STATE Health & Value STRATEGIES | Driving Innovation Across States
A grantee of the Robert Wood Johnson Foundation
PRINCETON UNIVERSITY

Proposed Marketplace and Insurance Changes in the 2027 Notice of Benefit & Payment Parameters: Implications for States

February 2026

Prepared by Sabrina Corlette, Georgetown Center on Health Insurance Reforms, Jason Levitis, the Urban Institute, and Tara Straw, Manatt Health

On February 9, 2026, the Centers for Medicare & Medicaid Services (CMS) released its annual proposed rule governing the Affordable Care Act (ACA) Marketplaces and insurance reforms. The proposed "Notice of Benefit & Payment Parameters," (NBPP) includes a broad set of policy and operational changes for 2027 that implement elements of the 2025 budget reconciliation law H.R.1, roll back several Biden-era policies, revisit provisions of the Marketplace Integrity final rule, and introduce several new policies. Combined, these proposals are projected to reduce Marketplace enrollment by 1.2 to 2 million people and lower federal spending by up to $10.4 billion in 2027.

The proposed rule creates uncertainty for state regulators, insurers, and stakeholders by including several provisions that are likely to be challenged in court, either because they have been successfully challenged in the past or because they take novel, aggressive legal positions.

This issue brief reviews provisions of the proposed rule with particular import for State-Based Marketplaces (SBMs) and state insurance departments. For a more detailed summary of the proposed rule, see the articles in Health Affairs Forefront, here and here. Comments on the proposed rule are due by March 13, 2026.

Provisions Implementing H.R.1

CMS proposes policies to implement provisions of H.R.1, referred to in the proposed rule as the "Working Families Tax Cut" Act. These include the termination of eligibility for certain categories of lawfully present immigrants and the elimination of special enrollment opportunities for low-income consumers.

Narrowing Eligibility for Non-Citizens

H.R. 1 significantly narrowed the categories of non-citizens who are eligible for premium tax credits (PTCs) and cost-sharing reductions in the Marketplaces, beginning in plan year (PY) 2027, and the proposed rule makes conforming amendments to implement this. Under long-standing ACA rules, any

lawfully present individual is eligible for PTC, provided they meet other eligibility requirements. Under H.R.1, while any lawfully present person can *enroll* in Marketplace coverage, financial help is only available to non-citizens who are lawful permanent residents (LPRs, or green card holders), Cuban-Haitian entrants, or Compact of Free Association (COFA) migrants. All Marketplaces will need to update their applications and rules to incorporate these changes.

The proposed rule also makes amendments to conform the Marketplace rules to H.R.1 with regard to non-citizens with income below 100% of the federal poverty level (FPL) who are ineligible for Medicaid by virtue of their immigration status. H.R.1 makes these non-citizens ineligible for PTC. The proposed rule states that this provision is "self-effectuating" and therefore must be operationalized for PY 2026.

In limiting PTC eligibility in H.R.1, Congress did not address what happens to eligibility in and funding for the Basic Health Program (BHP). Under this proposed rule, as with the new statutory cleaver between Marketplace enrollment eligibility and subsidy eligibility, states operating a BHP are required to cover all lawfully present individuals but can no longer collect PTC to help pay for their coverage. In light of this discrepancy, CMS issued guidance on December 10, 2025 stating that it would not take compliance action against any state that chooses not to cover this population in their BHP for three years (2026 through 2028).

In another amendment to conform Marketplace rules with H.R.1, CMS proposes to require Marketplaces to verify eligible non-citizen immigration status through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program and, failing verification, to issue a data matching inconsistency that requires an applicant to take action to prove their status. This is currently done through the federal data services hub.

Elimination of the Low-Income Special Enrollment Period

H.R.1 prohibits the expenditure of premium tax credits for coverage that was obtained via a special enrollment period (SEP) based solely on an individual's income. This provision was effective on January 1, 2026. The proposed NBPP interprets the H.R.1 provision to prohibit all Marketplaces, including SBMs, from paying advance premium tax credits (APTC) to anyone who enrolls in a plan through a SEP in which the triggering event is based solely on income.

Provisions Reversing Biden-Era Marketplace Policies and Insurance Standards

The proposed rule contains several provisions that roll back policies and standards adopted during the Biden administration, including standards for states seeking to transition to an SBM, standards for provider access, and quality improvement. The proposed rule, if finalized, also rescinds the ability of states to add routine dental services to essential health benefits, eliminates standardized health plans, and lifts limits on non-standardized plans.

Requirement for States Transitioning to a State-Based Marketplace

The proposed rule eliminates procedural requirements for states seeking to establish an SBM. These requirements were added in the NBPP for 2025. First, the rule eliminates the requirement that a state use a State-Based Marketplace on the federal Marketplace platform (SBM-FP) for a year before progressing to a full SBM. Second, the rule eliminates regulatory language requiring transitioning states to "provide, upon request, supplemental information to the Department of Health and Human Services detailing the state's implementation of its State Exchange functionality, including information on the ability to implement and comply with federal requirements for operating an Exchange." However, CMS notes that removing this latter language has little effect, as transitioning states are still required to provide such information upon request under the terms of the Blueprint for establishing an SBM.

Back to States: Network Adequacy Standards and Oversight

The proposed rule would give states a greater opportunity to set standards for and review Marketplace plans' network adequacy. Under current rules, SBMs and SBM-FPs must maintain quantitative time and distance network adequacy standards that are at least as stringent as those used by the Federally Facilitated Marketplace (FFM). They must also conduct reviews of each plan's compliance with those standards, prior to certifying them for Marketplace participation.

The proposed rule would remove these requirements for SBM and SBM-FPs. CMS notes that many SBMs and SBM-FPs have demonstrated that they already have network adequacy standards and review processes that met or exceeded federal standards. The agency observes that states "can better take into consideration the needs of specific enrollee populations."

For FFM states, CMS proposes to replace its current oversight framework with a process that largely defers to states, if the state has an "Effective Provider Access Review Program." Under the proposal, CMS would consider an FFM state to have an Effective Provider Access Review Program if it:

- Has established network adequacy standards in statute or regulation that are consistent with federally established network adequacy standards and reports to CMS whether an entity other than the state department of insurance will conduct the reviews;
- Has reporting systems and the capacity to collect and review provider access data, and receives from insurers the documentation and data sufficient to conduct a review;
- Includes procedures to ensure full compliance with the state's standards, including a process by which insurers can come into compliance if they fail to meet the standards;
- Establishes and maintains clear procedures and timelines for review, to align with the Marketplace plan certification cycle;
- Maintains a process for monitoring and addressing consumer complaints;
- Maintains a process to collect and review information sufficient to show that *non-network* plans provide access to a sufficient choice of providers that accept the non-network plan's payment

amount as payment in full. (States would need to meet this criterion if they certify non-network plans; see discussion of CMS' proposal relating to non-network plans, below).

If an FFM state does not have the authority or capacity to maintain an Effective Provider Access Review Program, then CMS would continue to conduct network adequacy reviews for that state. The agency is seeking comments, in particular, on the level of transparency and public reporting necessary to "safeguard public trust" in an Effective Provider Access Review Program.

Relaxing Essential Community Provider Standards and Shifting Oversight to States

The proposed rule would scale back requirements that Marketplace plans contract with a minimum number of essential community providers (ECPs) within their service areas. Under current rules, Marketplace plans must contract with at least 35% of available ECPs, and separately, at least 35% of available federally qualified health centers (FQHCs) and at least 35% of available family planning providers in the plan's service area.

CMS is proposing to reduce the overall threshold and the FQHC and family planning thresholds, from 35% to 20% for both Marketplace plans and stand-alone dental plans in FFM states, beginning with PY 2027. The agency argues that a majority of insurers on the FFM already meet or exceed the 35% threshold, and requiring them to demonstrate compliance with the higher threshold imposes an unnecessary administrative burden.

CMS is also proposing to remove requirements that insurers who do not meet the threshold provide justification for, and documentation of, their efforts to contract with ECPs in their service areas. The agency asserts that it can assess compliance simply by asking insurers to report the status of its contracting offers with ECPs.

Similar to its approach to network adequacy oversight, CMS is also proposing to delegate reviews of compliance with ECP standards to FFM states that can demonstrate that they have an "Effective Essential Community Provider Review Program." To determine whether an FFM states has such a program, CMS will assess the following factors:

- The legal authority to conduct reviews of ECP compliance;
- Standards that ensure Marketplace plans maintain a sufficient number and geographic distribution of ECPs;
- A description of the state's definition of ECP;
- Whether it will use the federal definition of ECP or its own;
- A description of the methodology and tools it will use to assess ECP data;
- Whether the state collects information about the status of contract offers;
- Whether an agency other than the department of insurance is conducting the reviews;
- Whether the state does compliance reviews and conducts enforcement;
- Whether the state has a process for monitoring and addressing consumer complaints.

CMS argues that states' knowledge of local market conditions and geographic constraints will strengthen ECP certification reviews.

Eliminating Coverage of Routine Adult Dental Services

The proposed rule would prohibit insurers from including routine, non-pediatric dental services as an essential health benefit (EHB), reversing a policy adopted in the 2025 NBPP. Under current rules, states seeking to improve access to oral healthcare services are able to update their EHB-benchmark plans to include a benefit for routine dental services for adults. The proposed rule, if finalized, would bar states from adding routine non-pediatric dental services to their EHB-benchmark plan.

Eliminating Standardized Plans and Plan Limits

CMS is proposing to discontinue the standardized plans currently available via the FFM, and would lift the current limits on non-standardized plan options. States would continue to have the option to require standardized plans or set limits on the number of plans an insurer can offer, including those states that rely on the FFM.

The agency argues that standardized plans have not met their stated objective of improving the consumer shopping experience, asserting that the introduction of standardized plans actually increased the total number of plan options consumers are required to choose from. CMS also asserts that given the "heterogeneity" among the 28 states that use the FFM, it is "impractical" for the federal government to design a standardized plan option that meets the "unique circumstances and market conditions" that exist within each state.

The proposed rule would also lift restrictions on the number of non-standardized plans that insurers can offer in the FFM. Under current rules, insurers are limited to two non-standardized plans per product network type, metal level, and inclusion of dental and/or vision coverage. The agency argues that these limits have "constrained insurers' ability to offer a sufficiently broad range of plans."

Provisions Revisiting the Marketplace Integrity Final Rule

On June 25, 2025, CMS finalized the "Marketplace Integrity and Affordability rule" (referred to here as the "Marketplace Integrity rule"), which included numerous changes to Marketplace eligibility and enrollment systems, reduced eligibility for PTCs, limited enrollment opportunities, and reduced federal spending. Many of these changes were challenged in federal court, in *City of Columbus v. Kennedy* and *State of California v. Kennedy*. Both cases are still being litigated, but the U.S. District Court in *City of Columbus* temporarily blocked ("stayed") CMS from implementing several provisions of the final rule. As of this writing, that stay is still in effect. The proposed rule now seeks to impose for 2027 some of the same rules that the court blocked for 2026.

Income Verification

The proposed rule permanently imposes two new paperwork requirements for consumers whose income cannot be verified using federal data sources. The *City of Columbus* court blocked both of these requirements for 2026.

Under the ACA, the Marketplace determines APTC eligibility by checking an applicant's best guess as to their income against data from their most recent tax return, which is generally from two years before the coverage year. If the individual's projected income is lower than the income in their tax return, the Marketplace generally flags a "data matching issue" (DMI), requiring the consumer to provide documentation of their projected income. But a DMI is not generated if the applicant projects higher income than their tax return shows, because APTC would typically be lower than what federal data sources show they are eligible for. This includes individuals whose tax data shows income below 100% FPL, since incomes among low-income individuals are highly volatile, making income below the poverty line one year a poor indicator of likely income two years later. A DMI is also not generated if federal tax information is unavailable, which is common and can happen for a variety of reasons, even for people who file a return annually.

The Marketplace Integrity rule imposed new requirements for Marketplaces to generate DMIs in both of these situations in 2026, requiring consumers to provide additional documentation of their incomes. CMS justified the change for people with tax data showing income below 100% FPL by arguing that, in states that have not expanded Medicaid, some applicants below the poverty line may be inflating their income projections above 100% FPL to receive APTCs. CMS justified the second on more general concerns about Marketplace fraud.

The District Court in *City of Columbus* blocked both provisions, finding that CMS did not adequately consider and address public comments in response to the proposed rule, and that CMS' estimates of fraud appeared flawed. (A provision requiring DMIs for individuals with tax return information showing income below 100% FPL was also finalized in the NBPP for 2019 and struck down in a prior round of litigation.)

Notwithstanding the court stays on these provisions for 2026, CMS now proposes them again, for plan years 2027 and beyond. CMS justifies both changes based on a claim of broad authority to determine eligibility and enrollment rules, and on H.R.1's elimination of the caps on repayment of APTC, which CMS argues raises the stakes for accurately projecting APTC eligibility. CMS however does not, however, acknowledge the larger stakes involved: H.R.1's elimination of provisional eligibility for APTC while the Marketplace processes documentation to resolve a DMI, as discussed below.

CMS estimates that the first change will result in an additional 548,000 DMIs per year and the second an additional 2.8 million DMIs per year. Together, they project these changes will create an additional 3.3 million hours of paperwork for consumers per year. CMS estimates that these provisions would reduce PTC spending by about $1.3 billion per year and coverage by hundreds of thousands. However, this

appears to ignore the effects of the H.R.1 provision, which would greatly increase the coverage losses in 2028 and beyond.

CMS estimates that SBMs would face additional annual costs of $12.4 million per year for implementing the first rule and $62.8 million per year for the second, as well as a one-time costs to update IT systems of $16.3 million from the first rule and $18.3 million from the second. In addition, consumers would face $83 million in costs from submitting extra paperwork under these provisions.

Loss of Eligibility for Failure to File and Reconcile Required Tax Forms

The proposed rule moves to impose "failure to reconcile" (FTR) rules in 2027, seemingly ignoring a recent court opinion finding no statutory basis for such rules in 2026. CMS would permit Marketplaces to choose between the "one-year" and "two-year" FTR rules in 2027. The rule also implements the H.R.1 provision that effectively imposes the one-year rule in 2028 and beyond.

The ACA permits Marketplace enrollees to receive APTC to reduce their monthly premium based on their projected income. APTC recipients must file a tax return to "reconcile" APTC with the PTC they are due based on their actual income for the year. Individuals who fail to do so are subject to the Internal Revenue Services' (IRS) normal enforcement measures, including withholding of tax refunds and liens and levies. CMS regulations promulgated in 2012 added an additional penalty: individuals who failed to file and reconcile would be denied APTC in subsequent years. During the Biden administration, CMS modified the rule so individuals could be denied APTC only after two consecutive years of FTR status (referred to as the two-year FTR rule). In May 2025, the Marketplace Integrity rule restored the one-year rule, effective for 2026 only. In July 2025, H.R.1 effectively codified the one-year rule, for 2028 and beyond. In August 2025, the District Court in the *Columbus* case found both versions of the FTR rules were likely unlawful, as they purport to impose an eligibility requirement without statutory authority.

CMS now pursues a sort of middle ground on FTR for 2027. Rather than complying with the Court's view that FTR rules are inconsistent with the ACA's original text or doubling down on imposing the one-year FTR rule, CMS proposes to permit each Marketplace to choose to enforce either the one-year or two-year FTR rule. This proposal gives states more flexibility than the Integrity Rule. But it is no more in keeping with the Court's opinion. As such, if this provision is finalized for 2027, it is likely to be litigated again.

For 2028 and later years, the picture is clearer: Congress has added statutory language that effectively imposes the one-year rule. The proposed rule provides implementing regulations.

Each version of the rules requires the Marketplace to notify consumers of the risk of losing APTC. However, both versions permit Marketplaces to rely on "indirect" notices, which do not specify the reason for the risk. This vagueness is motivated by tax privacy rules, which make it costly for Marketplace to provide clearer notices. Also, Marketplace staff may not generally confirm an applicant's FTR status, even when denying APTC on that basis. These concerns are compounded by the complexity

of the reconciliation process and by ongoing delays in the IRS processing of tax returns, which may cause the IRS to falsely flag applicants as having failed to file and reconcile, and IRS staffing reductions, which could impede efforts to resolve such issues. For all of these reasons, the FTR rules create ongoing concerns about consumer confusion and burden leading to eligible people being denied APTC.

Rules for the Collection of Premiums

If a state permits, issuers can accept slightly less than the full premium due without putting the enrollee into a grace period or terminating coverage. For PY 2026, CMS created additional rules to expand insurers' options to create a threshold that is: (1) an amount that is at least 95% of the net premium paid by the enrollee; (2) an amount that is at least 98% of the gross monthly premium, or (3) a fixed-dollar amount that is up to $10. Citing program integrity concerns, the 2025 Marketplace Integrity rule scaled back the circumstances in which the premium payment threshold is used to an amount that is no greater than 95% of net premium, but did so for only PY 2026. Here, CMS hypothesizes that permitting a generous premium payment threshold exacerbates the problem of unauthorized enrollments, since coverage could be continued without the enrollee paying a premium and generate a high repayment, if ineligible for the APTC received. CMS seeks comment on whether the two types of thresholds should sunset as planned (leaving one) and what flexibility SBMs should have to adopt these thresholds (even if the FFM does not).

Verification of Special Enrollment Eligibility

In the Marketplace Integrity final rule, CMS removed a restriction on the FFM that limited SEP verifications (SEPV) to just those triggered by an applicant's loss of minimum essential coverage. Under SEPV, a consumer's enrollment is "pended" until the Marketplace has verified their eligibility for the requested SEP. The final rule would have allowed the FFM to conduct SEPV for additional SEPs triggering events, and would have required the FFM to conduct SEPV for at least 75% of new enrollments. The final rule sunset its expansion of SEPV on December 31, 2026. However, the provision never went into effect because the U.S. District Court stayed implementation in *City of Columbus*.

In this proposed rule, CMS returns to the policy it finalized in the Marketplace Integrity rule, but without a sunset. The agency argues that increased SEPV will "deter bad actors" and prevent those who are ineligible from gaining access to the Marketplaces. It also posits that the policy will reduce adverse selection, because people will be less able to wait until they are sick to sign up for a plan. CMS estimates that this policy will reduce federal spending on APTCs by $105.4 million in 2027, and reduce premiums between 0.5% and 1%. The policy does not apply to SBMs.

New Policy Proposals

Several proposals in this rule would, if finalized, impose new financial obligations on states, new reporting requirements for insurers, and open up avenues for the marketing and sale of health

insurance products that do not meet the standards for coverage generosity and provider access currently expected of Marketplace health plans.

New Standards for Defrayal of State-Mandated Benefits

The proposed rule includes a provision that would consider certain state-required benefits to be in addition to "essential health benefits" (EHB), even if those benefits have been embedded in a state's EHB-benchmark plan. Under the ACA, individual and small-group market insurers must cover a minimum set of 10 categories of EHB. In addition, federal standards for plan cost-sharing, including the annual cap on out-of-pocket costs, apply to EHB but not benefits outside EHB. Further, the amount of PTC available to a Marketplace enrollee is tied to the premium cost of EHB, and PTCs may not be used to pay for benefits in addition to EHB.

Under current rules, CMS does not expect states to defray the costs of state-mandated benefits, if those benefits have been approved by CMS as part of the state's EHB-benchmark plan. However, arguing that state-enacted benefit mandates result in higher premiums and higher federal expenditures, CMS is proposing that a state-required benefit would not be considered to be an EHB if it:

- Was mandated by the state after December 31, 2011;
- Applies to the small-group and/or individual insurance markets;
- Is specific to required care, treatment, or services; and
- Is not required to comply with federal requirements.

Under this policy, states would be required to defray the cost of such benefit mandates, if they apply to Marketplace health plans, and the cost of such benefits would not be counted towards the premium for purposes of the PTC calculation. Benefits in addition to EHB are also not subject to the ACA's non-discrimination rules, nor would they be applied to the calculation of an enrollee's maximum annual out-of-pocket costs.

CMS asserts that states would not be expected to remove the state-mandated benefits from their EHB-benchmark plans, but if they meet the factors listed above, their inclusion would be considered "null and void" for purposes of determining the EHB-benchmark. States could avoid a defrayal obligation by repealing the mandated benefit, or by exempting Marketplace plans from the coverage requirement.

CMS acknowledges that this proposal will frustrate the efforts of a "small number" of states that have added state-required benefits to their EHB in reliance on CMS' current policy, and under the expectation that those new benefits would not need to be defrayed. CMS asks for states to comment on the administrative costs that would be incurred as a result of implementing this provision, as well as any estimates of what it would cost states to defray state-required benefits that would be considered in addition to EHB if this proposal were finalized.

Reporting of CSR Load/Silver Loading

Marketplace enrollees with income between 100% and 250% FPL are eligible for cost-sharing reductions (CSRs) to lower out-of-pocket costs. After the U.S. Attorney General determined in 2017 that the ACA's permanent appropriation could not fund CSR reimbursements to insurers, insurers began—and many state insurance commissioners required—"loading" qualified health plan premium rates to offset the added expense of unfunded CSR reimbursements. This was done in a variety of ways, most commonly by raising silver plan premiums, called "silver loading." CMS takes note that silver loading increases federal PTC expenditures and, it says, distorts bronze and gold plan premiums. As part of annual rate filing justifications that are submitted to CMS, in most cases via states, CMS instructed insurers to specify the actual CSRs the insurer paid on behalf of enrollees, specify the CSR load and how it was determined, and explain how the additional revenue from the CSR load compares to the expected CSRs provided to enrollees. This proposed rule would greatly expand this information requirement going forward. This information collection, while administratively and financially burdensome to issuers (estimated to cost more than $400 million in the first year), falls short of congressional proposals to appropriate CSRs, which would likely ban silver loading and bring down gross premiums, at the cost of reducing individuals' tax credits.

SBMs and Enhanced Direct Enrollment

In a significant step toward privatizing the Marketplaces, CMS proposes allowing SBMs to forgo offering a centralized, consumer-facing eligibility and enrollment website and instead have enrollments occur through a diffuse system of web brokers. The statutorily mandated SBM websites would be only informational to consumers and act as a back-end intermediary in certain functions, such as in transmitting Marketplace enrollment information to CMS and the IRS and conducting assessment or determinations of eligibility for Medicaid or the Children's Health Insurance Program.

As part of this new option, CMS proposes a new form of SBM, called an SBE-EDE (State-Based Exchange-Enhanced Direct Enrollment, hereinafter SBM-EDE), in which web brokers "serve as the exclusive enrollment pathways" for operating consumer-facing websites facilitating eligibility and enrollment. In order to establish an SBM-EDE, a state would need to ensure that at least one EDE entity selected by the state shows detailed comparative information and allows enrollment in any qualified health plan. With few exceptions, existing web brokers typically enroll consumers only in plans for which they are paid commissions or, in the case of a web broker website operated on behalf of an insurer, in their own plans. Other plans must be displayed with a disclaimer that they are available for purchase elsewhere. While the state's website would display links to authorized brokers, consumers would largely be responsible for finding the websites that offer legitimate Marketplace plans and those selling other products, such as short-term, limited duration plans or other non-ACA compliant plans.

CMS proposes oversight of SBM-EDEs consistent with that of current SBMs. States would need to comply with the existing 15-month approval process, the standard SBM compliance monitoring process, and could receive technical assistance from CMS. While program integrity and broker fraud feature prominently in other sections of this proposed rule, CMS does not address any heightened concern with broker fraud here.

This is a marked turn away from the statutory interpretation to-date but is not entirely unprecedented. In 2020, CMS approved Georgia's Section 1332 waiver proposing a very similar model of Marketplace privatization. Under Georgia's model, as here, the state would rely on web brokers (including those driven by health insurers) to serve the entire eligibility and enrollment function. Prior to its implementation, the waiver was suspended by the Biden administration when Georgia failed to supply information requested by CMS on whether the state's plan would meet the statutory guardrail that enrollment would be at least comparable to that in a without-waiver scenario. The state then decided to create an SBM.

Expansion of Catastrophic Plans

Multi-Year Catastrophic Plans

CMS proposes to permit insurers to offer multi-year catastrophic health plans, albeit with many open questions about how they would work. Under the ACA, catastrophic plans are required to offer free preventive benefits and three primary care visits pre-deductible, but enrollees are ineligible for PTC, making these plans unpopular. Under this proposal, catastrophic plans could have a term of up to 10 years. These multi-year plans would be permitted to use a value-based insurance design that incentivizes health promoting activities, in contrast to traditional one-year plans in which investments in long-term health promotion do not necessarily have a financial (or health) return in the short-term, according to CMS. The high-deductible plans could have various deductible structures. CMS notes that the annual limitation on cost-sharing could be designed by disease, so that, for example, a plan could single out cancer as a disease that requires treatment that spans multiple years. Deductibles could be based on the annual limitation averaged across five years, or it could be designed so that each month has its own deductible that is one-twelve of the entire plan deductible. CMS also proposes to allow these plans to operate in their own risk pool, in contrast to the ACA's single risk pool requirement.

Hardship Exemptions

The proposed rule codifies and broadens CMS guidance from September 2025 that expands eligibility for catastrophic plans.

Catastrophic plans are Marketplace coverage that imposes high deductibles and does not qualify for the PTC. Under the ACA, catastrophic plans are available only to individuals under age 30, those without an affordable offer of coverage, and those who qualify for a hardship exemption. Eligibility for hardship exemptions is determined by CMS in all but four states: California, Connecticut, the District of Columbia, and Maryland. In September of 2025, CMS released guidance providing that it would categorically

provide hardship exemptions to individuals with incomes under 100% FPL and over 250% FPL (and therefore ineligible for CSRs). CMS now proposes to require the four states that determine eligibility for themselves to do the same.

Higher Cost-Sharing for Bronze and Catastrophic Plans

CMS proposes to allow bronze and catastrophic plans to raise their cost-sharing above the statutory maximum out-of-pocket (MOOP) limitations. In essence, health costs are rising at a higher rate than plans can absorb without increasing their actuarial value (AV) standards. Even with some leeway in AV standards, catastrophic plans' AV is approaching bronze level and bronze level is approaching silver level. CMS cites this as an "inherent and unavoidable issue" that will soon "make issuer compliance with all these provisions mathematically impossible" at catastrophic, bronze, and even silver levels. To reconcile the ACA's requirement to meet the prescribed AV and the MOOP, CMS argues that the most reasonable statutory reading is for plans to meet the AV standards, even if it means not meeting the MOOP.

The solution CMS proposes is to allow bronze plans to raise their cost-sharing above the MOOP such that they can comply with existing de minimis variation (as low as 56% of expected costs paid by the plan or as high as 62% for a plan that does not cover unrequired services pre-deductible or 65% for bronze plans that do). The insurer must also offer at least one bronze plan in the individual market with a cost-sharing design that does not exceed the MOOP and complies with the existing de minimis variation.

Catastrophic plans would be prohibited from covering additional services beyond the statutory three primary care visits and free preventive care until cost-sharing of 130% of MOOP was reached ($15,400 in PY 2027). CMS believes this would appeal to healthier consumers who would be more motivated to accept a lower-premium catastrophic plan over a bronze plan.

Encouraging the Use of "Non-Network Plans"

CMS is proposing to encourage the certification and use of "non-network" health plans, arguing that such plans incentivize consumers to be more active shoppers for healthcare services and negotiate directly with providers, allowing these health plans to offer lower premiums and thereby reducing federal PTC spending. A non-network plan, by definition, does not maintain a network of contracted providers who agree to accept the plan's payment for services as payment in full. Instead, non-network plans determine what they will pay for services; if a provider wishes to be paid more than that amount, the plan enrollee is financially responsible for paying the balance.

In its 2024 NBPP, CMS required all Marketplace plans to use a network of providers, in part because there was no mechanism by which to ensure that a non-network plan could maintain a "sufficient choice of providers" to meet required network adequacy standards. In this proposed rule, CMS reverses that stance, and provides a framework under which non-network plans could be certified, marketed, and sold to consumers via the Marketplaces.

Under the proposed framework, if a non-network plan can demonstrate that it has a sufficient number of providers, including ECPs and behavioral health providers, that will accept its payment amount as payment in full, then it would satisfy network adequacy requirements. The proposal would allow FFM states to conduct reviews of non-network plans, if they maintain an Effective Provider Access Review and/or an Effective ECP Review Program.

To demonstrate that they meet the certification requirements, non-network plans would be required to report the following information to the FFM:

- The assessed percentage of available providers within the plan's service area that accept the plan's payment amount as payment in full; for ECPs, whether the plan has at least 20% of available ECPs accepting the plan's payment as payment in full;
- For ECPs, whether the plan offers the payment amount as payment in full to at least one ECP in each of the eight ECP categories, per county in the plan's service area;
- For ECPs, whether the non-network plan offers the payment amount as payment in full to all available Indian healthcare providers in the plan's service area;
- The plan's strategy for conducting "continuous" outreach to available providers to determine whether they would accept the plan's benefit amount as payment in full;
- The plan's strategy for making payment amounts available to the public, including plan enrollees, potential enrollees, and providers, in an easily accessible and understandable format;
- The plan's methodology for determining benefit amounts;
- The plan's strategy for providing consumer-facing information about potential balance billing scenarios and expected out-of-pocket costs;
- The availability of an exceptions process for enrollees who cannot find providers willing to accept the payment amount as payment in full; and
- The strategy for providing an adequate customer service or online provider directory assistance resource to help enrollees and potential enrollees to find providers who will accept the plan's payment amount as payment in full.

CMS notes that non-network plans would also need to satisfy EHB coverage requirements, although the agency does not address how, exactly, plan enrollees' out-of-pocket costs for services effectively delivered "out-of-network" would be calculated towards their deductibles or the annual maximum out-of-pocket limit. The agency also notes that such plans would be expected to participate in the ACA's risk adjustment program, though without contractual relationships with providers, they would likely have difficulty obtaining enrollee medical records, a requirement of the risk adjustment program.

Under the proposal, FFM states with Effective Provider Access Review Programs would have to conduct provider access certification reviews for both network and non-network plans, if they certify both types of plans. If an FFM state notifies CMS that it chooses not to certify non-network plans, then the agency warns that it would have to assess whether the state can be considered to have an Effective Provider Access Review Program. States in the FFM that choose to certify non-network plans would need to have

a process and timeline for doing so, and have the authority and capacity to assess whether the non-network plan has a sufficient choice of providers willing to accept the plan's payment as payment in full.

CMS is seeking comment from states on what, if any, requirements states currently have to ensure that non-network plans provide reasonable and timely access to providers, and for information about states' experiences conducting reviews of non-network plans.

Other Provisions

New Requirements for Marketplace Brokers and Marketing Restrictions

The proposed rule would require agents, brokers, and web-brokers (referred to here collectively as "brokers") in the FFM to use a CMS-created and approved consumer consent form for all Marketplace enrollments. The agency has found numerous instances in which required documentation of consumer consent is not provided or missing required information. Further, the agency would require brokers to show that their clients have reviewed and approved their application information as accurate, through either: a hand-written or electronic written signature or initials; an email from the consumer or consumer's authorized representative; a recorded verbal conversation; or other clear and verifiable means. This latter requirement codifies CMS guidance provided to brokers in 2024.

The proposed NBPP also lists certain marketing practices that would be prohibited for brokers in the FFM. Many of these practices are the most common misleading advertising types that CMS has found on social media platforms. Specifically, brokers would be prohibited from:

- Offering consumers gifts unless they are not cash or cash-equivalents, of nominal value, and offered regardless of whether or not they enroll;
- Falsely asserting or suggesting that consumers could qualify for zero-premium plans;
- Miscommunicating enrollment timelines and deadlines;
- Misconstruing legislation, regulations, or executive orders;
- Using images, likenesses, or quotes from notable figures to suggest that the figure has endorsed the broker or broker agency, when there has been no such endorsement.

The agency believes that many of these marketing prohibitions are already prohibited under state law, and emphasizes that they do not intend to supersede state laws in this area. CMS would inform state regulators about brokers who are terminated because they violate the marketing restrictions.

User Fees for the FFM and SBMs-FP

CMS proposes to maintain the same user fees in 2027 that are in place for PY 2026. Specifically, the proposed rule includes a 2027 user fee rate of 2.5% for the FFM and 2% for the SBM-FP.

HHS Audits, Civil Monetary Penalties, Administrative Law Judge Subpoenas, and the Netting of Payments

The proposed rule creates extensive new rules creating a regime for measuring improper APTC payments, correcting errors, and penalizing non-compliant issuers. Of greatest relevance to state officials, the rules require SBMs to submit "detailed" and "comprehensive" information to permit CMS to produce an estimate of improper payments through SBMs. This includes detailed program documentation concerning business rules and APTC calculations for enrollment and eligibility processes, details about the SBM's data system architecture of the State Exchange, a listing of all tax households that received APTC payments for the respective plan year, and–for the subset of these tax households chosen as the sample–comprehensive information relevant to eligibility, enrollment, APTC, and any documentation submitted. The proposal also includes rules about sampling, timing, appeals, payment error calculations, corrective action plans, and sanctions for failure to comply. Finally, the proposal permits SBMs to satisfy existing annual independent external programmatic audit requirements by completing the proposed required annual State Exchange Improper Payment Measurement (SEIPM) program process.

The proposed rule also clarifies and strengthens rules under which CMS can audit insurers' compliance with requirements related to the APTC, CSR, and user fee programs, including in the SBMs. The proposed rule clarifies rules for imposing civil monetary penalties on insurers, including rules for review by administrative judges and rules for netting penalties against ongoing payments. CMS estimates this will cost SBMs $1.1 million annually.

Request for Comment on the Medical Loss Ratio

CMS is seeking comment on how the ACA's medical loss ratio (MLR) standard has affected individual market stability and its impact on healthcare costs and premiums. The agency signals that this request for comment may be a precursor to regulatory changes. In particular, the proposed rule notes that the ACA gives CMS the authority to adjust the 80% individual market MLR in a state if it determines that the application of the MLR standard will destabilize the individual market in that state. Of note, CMS seeks comment on whether and how it should amend the current regulations to allow for an adjustment to the MLR standard in states that do not request it. For example, CMS asks for comment on whether CMS should "consult" with the state and/or provide an opportunity for public comment on a potential MLR adjustment in a state, in the absence of a state-initiated request; how to resolve disagreements between CMS and states over whether an MLR adjustment would help stabilize the market; the size of the adjustment; and whether CMS should publish the data and analyses that led to its determination that an adjustment was needed.

CMS also is considering whether to allow states to request an MLR adjustment for up to five years, instead of the current three-year limit, and whether to reduce the data submission requirements and modify the criteria CMS uses to assess a state's request for an adjustment to "reduce administrative burden" for states.

Support for this issue brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is a leading national philanthropy dedicated to taking bold leaps to transform health in our lifetime. Through funding, convening, advocacy, and evidence-building, we work side-by-side with communities, practitioners, and institutions to get to health equity faster and pave the way together to a future where health is no longer a privilege, but a right.
RWJF believes that achieving strong, lasting connections across the healthcare, public health, and social services systems helps build healthier and more equitable communities that provide everyone a fair and just opportunity for health and wellbeing.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT GEORGETOWN CHIR

The Center on Health Insurance Reforms (CHIR) is an independent policy and research center at Georgetown University's McCourt School of Public Policy. Through real-world research, policy analysis and practical advice, CHIR guides state and federal policymakers in advancing evidence-based solutions that strengthen health insurance, increase affordability and improve access to care. Learn more at chir.georgetown.edu.

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit research organization that provides evidence and technical assistance to help improve policy decisions and support upward mobility and equity. The Urban Institute has been a source of rigorous analysis of complex economic social and economic policy issues for more than 50 years. For nearly 40 years, researchers from Urban's Health Policy Division have analyzed the country's healthcare system and helped lawmakers understand how health policies affect lives.

ABOUT MANATT HEALTH

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit https://www.manatt.com/health.