Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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CMS Proposes Exchange Pre-Eligibility Verification

The Centers for Medicare & Medicaid Services (CMS) are issuing a proposed rule to implement new requirements specified under the ***Working Families Tax Cut*** (WFTC) legislation related to Exchange eligibility and verification.

This proposed rule contains related updates to provisions affecting inconsistency periods, inconsistency verification procedures, annual eligibility redeterminations and eligibility redeterminations during the plan year, as well as expanding enrollment methods during the verification process and establishing new coverage effective dates.

The rule is scheduled for publication in the ***Federal Register*** on October 27. A display copy of the 203-page rule is currently available at: https://public-inspection.federalregister.gov/2026-21891.pdf.

A 30-day comment period, ending 30 days after publication is provided.

Comments

The proposal does not appear to directly impact hospitals. However, if reductions from individuals not meeting the revised criteria, such individuals may become uninsured.

The rule does not provide a table-of contents and we are adding below.

Summary of the Key Provisions

The following material is part of the summary of major provisions to this proposal. (Pages 5-8)

- CMS proposes "to modify 45 CFR 155.106 to require that the 15-month requirement for a State to submit its application for HHS' review and approval be oriented around when a State begins operations as a State Exchange for the pre-open enrollment (pre-OE) verification period, instead of the Open Enrollment period (OEP)."

- CMS proposes "to retain the existing regulatory requirements in § 155.315(d) related to verification of residency. We seek comment on how HHS might strengthen requirements for Exchanges to verify residency in the short and long term to improve program integrity, and ideas on how Exchanges can move away from primarily accepting self-attestation of residency without further verification."

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 136 or awheeler@MoHospitals.org

4712 Country Club Drive, Jefferson City, Mo. 65109
P.O. Box 60, Jefferson City, Mo. 65102
573-893-3700 | MoHospitals.org

- CMS proposes "to amend § 155.315(f)(4)(ii) to state that Exchanges would not be able to authorize payment for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs) for applicants who have data matching issues (DMIs) described in § 155.315(c) for citizenship and lawful presence status; § 155.315(d) for residency; § 155.320(b) for non-employer sponsored minimum essential coverage (MEC); § 155.320(c)(3) for annual household income, family size, and eligible noncitizen status; and § 155.320(d) for employer-sponsored plans, until such DMIs are adjudicated by the Exchange, if otherwise eligible**."**

- CMS proposes "to add in § 155.315(f)(4)(ii) that the above requirement would not apply if the applicant's tax household is eligible for a special enrollment period (SEP) described in § 155.420(d)(2)(i) or (ii)."

  CMS proposes "to add new § 155.315(f)(4)(iii) to describe the requirements related to providing APTC and CSRs for enrollees who have reported a change to eligibility criteria during the plan year after an Exchange has completed verification of those same criteria."

- CMS also proposes "to add new § 155.315(f)(4)(iv) to specify that Exchanges would be required to determine eligibility for APTC and CSRs on behalf of an applicant following successful verification of information as described in proposed new § 155.315(f)(4)(ii) and to establish effective dates of those eligibility determinations or redeterminations."

- CMS also proposes "to add new § 155.315(f)(4)(v) to state that applicants with DMIs unrelated to the information outlined in proposed § 155.315(f)(4)(ii) receive APTC and CSRs during an inconsistency period if otherwise eligible, as currently required."

- Further, CMS proposes "to add new § 155.315(f)(4)(vi) to move the requirement that a tax filer must acknowledge that any APTC are subject to reconciliation that is already outlined in existing § 155.315(f)(4)(ii). CMS proposes to amend § 155.315(f)(4)(i) to remove language around proceeding with all other elements of eligibility determination to align with proposed changes to § 155.315(f)(4)(ii)."

- CMS proposes "to retain the existing regulatory requirements at § 155.320(c) related to verification of family size, and seeks comments on how it might strengthen requirements for Exchanges to verify family size to improve program integrity."

- CMS proposes "to amend § 155.330(f) to specify effective dates for eligibility redeterminations during the plan year. Specifically, we propose that eligibility redeterminations resulting from enrollee-reported changes would be effective on the first day of the month following the eligibility redetermination, unless the enrollee qualifies for certain SEPs."

- At § 155.330(f)(2), CMS proposes "to add cross-references to the newly proposed effective date rules at § 155.315(f)(4)(iv) that apply when an Exchange resolves a consumer's DMI described in § 155.315(f)(4)(ii) or § 155.315(f)(4)(iii)(A). Finally, at § 155.330(f)(3), we propose effective date rules for consumers whose DMIs are expired because they do not submit sufficient documentation**.**

- CMS proposes "to amend § 155.335 to require that Exchanges continue redetermining the eligibility of an enrollee on an annual basis but newly require that an Exchange may not redetermine an enrollee eligible for APTC and CSRs for the subsequent plan year unless the enrollee or the enrollee's application filer provides or confirms household income and family size; U.S. citizenship or status as an eligible noncitizen; eligibility for or enrollment in other MEC; and place of residence for the subsequent plan year on or after August 1 and no later than December 31 of the year preceding the applicable plan year, and the Exchange would be required to attempt to verify the specified eligibility information using the processes in §§ 155.315 and 155.320, including the relevant provisions in those sections regarding DMIs.

- CMS proposes "to amend § 155.335(b) to state the annual eligibility redetermination would be effective on the first day of the applicable plan year, and the Exchange would be required to adhere to the existing notification standard for eligibility determinations under § 155.310(g). (We) propose an exception in instances where an enrollee has an unresolved DMI under § 155.315(f)(4)(ii) as of December 31 of the year preceding the plan year and for whom APTC and CSRs are not provided during the inconsistency period. In these cases, (we) propose that the redetermination of APTC and CSRs take effect in accordance with §§ 155.315(f)(4)(iv)(A) or 155.330(f)(3), as applicable. (CMS) proposes to remove § 155.335(c) through (i); redesignate § 155.335(j) as new § 155.335(c); and remove § 155.335(k) through (n)."

- CMS proposes "to modify § 155.400(e) to account for new enrollment requirements proposed in this rule. Specifically, we propose that Exchanges may, and the Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal platform (SBE-FPs) would be required to, make retroactive enrollments under proposed §§ 155.410(f)(5)(i)(A) and (B), 155.410(f)(ii)(A) and (B), and 155.420(b)(6)(i), subject to the current binder payment rules for retroactive enrollments under § 155.400(e)(1)(iii).

- CMS proposes "to make conforming amendments at § 155.400(e)(1), including combining current (i) and (ii) as proposed (i), and redesignating current (iii) as proposed (ii). We propose to add new § 155.400(i) to require that Exchanges permit applicants and enrollees to "pend" their plan selection such that the plan selection would only be sent to the issuer, and qualified health plan (QHP) coverage only becomes effective, after the Exchange determines the applicant or enrollee eligible for APTC and CSRs, as applicable, as described by § 155.315(f)(4)(iv).

- CMS proposes "to add § 155.410(h) to require all Exchanges to provide a pre-OE verification period during which Exchanges would enable consumers to choose to provide certain eligibility information for the subsequent plan year. Exchanges would be required to attempt to verify such information provided. We propose that the pre-OE verification period for all Exchanges begin each year on August 1 and continue until an Exchange's OEP begins."

- CMS proposes "new effective date rules for pended plan selections made during the annual OEP or during an SEP, in § 155.410(f)(5) and § 155.420(b)(6), respectively. These rules would provide that, in general, if an Exchange resolves all of a consumer's DMIs described in

  § 155.315(f)(ii) by the 15th of the month following the consumer's otherwise prescribed effective date under § 155.410(f)(5) or § 155.420(b)(6), then the consumer can maintain that coverage effective date. If, however, they do not resolve all of their DMIs by the 15th of the month following their otherwise prescribed effective date, then their coverage effective date would depend on when their DMIs were resolved. If their DMIs were resolved by the 15th of the month, their coverage effective date would be the first of the month of resolution. If their DMIs are resolved between the 16th and the end of the month, then their coverage effective date would be the first of the following month."

- CMS is "considering expanding the application submission timeframe described in the SEP at § 155.420(d)(11), which is commonly referred to as the Medicaid denial SEP, and seek comment on this possible change. For this SEP, if a consumer applies for Medicaid and CHIP coverage, either through the Marketplace eligibility application or directly with the State Medicaid or CHIP agency during the OEP and is denied Medicaid and CHIP, the consumer is granted an SEP to gain access to Exchange coverage. Specifically, we seek comment on whether consumers who apply for Medicaid or CHIP during the pre-OE verification period should also be eligible for this SEP, if otherwise eligible."

The rule does not provide a table-of-contents. We have constructed one as noted below.

Table of Contents

Section	Page
I. Executive Summary	4
A. Purpose	4
B. Summary of Major Provisions	4–8
II. Background	9
A. Legislative Overview	9–13
III. Provisions of the Proposed Regulations	13
A. Part 155 – Exchange Establishment Standards	13
1. Election to Operate an Exchange (§155.106)	13
2. Definitions and General Standards (§155.300)	15
3. Eligibility Process (§155.310)	15
4. Verification Process, QHP Eligibility (§155.315)	16
a. Verification of Residency	16
b. DMIs	25
(i) Statutory and Regulatory Overview	26

Section	Page
(ii) APTC/CSRs during Certain Inconsistency Periods	37
(iii) Eligibility Redeterminations during the Plan Year	41
(iv) Resolution of DMIs	42
(v) APTC/CSRs during Other Inconsistency Periods	50
(vi) Conclusion	51
c. Family Size SEP Waiver	51
d. Eligibility Redeterminations During the Plan Year	55
5. Verification, Insurance Affordability Programs (§155.320(c))	64
6. Eligibility Redetermination During a Plan Year (§155.330)	69
a. Effective Dates for Enrollee-reported Changes	69
b. Effective Dates, Resolution of DMIs	75
c. Effective Dates, Expiration of Inconsistency Period / Periodic Data Matching	77
d. Effective Dates for Appeals	81
7. Annual Eligibility Redetermination (§155.335)	81
8. Enrollment of Qualified Individuals into QHPs (§155.400)	98
a. Binder Payment for New Enrollments	98

Section	Page
b. Plan Selection in the Case of Certain DMIs	104
9. Initial and Annual Open Enrollment Periods (§155.410)	108
a. Notice of Annual Open Enrollment Period	108
b. Effective Dates for QHP Selections	109
c. Annual Pre-OE Verification Period	117
10. Special Enrollment Periods (§155.420)	129
B. Severability	131
C. Applicability Dates (incl. Table 1)	132–133
IV. Collection of Information Requirements	133
A. Wage Estimates	134
B. ICRs Regarding DMIs	135
C. ICRs Regarding Annual Eligibility Redetermination	138
D. ICRs Regarding Plan Selection during Inconsistency Period	143
E. ICRs Regarding Pre-OE Verification Period	145
F. Summary of Annual Burden Estimates	146

Section	Page
G. Submission of PRA-Related Comments	146
V. Response to Comments	147
VI. Regulatory Impact Analysis	147
A. Statement of Need	147
B. Overall Impact	147
C. Detailed Economic Analysis	148
1. DMIs	148
2. Annual Eligibility Redetermination (a. Costs 155; b. Benefits 158)	154
3. Plan Selection during Inconsistency Period	159
4. Pre-OE Verification Period	161
5. Regulatory Review Cost Estimation	164
6. Overall Impact (a. Enrollment 167; b. APTC 169; c. Revealed-Preference Valuation 171; d. Premiums 173)	165
D. Accounting Statement and Table	174
E. Regulatory Alternatives Considered	176
1. Redeterminations During the Plan Year	176

Section	Page
2. Effective Dates	177
3. Notice of Annual OE Period	179
4. Pre-OE Verification Period	179
F. Regulatory Flexibility Act	180
G. Unfunded Mandates Reform Act	184
H. Federalism	184
I. E.O. 14192	185
Regulation Text (amendatory instructions)	188–202