



Proposed 2027 Notice of Benefit & Payment Parameters: Key Considerations for States

February 27, 2026

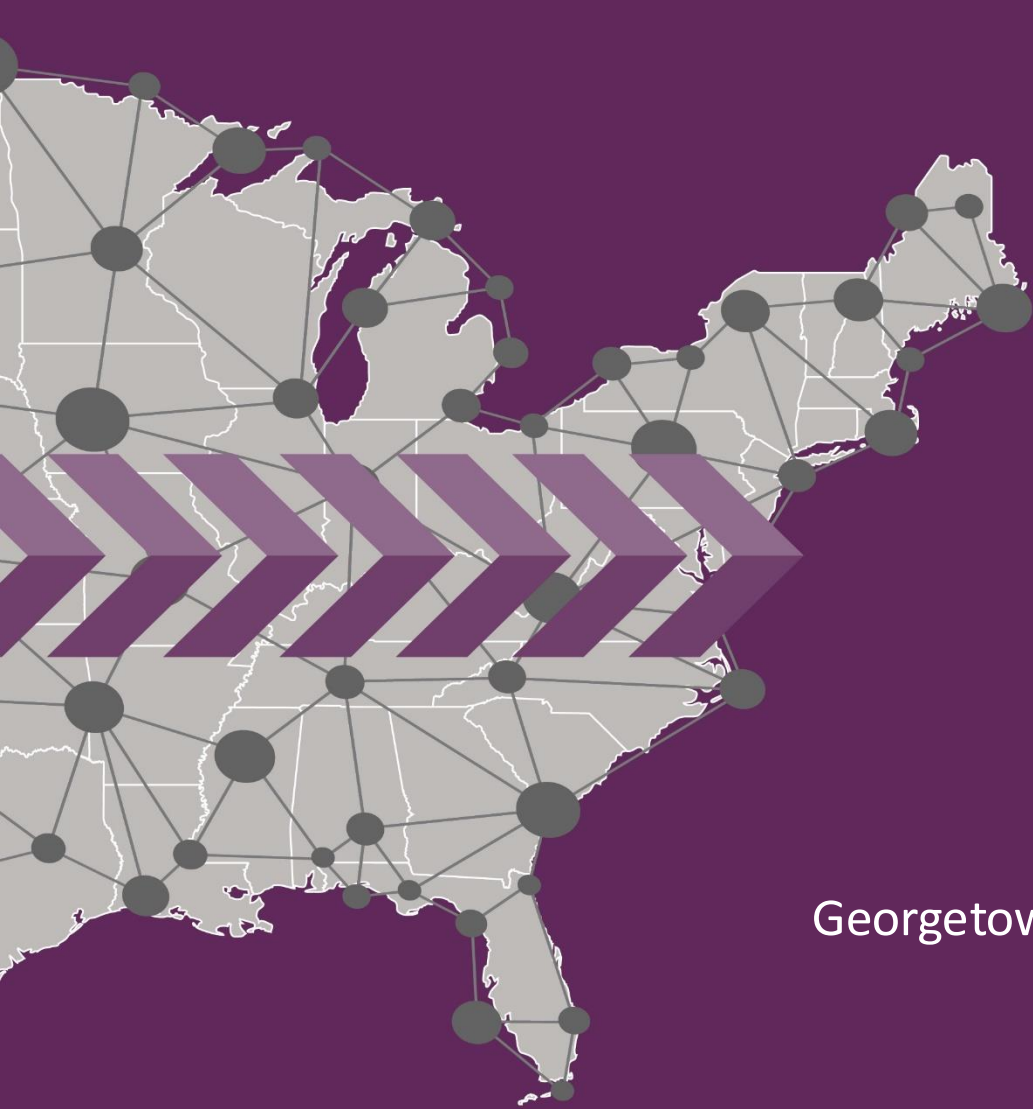
12:30 to 1:30 p.m. ET

Please stand by, this webinar will begin shortly

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Proposed 2027 Notice of Benefit & Payment Parameters: Key Considerations for States

Manatt Health
The Urban Institute
Georgetown Center on Health Insurance Reforms

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Questions? Email Heather Howard at heatherh@princeton.edu.

*Support for this webinar was provided by the Robert Wood Johnson Foundation.
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- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- A copy of the webinar transcript is available upon request. Please **contact us** to request a copy.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org**.

Agenda

- **Welcome**
- **Background & Key Themes for Policies in the 2027 Notice of Benefit and Payment Parameters Proposed Rule**
- **Provisions Implementing H.R.1**
- **Provisions Reversing Current Policies and Insurance Standards**
- **Provisions Revisiting the Marketplace Integrity Final Rule**
- **New Policy Proposals & Other Provisions**
- **Looking Ahead / Closing**

Key Themes for Policies in the 2027 NBPP



**Provisions
Implementing H.R.1**



**Provisions Reversing Current
Policies and Insurance
Standards**



**Provisions Revisiting the
Marketplace Program Integrity
Final Rule**



New Policy Proposals



Provisions Implementing H.R.1

Narrowing Premium Tax Credit (PTC) Eligibility for Non-Citizens

H.R.1 significantly narrowed the categories of non-citizens who are eligible for PTCs and cost-sharing reductions (CSRs) in the Marketplaces, beginning in Plan Year (PY) 2027, and the proposed rule makes conforming amendments to implement this.

- **Reminder:** Financial help became limited to lawful permanent residents (LPRs, or green card holders), Cuban-Haitian entrants, or Compacts of Free Association (COFA) migrants.
- Corresponding with H.R.1, the proposal eliminates PTC eligibility for non-citizens who: **1) have income below 100% of the Federal Poverty Level (FPL)** (in 2026), and **2) have income above 100% FPL and are not within the immigration statuses listed above** (in 2027).
- Would require Marketplaces to **verify eligible non-citizens' immigration status using the Department of Homeland Security's "Systematic Alien Verification for Entitlement" program.**



States with a Basic Health Program (BHP) are required to cover all lawfully present non-citizens, including those with income under 100% FPL. However, for those under 100% FPL in 2026, the BHP formula would reflect PTC of \$0 attributed to their enrollment. In [guidance](#) released on December 10, CMS indicated it will use enforcement discretion to permit BHP states to not cover non-citizens with income under 100% FPL for three years (through December 31, 2028).

Elimination of the Low-Income Special Enrollment Period (SEP)

The proposed rule implements the H.R.1. provision eliminating SEPs based solely on income.

- Proposes to **prohibit all Marketplaces—Federally-Facilitated Marketplaces (FFM) and State-Based Marketplaces (SBMs)—from paying advance premium tax credits (APTC) to individuals that enroll in a plan through an SEP in which the triggering event is based *solely* on income, as provided in H.R.1.**
- **Reminder:** H.R.1's provision prohibiting the expenditure of tax credits for coverage obtained through an income-based SEP became effective on January 1, 2026.





Provisions Reversing Current Policies and Insurance Standards

Changes to Defrayal Policies for State-Mandated Benefits

Under the ACA, individual and small-group market insurers must cover a minimum set of 10 categories of Essential Health Benefits (EHB).

- **Exclusions of State-Mandated Benefits from EHB.** Provision would consider state-mandated benefits, enacted after 2011, to be in addition to EHB, even if already embedded in a state's EHB-benchmark plan, and therefore not included in the benefits eligible for APTC.

 If finalized, states would need to repeal its mandate or exempt Marketplace plans to avoid a defrayal obligation.

 CMS is seeking comments on whether to delay this change to PY 2028, the administrative costs incurred from this policy, and estimates of what it would cost states to defray state-required benefits if it's finalized.

- **Pause on EHB Benchmark Applications.** CMS has paused review of state applications to update EHB benchmark plans while it conducts a broader review of the ACA's EHB provisions and related regulatory standards.
- **Eliminating Coverage of Routine Adult Dental Services.** Proposes to prohibit issuers from treating routine non-pediatric dental services as EHB, even if those services are included in a state's EHB benchmark plan.

Relaxing/Removing Federal Time and Distance Network Adequacy Requirements

CMS currently has federal time and distance standards for the FFM to ensure provider networks translate into meaningful access for enrollees. The PY 2025 NBPP required SBMs and SBMs on the federal Marketplace platform (SBM-FP) to impose network adequacy standards at least as stringent as the FFM's and conduct related quantitative compliance reviews starting in PY 2026.

- The rule proposes these changes to federal time and distance network adequacy standard:
 - Proposes to **remove the requirement that SBM and SBM-FPs** meet or exceed the federal standard.
 - Proposes to **keep federal time and distance and appointment wait-time standards only in states that do not operate an approved Effective Provider Access Review Program.**

Increased State Flexibility for Plan Network Adequacy Standards and Oversight

The proposed rule seeks to grant states greater opportunity to set standards for and to review Marketplace plans' network adequacy.

- *[For FFM states only]* Would **replace the current CMS oversight framework with a process that largely defers to states** so long as they have a, newly created, “Effective Provider Access Review Program.” *(See Appendix for CMS Criteria for an Effective Provider Access Review Program.)*
 - CMS would continue to conduct network adequacy reviews for FFM states that do not have the authority or capacity to maintain an Effective Provider Access Review Program.



CMS is seeking comments on the level of transparency and public reporting necessary to “safeguard public trust” in an Effective Provider Access Review Program.

Relaxing Essential Community Provider (ECP) Minimum Contracting Standards

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.

- *[For FFM states only]* Proposes to **reduce the overall ECP contracting threshold and contracting thresholds for FQHCs and family planning services from 35% to 20% of available providers within a service area** beginning PY 2027 for Marketplace plans and standalone dental plans.
- Would **remove the requirement that insurers who do not meet the contracting threshold provide justification for, and documentation of, their efforts to contract with ECPs in their service areas.**
- Seeks to **delegate reviews of compliance with ECP standards to FFM states** that can demonstrate that they have an "Effective Essential Community Provider Review Program." (*See Appendix for CMS Criteria for an Effective Provider Access Review Program.*)

Eliminating Federal Standardized Plans



Eliminating Standardized Plans and Plan Limits *[For FFM States Only]*

- Proposes to **discontinue standardized plans currently designed by CMS and available on the FFM.**
- Seeks to **remove restrictions on the number of non-standardized plan options an insurer may 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.”
- **SBMs may continue to require insurers to offer standardized plans.**

Loosened Requirements for States Transitioning to a State-Based Marketplace

The proposed rule seeks to eliminate two procedural requirements from the 2025 NBPP regarding states seeking to establish an SBM.

1. Proposes to eliminate the requirement that a **state use an SBM-FP for one year prior to becoming a full SBM.**

The transition year was originally required to ensure readiness to perform all SBM functions except for the application interface before full functionality.

2. Proposes to **eliminate the regulatory language** requiring transitioning states to provide, upon request, all supporting and supplemental documentation of its readiness to CMS.

CMS notes removing this language will have little impact, as states are still required to provide such information upon request under the terms of the Blueprint for establishing an SBM.



Provisions Revisiting the Marketplace Integrity Final Rule

New Income Verification Requirements

The rule would permanently impose new paperwork requirements for consumers whose income cannot be verified using federal data sources, imposing new administrative burdens that would be especially harmful when H.R.1 provisions take effect in 2028.



Income Verification Requirements

- Would require Marketplaces to **flag a “data matching issue” (DMI) and request additional information from consumers if:**
 1. A consumer attests to income at or above 100% FPL but federal data sources suggest income below 100% FPL, and/or,
 2. Federal tax information on the consumer is unavailable (which is very common)
- CMS estimates this **would add about 3.3 million DMIs per year.** That may be an underestimate.

Interaction with H.R.1 provisions

- Starting in 2028, H.R.1 generally **denies APTC to applicants while the Marketplace makes a final eligibility determination**, which often takes months in the case of a DMI.
- As a result, this provision **could deny millions of people APTC for several months.**

Loss of APTC Eligibility Due to Failure to File and Reconcile Status

The proposed rule moves to impose “failure to reconcile” (FTR) rules in 2027, notwithstanding a recent court opinion finding no statutory basis for such rules.

- FTR rules deny APTC to consumers who received APTC for prior years and failed to file a tax return to reconcile the APTC with the PTC they are due based on their actual income.
 - This penalty is in addition to the Internal Revenue Services' (IRS) normal enforcement procedures.
 - FTR rules were created by regulation and do not appear in statute.
 - FTR rules raise concerns due to IRS processing backlogs and since the Marketplace may not discuss FTR status with applicants, even when denying APTC on that basis.
- For 2027, the rule would **require SBMs to choose** to deny APTC after consumers fail to reconcile APTC for either one year or two years. The **FFM would use the one-year rule**.
- The U.S. District Court in *City of Columbus v. Kennedy* made a preliminary determination that there is no legal basis for either FTR rule, since eligibility is set by statute.
- The rule also implements H.R.1’s provision that effectively **imposes the one-year rule in 2028 and beyond**.

Additional Provisions Revisiting the Marketplace Integrity Final Rule



Reducing Flexibility in Cases of De Minimis Non-Payment of Premiums

- The 2026 NBPP created additional options for insurers to permit consumers to retain coverage when they under-pay premiums by a de minimis amount.
 - For example, insurers could establish a fixed-dollar threshold of up to \$10.
- The Integrity Rule delayed the effective date of these options until 2027.
- CMS requests comment on permanently eliminating these options.



CMS also seeks comment on whether SBMs should have flexibility to adopt additional premium thresholds, even if the FFM does not.




Verification of Special Enrollment Period (SEP) Eligibility [For FFM States Only]


- Proposes **permanently expanding the verification requirement for SEPs in the FFM.**
- Would extend the verification requirement to additional SEP-triggering events and also require verification for at least 75% of SEPs.
- This revisits a provision in the Integrity Rule that never went into effect because the U.S. District Court stayed implementation in *City of Columbus v. Kennedy*.

2027 Coverage Parameters

On January 29, CMS released its annual guidance with key ACA parameters for 2027, showing large increases in the caps on out-of-pocket spending and deductibles.

- Several ACA parameters are adjusted each year based on a measure of premium growth:
 - The maximum annual limitation on out-of-pocket spending (**MOOP**).
 - The payment amounts under the ACA's **employer shared responsibility provisions**.
 - The **affordability percentage** used to determine eligibility for catastrophic coverage.
- The Integrity Rule **revised the indexing rules** starting in 2026, raising these parameters.
- Under the new guidance, **MOOPs increased about 13%: from \$10,600 in 2026 to \$12,000 in 2027** (double those amounts for families).
 - The MOOP applies to **both individual and employer-sponsored** health coverage.
 - The MOOP acts as a cap on deductibles; catastrophic plan deductibles are set at the MOOP.

 The MOOP potentially affects about 180 million people.

 Key PTC parameters are generally, but not always, adjusted using the same rules. The IRS will announce the 2027 PTC parameters this summer.

Expanded Oversight from the U.S. Department of Health and Human Services (HHS)

The proposed rule includes policies that greatly expand HHS' program oversight authority in the Marketplaces.



State Improper Payments. Proposes to require SBMs to submit detailed information for all tax households receiving APTC and more comprehensive individual-level data for each household CMS chooses to sample for accuracy. CMS would use this data to estimate the SBM's total improper payment rate. Identified errors would be corrected through a corrective action plan.



Increased Audit Authority. Proposed to expand CMS' audit authority to encompass all requirements related to the administration of APTC, CSRs, and user fee programs, and clarifies that it *may* audit issuer compliance in all Marketplaces.



Clarifying Civil Monetary Payment (CMP) Authority. CMS has existing authority to impose CMPs on qualified health plan (QHP) issuers that violate Marketplace requirements, up to \$100 per day, per affected individual. The rule proposes to clarify how it determines CMP amounts and clarifies CMS' authority to impose CMPs on issuers in SBMs and SBM-FPs when a state notifies or CMS determines that the state is not substantially enforcing requirements.



New Policy Proposals

New Option for SBMs Relying Exclusively on Private Brokers

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.

- Proposes allowing SBMs the option to become a **State-Based Exchange-Enhanced Direct Enrollment (SBE-EDE)** in which web brokers “serve as the exclusive enrollment pathways” for operating consumer-facing websites facilitating eligibility and enrollment.

The previous administration suspended a waiver proposal from Georgia with similar features.

- **At least one EDE-entity selected by a state** would need to show detailed comparative information and allow enrollment into any QHP to establish an SBM-EDE.
- Oversight of SBM-EDEs would be **consistent with current SBM standards**.

Reporting on Silver Loading Practices

CMS proposes to greatly expand information collection about silver loading while emphasizing that it must reflect actual experience.

- The proposed rule requires **issuers to provide substantial additional information sharing** to CMS about the costs of CSRs, silver loading practices, and effects on subsidy spending.
- CMS explains that “an actuarially justified CSR load factor is one that is **calibrated on actual experience** and that only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount.”
- CMS estimates **over \$400 million in implementation costs for issuers for the first year alone, and \$200 million per year after that.**



This information collection, while administratively and financially burdensome to issuers, falls short of congressional proposals to appropriate CSRs, but does suggest CMS could seek to limit state silver loading methodology.

Expansion of Catastrophic Plans

CMS proposes to greatly expand catastrophic health plan options in the Marketplace.




Hardship Exemptions. Proposes to codify the expansion of hardship exemption eligibility to individuals who are ineligible for APTC or CSR due to projected household income below 100% or above 250% FPL in all states (in alignment with CMS' September 2025 [guidance](#), which the proposed rule seeks to codify).




Multi-Year Catastrophic Plans. Proposes to permit insurers the option to offer catastrophic health plans of up to 10 years with additional allowances for MOOP and deductible averaging over years and allowances for "value-based" design.

Higher Cost-Sharing for Bronze and Catastrophic Plans

- Proposes to allow **bronze and catastrophic plans to raise their cost-sharing above the statutory MOOP** limitations.
- CMS argues that the **change is necessary to meet required actuarial value standards as healthcare costs increase**.
- 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.
- CMS proposes that **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)**.


 This proposal reinterprets the ACA requirement that plans meet both actuarial value (AV) and MOOP, raising the risk of litigation.

 CMS requests comment on key implementation issues, including effects on risk adjustment, appropriate cost-sharing thresholds, whether limits on exceptions should apply, and whether the MOOP calculation methodology should be updated.

Permitting the Use of “Non-Network Plans”

The proposed rule seeks to encourage the certification and use of “non-network” health plans, asserting they promote active consumer shopping and direct price negotiation with providers, allowing for lower premiums and reduced federal PTC spending.

- Proposes a **framework where non-network health plans may become certified, marketed, and sold to consumers via the Marketplaces.**
- Under the framework, a non-network plan **may satisfy network adequacy requirements if it 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.**
- 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, nor how such plans would satisfy preventive services coverage requirements or No Surprises Act protections.

 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

Request for Comment on the Medical Loss Ratio (MLR)

CMS identifies a variety of questions and policy focus areas for comment in the proposed rule, including a request for comment on the ACA's MLR standard.

- CMS is seeking comment on the ACA's MLR standard with a particular focus on how the MLR standard has:
 1. Affected **individual market stability**;
 2. Impacted **healthcare costs** and **premiums**;
 3. Whether and how CMS **should amend current regulations to allow an adjustment to the MLR standard in states that do not request it**; and,
 4. *[In connection to the proposal for multi-year catastrophic plans]* **how these potential plans should be treated for the purposes of MLR rules.**
- CMS also seeks comment on 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 data submission requirements and modify CMS criteria for assessing a state's adjustment requests to reduce state administrative burden.

 CMS signaled in the proposed rule that this request for comment may be a precursor to future regulatory change.

Other Provisions



New Requirements for Marketplace Brokers and Marketplace Restrictions

- The proposed rule would require agents, brokers, and web-brokers in the FFM to **use a CMS-created and approved consumer consent form for all Marketplace enrollments.**
- Seeks to **prohibit the following marketing practices in the FFM:**
 - 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, likeness, or quotes from notable figures to suggest that the figure has endorsed the broker or broker agency, when there has been no such endorsement.



FFM and SBMs-FP User Fees

- 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.**

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Looking Ahead

Comments are due March 13, 2026.

Q&A

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You & Closing

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Appendix

Increased State Flexibility for Plan Network Adequacy Standards and Oversight: Effective Provider Access Review Program Criteria

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.)*

Relaxing Essential Community Provider (ECP) Minimum Contracting Standards: Effective Provider Access Review Program Criteria

To determine whether an FFM state 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.