMI documents September 1: Exchange approval on September 10 yields September 1 coverage; approval on September 16 yields October 1 coverage. NABIP recommends revising the effective-date test so that, once the Exchange ultimately verifies adequate evidence, it considers the date the consumer submitted the complete documentation rather than relying solely on the date staff finished reviewing it. At a minimum, CMS should preserve the earlier effective date where documentation was sufficient and timely but Exchange or federal-source processing crossed the cutoff.

An objective submission-based rule is also a workable response to CMS's concern about adverse selection: consumers would not be permitted to wait until after incurring medical expenses and then retroactively choose when to furnish their evidence. The Exchange could

retain a verified timestamp for a complete submission and still withhold transmission of the pended enrollment and payment of APTC/CSRs until verification succeeds. Where the initially submitted package is incomplete, the date on which the missing material is furnished should control; CMS should define how that date is recorded and reviewed.

NABIP recommends that CMS require issuers to clearly explain the payment and coverage options available when verification is completed after a consumer's anticipated effective date. Where consumers may elect retroactive or prospective-only coverage, issuers should provide the applicable effective dates, initial premium amounts, and payment deadlines before collecting a binder payment. Consumers should understand the financial consequences of each option before making a decision.

Additionally, when consumers are determined eligible for retroactive APTC or CSRs, CMS should establish consistent procedures for issuers to apply applicable premium credits or refunds and correct affected medical claims and cost-sharing amounts. Consumers should not face unnecessary delays or administrative obstacles in receiving financial adjustments for which they have been determined eligible.

Under proposed § 155.315(f)(4)(iv)(A)(4), CMS would prohibit prior-year APTC payments in certain DMI-resolution cases but continue to require applicable retroactive CSR adjustments. NABIP requests expedited handling of complete year-end DMI submissions, clear notices explaining when consumers must claim PTC on their tax returns, and a standardized process for correcting prior-year cost sharing, including claims reprocessing and reimbursement.

**5. Ensure Residency and Household-Size Verification Is Evidence-Based and Targeted (45 CFR 155.315(d) and 155.320(c))**

CMS is considering additional residency and household-size verification requirements but has not proposed a universal new documentation requirement. NABIP recommends against imposing additional documentation requirements on all applicants without evidence that the measures would meaningfully improve program integrity. Government data may not accurately reflect recent moves, shared living arrangements, births, or other legitimate household changes. Before adopting additional requirements, CMS should evaluate the accuracy of available data sources, the likelihood of incorrectly flagging eligible consumers, and whether targeted verification of applications presenting identifiable risks would achieve the same objectives without creating unnecessary enrollment barriers.

Separately, § 155.315(f)(4)(ii) proposes a family-size SEP exception allowing APTC and CSRs during qualifying inconsistency periods. NABIP supports applying the exception to qualifying new applicants and existing enrollees and recommends requiring Exchanges to offer the loss-of-dependent SEP under § 155.420(d)(2)(ii), as CMS solicits comment on. Any State Exchange delay should preserve comparable interim protection.

**6. Expand the Medicaid/CHIP denial SEP to pre-OE applicants (45 CFR 155.420(d)(11))**

CMS expressly solicits comment on expanding the existing Medicaid/CHIP denial SEP for applications submitted during the pre-OE verification period. NABIP supports that expansion and recommends codifying it in the final rule. Eligibility for the SEP should not turn on whether the Medicaid/CHIP application was submitted shortly before OEP rather than during OEP; the

Exchange should recognize the relevant application, start the SEP from the denial determination or notice as appropriate, and provide an enrollment window and effective date that prevent a coverage gap after a delayed Medicaid decision. CMS should explain how the SEP works with an already-pended QHP selection so consumers do not need to start a second application.

The separate DMI-resolution SEP at § 155.420(d)(13) is optional for Exchanges. CMS should clarify how it will coordinate with the new verification rules and pended selections when coverage terminates before a consumer resolves the DMI, without forcing a duplicate application.

**7. Address the related 2026 agent-guidance conflicts through companion instructions**

Separately from CMS-9873-P, CMS's October Marketplace Enrollment Pathways guidance and October 27 Issuer Agent-of-Record Processes memorandum limit the addition or retention of NPNs in certain transactions; the October 19 issuer-oversight guidance recommends that issuers investigate patterns of unresolved DMIs but states that an open DMI is not itself evidence of agent noncompliance. NABIP requests companion written guidance addressing two specific situations: (1) how an authorized agent can continue assisting with an SSN or immigration DMI after the consumer must change enrollment channels and the original transaction cannot retain the NPN; and (2) whether an objectively documented transmission or administrative error can be corrected through a narrowly controlled process supported by contemporaneous consumer authorization, without reviving unrestricted post-enrollment NPN changes. Issuer review of DMI trends should distinguish technical or delayed verification from established misconduct. These are requests to clarify separate guidance, not amendments sought through this rulemaking.

NABIP appreciates CMS's consideration of these focused changes. They would preserve the statutory verification standards while ensuring that consumers who act on time do not lose enrollment opportunities, unexpectedly incur unsubsidized premiums, or face coverage gaps caused by administrative processing.

Sincerely,

Mychal H Walker

Mychal Walker

President

National Association of Benefits and Insurance Professionals (NABIP)