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2027 Proposed NBPP: Analyzing State and Consumer Impacts

New and Returned Trump Administration Policy Priorities

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INTRODUCTION AND SUMMARY

On February 9, 2026, the US Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027. The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2027 and beyond. This paper summarizes key provisions in the proposed notice with a focus on the major changes to plan types, cost-sharing, network design and oversight, Marketplace philosophy, and the shift of responsibilities from the federal government to states. It also evaluates any changes to returning policies from the Marketplace Affordability and Integrity rule from last year, which are now being challenged in court, and codifies relevant statutory changes in the Budget Reconciliation Act (P.L. 119-21, OBBBA).

This paper reviews the potential effect of these proposed policies on consumer affordability and access as well as the impact and associated level of effort on state regulators and Marketplaces. It also touches on policies not included in this rule, including those highlighted as issues that may be or will be addressed in rulemaking, as well as issues not covered in this proposed rule, such as revisions to the section 1332 waiver process and on how states could explore and pursue a 1333 interstate compact. Comments are due no later than March 13, 2026.

OVERVIEW OF PLAN TYPE CHANGES

The proposed rule introduces several new plan design requirements and flexibilities. These changes would expand the availability and duration of catastrophic plans, prioritize lower premium products, allow issuers to exceed standard out-of-pocket cost-sharing maxima for on certain products and removes certain Biden-era policies, including standard plans and associated plan limits, as well as the ability for states to include adult dental in their essential health benefit (EHB) plans.

Catastrophic Eligibility and Availability Changes

The HHS Centers for Medicare & Medicaid Services (CMS) proposes to formally adopt the catastrophic plan eligibility criteria published in sub-regulatory guidance[1] to expand the availability of catastrophic plans to more populations. Until this change last fall, catastrophic plans were available only to individuals 30 years old and younger or who had a hardship exemption, such as people who were experiencing homelessness, eviction or foreclosure, domestic violence, a natural disaster, bankruptcy, or other financial or personal circumstances that prevented them from obtaining coverage. This change codifies the guidance allowing individuals 30 or older to enroll in catastrophic plans through a hardship exemption if they meet the following criteria:

- Their household income is below 100% of the federal poverty level (FPL), making them ineligible for advance premium tax credit (APTCs) and cost-sharing reductions (CSRs), which, starting in 2026, includes lawfully present immigrants ineligible for Medicaid because they have lived in the country for fewer than five years.
- Their household income is above 250% of FPL and they are ineligible for CSRs, which includes all applicants with those income levels except for Native Americans and Alaska Natives.

The proposal also requires this hardship exemption to be offered in all states, including California, Washington, Maryland, and the District of Columbia, which do not defer exemption processing to the federal government.

CMS also proposes changes to the design and duration of the policy period for catastrophic plans. Starting in 2027, issuers will be able to offer catastrophic plans for multiyear periods. Issuers can continue to offer 1-year policies, or any multiple of years, up to and including ten years. Issuers are encouraged to incentivize take-up and continuity of enrollment in these multiyear catastrophic plans through "value-based" plan designs and alternative approaches to cost-sharing. CMS believes that consumers enrolled in catastrophic plans over a longer time horizon will allow issuers to better manage their health which will improve outcomes and save money. The rule encourages creative thinking on plan design, suggesting that additional preventive benefits could be covered before the maximum cost-sharing limit is reached.

[1] Centers for Medicare & Medicaid Services. Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage. September 4, 2025. Available at: https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf.

The rule also opens the possibility of alternative cost-sharing approaches with disease-based, or monthly caps, on cost-sharing. The goal behind these proposals would be to give issuers flexibility to comply with different maximum cost-sharing requirements. How this approach would function in a multiyear plan is an open question on which CMS will certainly receive feedback, including requests for clarifications and more detailed parameters. CMS acknowledges that expanded catastrophic enrollment and multiyear plan terms raise new risk-mix and payment concerns and seeks comments on whether changes to risk-adjustment model calibration or treatment of catastrophic plans may be warranted in the future. Expanded catastrophic enrollment could affect the individual market risk pool, resulting in higher premiums for consumers; without an understanding of the risk-adjustment impact, these effects become even more unclear.

Changes in Catastrophic and Bronze Cost Sharing

To foster and enable lower actuarial value of catastrophic and bronze-level plans, the proposed rule provides flexibility for issuers to exceed the cost-sharing maxima for both plan types. For catastrophic plans, the proposal is to allow issuers to design plans with caps on out-of-pocket spending up to 130% of the allowable limitation on cost sharing, rounded to the next lowest multiple of $50. This approach would allow for catastrophic plans with out-of-pocket spending caps of more than $13,000 for an individual and over $27,000 for a family plan. Although catastrophic plans have no specific actuarial value (AV) targets, the proposal explains that the intent of going up to 130% of the allowable cost-sharing limit is to achieve an AV of 55%.

For bronze plans, the proposal allows for maximum out-of-pocket spending to exceed the allowable limitation on cost sharing for bronze plans up to the point where the plan would fall out of the AV de minimus range, which is now 58% on the low-end, and would be 56% if the policy change in the Marketplace Affordability and Integrity rule of 2025 were not currently under a legal stay in a court challenge. Issuers who elect to offer these higher cost-sharing bronze plans would also be required to offer bronze plans that remain within the allowable limitation on cost sharing.

Elimination of Standard Plans in the Marketplace

The proposed rule changes course on CMS's multiyear effort to move toward standardization in plan options and simplified plan display and decision support through the Marketplace (Healthcare.gov). CMS and many state-based Marketplaces (SBMs) have used standard plans in recent years to address concerns about their proliferation, driven by increased competition, resulting in consumer "choice paralysis."

Over the past several years, issuers have been required to comply with Healthcare.gov standard plan design requirements on benefit cost-sharing, including requirements regarding which benefits may be subject to the deductible as well as benefits required to be subject to a copayment, a fixed dollar amount, and not coinsurance, a percentage of the cost of the relevant healthcare service, which can fluctuate dramatically and is more difficult for consumers to calculate or understand.

In coordination with standard plan requirements, CMS has also sought to limit the number of non-standard plans issuers offer through Healthcare.gov. These limits were at the plan type level and in 2024 allowed for a maximum of four non-standard plans, down to two non-standard plans in 2025 and 2026. Issuers could also receive exceptions to offer additional plans if they met certain criteria.

CMS argues that the goal of mitigating plan proliferation and addressing choice paralysis has yet to be realized among standard plans and points to data showing that the number of plan options has remained static because of the number of standard plans and consumer enrollment in these plans, compared with non-standard plans, have fallen short of expectations. CMS also asserts that standard plans stifle plan design innovation and for this reason and those previously stated finds they should no longer be required.

The proposal removes standard plan design requirements as well as the plan limit requirements starting in 2027. Issuers are able to continue offering these plans, but the proposal removes the requirement that they do so, as well as the associated Healthcare.gov plan display and decision support tools specific to the standard plan options.

Adult Dental EHB Reversal

he proposed rule rescinds the policy change in the 2025 NBPP that allowed states to include adult dental as a benefit required to be covered under EHB starting in plan year (PY) 2027. This change had allowed states to revise their benchmark EHB plans to cover adult dental benefits, which would have allowed adults to access dental benefits as a part of the benefits package of all plans available through the state and, importantly, to apply Marketplace subsidies toward the cost, which has historically been unavailable for non-EHB benefits. Several states had been exploring an EHB change to add adult dental to their benchmark plans and CMS halted review of EHB applications last year. Given that no state implemented this EHB change, none will have to revise the EHB benchmark plan to remove adult dental as a covered benefit.

IMPLICATIONS

Consumers

Although it is unclear at this time how aggressively issuers will pursue alternative plan types, such as multiyear catastrophic plans, for 2027, consumers shopping for plans during the open enrollment period may be faced with additional bronze and catastrophic plan options. Understanding the cost of the plans, and specifically the cost of using these plans to access and pay for healthcare, will be critically important for consumers as the number of plans with higher out-of-pocket maxima may be higher in 2027. The ability of Marketplace applicants to qualify for and access catastrophic plans will be easier in 2027 because the guidance issued last fall was too late for Marketplaces, including Healthcare.gov, to operationalize in a consumer-friendly way. The ability of consumers to access and enroll in catastrophic plans will be much simpler and as a result and by design, the number of consumers exposed to these lower premium plans that only pay for benefits after the out-of-pocket maximum has been reached will be significantly higher in 2027.

Consumers will lose the ability to filter and sort by standard plan indicators on Healthcare.gov, and to the extent issuers decide to stop offering standard plans in 2027, consumers enrolled in those plans may be mapped to a different plan type in 2027, or may be required to actively select a new plan during open enrollment. Consumers should carefully monitor their options during open enrollment, paying close attention to changes in plan offerings, premium tax credit values, overall premium costs, out-of-pocket spending changes, and any administrative actions necessary to maintain their coverage and financial assistance eligibility.

States and Marketplaces

States will be faced with trying to determine how aggressively to embrace and implement the policies in this proposed rule, many of which will take effect in a few months. Many states will likely wait for the rules to be finalized and court challenges to be worked through before investing too much effort into regulating the new plan options. Marketplace plan certification authority, which includes broad authority to not certify plans that are not in the interest of consumers, may be a tool some SBMs use to not allow the plan flexibilities, multiyear catastrophic, higher out-of-pocket cost plans, non-network plans, proposed in this proposed rule.

States that had previously been pursuing adding adult dental to their EHB benchmark plan will need to forgo and abandon that effort.

OVERVIEW OF NETWORK REFORMS

CMS proposes several major changes to Marketplace network requirements and plan options in the 2027 NBPP, generally reducing federal requirements, deferring more oversight authority to states, and a focus on reducing burden for issuers with potential for less consumer access.

Network Adequacy Standards

First, CMS proposes to eliminate federal quantitative network adequacy standards for SBMs and SBMs on the federal platform (SBM-FP) that are at least as stringent as those used in the federally facilitated Marketplace (FFMs). Instead, the rule would defer primary oversight of provider access to states that conduct effective rate review, while retaining federal essential community provider (ECP) requirements and issuer access attestations. The proposed rule allows the federal government to continue conducting these reviews in states that do not elect to become an Effective Provider Access Review Program, and CMS would continue to collect network adequacy data from issuers in FFM states. The rule does not specify detailed steps for designation but indicates that states would need sufficient legal authority—such as state laws or regulations establishing ECP requirements—and technical capacity to perform these reviews.

Non-Network Plans

Second, CMS proposes to allow non-network plans to be certified as qualified health plans (QHPs) for the first time. These plans would not rely on contracted provider networks, but instead would establish fixed payment amounts for covered services, allowing enrollees to seek care from any provider. Issuers would be required to demonstrate sufficient access to

providers—including ECPs and mental health and substance use disorder providers—who are willing to accept the plan's reimbursement amount as payment in full.

Although this approach could increase plan design flexibility and potentially lower premiums, it could also expose enrollees to balance billing risk if providers decline to accept the plan's payment terms. Under the Biden Administration, CMS denied certification of plans proposed to be offered in Ohio by Sidecar Health based on concerns related to enrollee cost-sharing protections, including compliance with maximum out-of-pocket limits.

Essential Community Provider Standards

In addition, the proposed rule lowers the minimum ECP contracting threshold from 35% to 20% beginning in plan year 2027, including separate lower thresholds for federally qualified health centers and family planning providers. CMS also proposes eliminating the narrative justification requirement for issuers that fall short of the ECP thresholds. This change affects both network and non-network plans by lowering the minimum federal ECP participation standard applicable across Marketplace plan types (Marketplace plans and stand-alone dental plans). The rule notes that many states are already meeting the higher standard. The proposal allows SBMs to enforce higher standards.

State-Led ECP Review

The proposed rule also allows Healthcare.gov states, including states performing plan management functions, to conduct their own reviews of issuer ECP data if they are designated as having an Effective ECP Review Program. States could tailor ECP reviews to their community needs, while CMS would continue to collect ECP data from issuers. The rule does not specify detailed steps for designation but indicates that states would need sufficient legal authority—such as state laws or regulations establishing ECP requirements—and technical capacity to perform these reviews.

For states with an approved Effective ECP Review Program, responsibility would also extend to ensuring that non-network plans applying for QHP certification provide reasonable and timely access to ECPs that accept the plan's payment amount as payment in full. If a state does not establish these programs or is not approved, CMS would continue to operate the ECP review process in that state.

IMPLICATIONS

Consumers

Non-network plans would only affect consumers in states and service areas where issuers seek QHP certification for such products, meaning consumer experience may vary across states. Where offered, these plans could result in lower premiums, but access to providers would depend on a provider's willingness to accept fixed payment amounts. This change could introduce variability in care access and potential balance billing exposure, particularly for consumers with complex or specialized health needs.

ECP and network adequacy standards may also vary more across states if some states adopt higher thresholds. Reduced federal ECP thresholds could affect access to safety net providers, particularly for low-income and medically underserved populations. As CMS notes, "[L]ess expansive requirements for network size would lead to both costs to consumers and cost savings to issuers."

States and Marketplaces

At the federal level, the proposed rule does not specify how CMS will operationalize or enforce the requirement that non-network plans offer a "sufficient choice of providers" under the revised provider access standards at 45 CFR § 156.230, nor does it explain how the proposed reduction in minimum ECP participation thresholds at 45 CFR § 156.235—from 35% to 20%—will ensure continued access for low-income and medically underserved populations.

It remains unclear how many issuers may seek to offer non-network plans during QHP certification. For states in the FFM that assume Effective ECP Review authority, oversight of non-network plans would shift from evaluating provider contracts to assessing whether a "sufficient choice of providers" exists in practice, potentially complicating monitoring and enforcement of consumer protections. Furthermore, there could be state costs associated with taking on these additional responsibilities and the rule does not speak to any federal funding or grant opportunities.

States may also need to closely review issuer solvency. If non-network plans are priced aggressively low—as observed with Sidecar Health offerings off-exchange in 2022 and 2023—they could disproportionately attract healthier enrollees, resulting in substantial risk-adjustment liabilities that may not outweigh the revenue from the new enrollees. Issuers offering these plans would therefore need sufficient reserves and financial capacity. As part of

rate review, states may also monitor aggressively priced non-network plans that could also affect benchmark plan calculations. In addition, State Marketplaces concerned about the impact of potential non-network plan offerings on market stability, access, and affordability could determine offering those plans is not in the interest of consumers under 45 CFR 155.1000(c)(2) and decline their certification, something the rule explicitly notes as within Marketplace authority.

States that adopt Effective ECP Review authority would assume increased responsibility for defining, monitoring, and defending access determinations. SBEs retain the option to maintain higher ECP or network adequacy standards than the federal minimum. States may consider further adopting state standards or state-specific subcategories in the absence of federal standards on telehealth-related network reporting.

STATE MARKETPLACE POLICY SHIFTS AND PROGRAM INTEGRITY

State Exchange Enhanced Direct Enrollment

CMS proposes a new optional State Exchange Enhanced Direct Enrollment (SBE-EDE) model that would allow SBEs to rely exclusively on approved non-Exchange entities; that is, web brokers to operate consumer-facing eligibility and enrollment websites. If finalized, CMS would remove the requirement that SBEs maintain a centralized eligibility and enrollment consumer interface on the State Marketplace website (the one-stop model envisioned in the Affordable Care Act) if they adopt this model. Consumers would potentially navigate multiple websites to compare plan options and complete enrollment.

Although the SBM would not be required to maintain a centralized consumer interface, the State Marketplace would retain responsibility for the eligibility and enrollment determination system, including verification of eligibility and final enrollment determinations. Furthermore, Marketplaces would still be required to have a consumer facing informational website. The SBM would also remain responsible for certifying, monitoring, and overseeing participating enrollment entities.

Relationship to Existing Federal/State Models

The proposed SBE-EDE option builds on CMS's existing Direct Enrollment (DE) and enhanced direct enrollment framework used in the FFM, where a substantial share of enrollment already occurs through approved web-broker platforms. CMS frames SBE-EDE as an optional model that states may adopt, not a mandatory replacement for existing SBE enrollment approaches.

The Georgia Access Model operates using an EDE-based structure but still maintains a centralized state-managed website that directs consumers to approved private enrollment partners. Under the proposed SBE-EDE model, Georgia—and other SBMs—could choose to eliminate a centralized consumer-facing Marketplace website entirely, relying solely on third-party platforms for the consumer enrollment experience while retaining backend eligibility systems. CMS previously proposed a similar, fully privatized enrollment approach during the first Trump Administration (and it approved a section 1332 waiver from Georgia[2] that took a similar approach), making this proposal a re-emerging rather than a novel policy direction. Nonetheless, its reintroduction is notable given it increases consumer exposure to agent/broker enrollment while CMS's simultaneous emphasis on program integrity, documentation requirements, and efforts to curb agent and broker misconduct elsewhere in the proposed rule. The rule does not prescribe any further requirements for uniformity across EDE partners.

State Exchange Improper Payment Measurement

CMS proposes implementing State Exchange Improper Payment Measurement (SEIPM) beginning in 2027 to measure improper APTC payment in SBEs, aligning SBE oversight with existing FFE processes. CMS also proposes allowing SBEs to satisfy certain independent audit requirements through SEIPM participation, which could avert duplication.

If finalized, SEIPM would replace the current Improper Payment Pre-Testing and Assessment (IPPTA) initiative, which CMS previously established as a preparatory step for SBEs, thereby transitioning SBEs from voluntary pretesting to a formal, ongoing improper payment measurement program. CMS also issued a related proposed data collection, including a SEIPM data request,[3] to support implementation of the program; the public comment period for this data collection closed February 9, 2026. The rule notes that information collection costs incurred by State Marketplaces related to SEIPM are estimated to be a recurring annual cost of approximately $1 million across all required State Marketplaces in calendar year 2027, and approximately $2 million beginning in 2029 for State Marketplaces submitting corrective action plans (CAPs).

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[2] Georgia's section 1332 waiver including one part that implemented the Georgia Access Program, which was suspended on August 9, 2022. Letter is available here: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-ga-suspension-letter-of-ga-access-model-for-py-2023.pdf.

[3] Centers for Medicare & Medical Services. Agency Information Collection Activities: Proposed Collection; Comment Request. Federal Register. December 11, 2025. Available at: https://www.federalregister.gov/documents/2025/12/11/2025-22478/agency-information-collection-activities-proposed-collection-comment-request.

Essential Health Benefits

Beginning in plan year 2027, CMS proposes that state-required benefits enacted after December 31, 2011, would be treated as "in addition to Essential Health Benefits (EHB)" if they meet specified criteria. States would be required to defray the cost of these benefits for QHP enrollees, even if the benefits are embedded in the state's EHB benchmark plan. This action was previously proposed by the Trump Administration in the 2018. A state that wants to avoid defrayal obligations for state-required benefits that are already in its EHB benchmark could do so by repealing the applicable state requirement as being applicable to QHPs. CMS also proposes to disallow states from proposing adult routine dental services to the state's EHB benchmark.

IMPLICATIONS

Consumers

Under SBE-EDE, consumers may encounter multiple enrollment entry points, depending on which approved third-party platform they use. The proposed rule does not require a single standardized consumer interface across enrollment partners, which may lead to in variation in how plan options are displayed, compared, or marketed. This proposal also could result in greater variation in consumer journeys, consumer confusion — especially for vulnerable populations—and exposure to broker-driven marketing if reliable safeguards are not in place to prevent misleading marketing.

SEIPM could increase the likelihood of post-enrollment eligibility and APTC verification, which, in turn, could lead to more frequent corrections of APTC amounts. EHB defrayal changes may result in potential indirect effects if states reconsider adopting or expanding benefit mandates due to defrayal costs.

States

For states, these changes present additional burden and potential costs. For states that adopt the SBE-EDE model, this presents a shift from operating a one-stop model website that includes enrollment infrastructure to contracting, certifying, and overseeing multiple third-party enrollment entities. Although states may have yet to create a one-stop model, they still need to clear a landing page website, and states that implement this framework may need to also account for additional operational costs and oversight efforts, including monitoring, compliance, and enforcement for the EDE entities, and may want to consider their staffing structures to support this approach.

- As a result of SEIPM, states may face new sampling, reporting, and remediation responsibilities that formalize ongoing program integrity oversight. In the proposed rule, CMS acknowledges that these requirements may increase administrative and operational burden for states, particularly for Marketplaces that have not previously participated in statistically valid improper payment measurement, but also may reduce some duplicative audits over time.
- States may also face increased fiscal and administrative responsibility for benefit mandates, requiring new cost-tracking and defrayal mechanisms.

OBBBA IMPLEMENTATION

OBBBA[4] Implementation: The NBPP proposes a number of codifications of the recently passed legislation. P.L. 119-21 removed APTC eligibility for certain lawfully present immigrants. In 2026, legally present immigrants with incomes below 100% of FPL and otherwise would have been eligible for Medicaid except for immigration status will no longer qualify for APTCs. In 2027, APTC eligibility would be removed for other legal immigrants and eligibility for legal immigrants would generally be limited to green card holders, certain Cuban/Haitian immigrants, and individuals living in the United States through the Compact of Free Association.

The law also permanently ends the ability of Marketplaces to offer Low-income Special Enrollment Periods (SEPs). Low-Income SEPs were barred as part the Marketplace Integrity and Affordability (MIA) rule[5] (i.e., the rule is already affecting Marketplace enrollment); however, this regulation makes permanent the elimination of the low-income SEP (without this rule Low-Income SEPs could have returned in 2027). The rule does not include any details on pre-enrollment verification requirements that are expected to affect PY 2028.

Implications

CMS estimates that 1,227,000 people now receive APTCs through the Marketplaces who are lawfully present noncitizens who would lose eligibility for APTCs starting in 2027. It is expected that nearly all of those who lose eligibility for APTCs will exit the individual market. The result should be a significant decrease in enrollment as well as higher premiums due to increased morbidity in the risk pool. Marketplaces will also incur additional costs needed to change systems to remove eligibility. CMS estimates that it will cost Marketplaces nearly $16 million to make the changes.

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[4] 119th US Congress. H.R.1 - An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14. Enacted July 4, 2025. Available at: https://www.congress.gov/bill/119th-congress/house-bill/1/text.

[5] US Department of Health and Human Services. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Rule. Available at: https://www.cms.gov/files/document/cms-9884-f-2025-pi-rule-master-5cr-062025.pdf.

INCREASED VERIFICATION

CMS proposed several policies that would increase income verification requirements on consumers. First Marketplaces would be required to generate data matching issues (DMIs) for APTCs applicants if federal data sources indicate that the applicant's income is below 100% FPL. Second, the rule would require DMIs if the hub indicates that no data are available for verification. This requirement would affect all Marketplaces starting in 2027.

Implications

FFMs and SBMs would face significant operational burdens for implementing these provisions. CMS estimates that annual operation costs could be approximately $160 million and implementation costs could be nearly $20 million. Beyond costs to Marketplaces, there are potential coverage and risk pool implications. CMS estimates that the provision could generate approximately 3.3 million DMIs and result in approximately 488,000 disenrollments.

Wakely colleagues believe the total disenrollment estimate relies on the assumption that only 10% of people who receive DMIs ultimately will lose coverage. Our prior analysis estimated that Marketplaces, especially if they must quickly adopt the provisions, could have higher disenrollment rates.[6] For example, if disenrollment rates were 50%, which is the high end of our estimated disenrollment resulting from DMIs, then 2.3 million enrollees would lose coverage in 2027. This number could be even higher in 2028 when enrollees must pre-verify their income or lose access to APTCs. As a result of requirements in OBBBA, enrollees would be able unable to access APTCs while they have a DMI.

Consequently, if enrollees sign up during a SEP or during open enrollment and receive a DMI the consumer would be ineligible for APTCs until the DMI is resolved, which could take months. Wakely's prior analysis estimates that 80% or more of enrollees could be at risk of losing access to APTCs if they receive a DMI starting in 2028. As a result, our high-end estimate of the disenrollment rate in 2028 would be substantially higher than the 50% rate we would project for 2027. We estimate approximately 4.7 million enrollees could receive DMIs as a result of this provision and therefore upward of 80% of them could lose access to APTCs and be at risk for dropping coverage. As such, coverage losses have the potential to exceed 3 million enrollees. It is important to note that actual enrollment losses will be lower as interactions with other provisions (e.g., failure to file taxes) would reduce enrollment losses in aggregate. Nonetheless, the increased verification requirements could produce sizable enrollment losses if finalized as proposed.

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[6] Anderson M, Whittal K, Hegemann J, Sherman Z. Future of the Individual Market: Impact of the House Reconciliation Bill and Other Changes on the ACA Individual Market. Wakely. June 23, 2025. Available at: https://www.wakely.com/wp-content/uploads/2025/06/Reconcilliation-Bill-Impacts_6_23_25_FINAL.pdf.

POTENTIAL COMING ATTRACTIONS / WHAT DIDN'T CMS DO?

Medical Loss Ratio

CMS is requesting feedback from issuers on how the federal medical loss ratio (MLR) standard in the individual market (80% MLR measured over a three-year period) affects premiums, issuer behavior, and overall market stability. Specifically, CMS is seeking comment on whether to extend the maximum adjustment period (e.g., from three to five reporting years), further reduce data submission requirements to relieve administrative burdens, and modify the evaluative criteria for state-specific considerations.

Currently, states may pursue changes to the MLR standard by initiating a request with CMS in which the state demonstrates a reasonable likelihood that the current standard would destabilize the market. Despite CMS streamlining the framework for this request in the 2019 payment notice, no state has yet sought to make an MLR adjustment. CMS, therefore, is also requesting comment on whether regulations should be amended to allow the CMS to adjust the state's MLR standard absent a state-initiated request.

Silver-Loading

CMS did not attempt to disallow silver-loading in the 2027 NBPP, but did propose to require issuers to report on CSR-related information. The rule discusses concerns around CSR adjustments being too high. It is possible, especially for states with mandated CSR/silver-loads, that CMS will examine the data submitted and use that data, in future rulemaking, to enact changes which could include limits on silver-loading requirements or outright elimination of the practice.

EHB Reforms

CMS announced in the proposed rule that it would be suspending review of changes to EHB benchmarks. The rule states that CMS is conducting a review of EHB requirements and is considering changes to EHB benchmark plan requirements and EHB standards in future rulemaking. Consequently, states should expect changes to their ability to make changes to their EHB benchmark and potentially changes to their current EHB benchmark.

1332/1333 Reforms

CMS did not announce any changes to the current requirements around section 1332 waivers. Section 1332 waivers allow states to waive certain provision of the Affordable Care Act and receive pass-through funding if they reduce financial assistance (e.g., PTC), provided that they meet certain guardrails. During the first Trump Administration, the requirements for section 1332 waivers were relaxed, which gave states more flexibility in the types of waivers that would be considered acceptable. It also did not propose any regulations around Section 1333 of the ACA, which allows states to form health care choice compacts. Regulations on both could emerge in future rulemaking.

CMS has consulted with states that have National Association of Insurance Commissioners (NAIC) on implementation of section 1333 compacts. States have responded that they need the maximum flexibility for states allowed under law, start-up funding for planning and analysis, or technical assistance given the heavy lift of revising insurance laws for a multistate compact.[7]

CLOSING

Taken together, the proposed 2027 Notice of Benefit and Payment Parameters reflects a clear shift in federal Marketplace policy—one that prioritizes issuer flexibility, lower-premium plan options, and a mix of increased federal oversight along with greater deferment of certain oversight activities to the states. Many of the proposed changes, including expanded catastrophic eligibility, relaxed network and ECP standards, and new state-led enrollment and program integrity models, could materially reshape consumer choice, affordability, and access, particularly for lower-income and medically underserved populations. At the same time, increased verification requirements and statutory changes codified from P.L. 119-21 raise the prospect of significant enrollment losses and operational burden for states and issuers.

As CMS finalizes the rule, states and Marketplaces will need to carefully weigh whether and how to adopt new flexibilities, assess their capacity to absorb additional oversight responsibilities, and consider the potential downstream effects on market stability and consumer protections. Engagement during the comment process and continued monitoring of implementation will be critical to understanding how these policy shifts ultimately affect coverage, affordability, and the functioning of the individual market in 2027 and beyond.

[7] See response letter available at: health-letter-to-cms-sec-1333-naic-response-oct-2025.pdf

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