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ISSUE BRIEF

Impacts of the 2027 Final NBPP

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JUNE 2026

INTRODUCTION

On May 15, 2026, the US Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) released the final Notice of Benefit and Payment Parameters (NBPP) for 2027,1 which was proposed on February 9, 2026. The notice includes important rules and parameters for the operation of the individual and small group health insurance markets in 2027 and beyond. Certain provisions take effect July 20, 2026 (the effective date of the final rule), while some will become effective in 2027, and others were punted to 2028.

This paper summarizes key provisions in the final notice, with a focus on which proposed changes were finalized, which were modified, and what signals the rule provides about future policy changes. According to CMS, the final rule will reduce marketplace enrollment by 1.2 to 2.0 million individuals, but we expect the rule will may result in larger reductions in coverage.

Overall, the rule finalized many proposed changes and sets the stage for significant shifts in plan types, cost-sharing, network design, and oversight beginning in 2027 and 2028. The rule offers a mixed approach to state/federal responsibilities, continuing to defer to states on network adequacy and essential community provider reviews while increasing federal oversight of state compliance through the State Exchange Improper Payment Measurement (SEIPM) program and potential audits of issuers performing Exchange functions. The rule maintains the requirement for a centralized website to determine eligibility and enrollment for State-Based Exchanges (SBEs), but only because CMS cites that it had limited time to address comments.

CMS finalized the reproposed income verification and other policies from last year's Marketplace Affordability and Integrity rule—which are currently being challenged in court—and codified relevant statutory changes, such as eligibility changes for immigrant populations, from the (P.L. 119–21, now known as the Working Families Tax Cut Act [WFTCA]).

Contact our experts with questions about NBPP, and to discuss opportunities to address the trends and forthcoming changes in the market.

[1] Federal Register. Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024; and Basic Health Program. Available at: https://www.federalregister.gov/documents/2026/05/20/2026-10050/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and.

What You Need to Know About Major Changes

Following are highlights of the major changes and key considerations related to the finalized policies affecting states, consumers, and issuers.

Cost-Sharing Reduction Silver Loading

CMS finalized the requirement that issuers that silver load (i.e., increase silver plan rates to account for unreimbursed cost-sharing reductions [CSRs]) will need to submit information related to CSR loading in the Unified Rate Review Template and the Actuarial Memorandum for each year that CSRs are unfunded, beginning with payment year (PY) 2027 rate filings. CMS affirmed that the agency is not finalizing a single CSR loading methodology at this time.

The final rule flexes CMS's authority and puts states on notice with limited guidance. CMS indicates that it will review the submitted CSR data and assess whether issuers are using a reasonable methodology to estimate unpaid CSR amounts. If CMS determines the methodology is unreasonable—and the state does not identify or address the issue—CMS may exercise its authority under § 154.301(d) to evaluate whether the state continues to meet the criteria for an Effective Rate Review Program.[2] If not, CMS could determine that the state no longer maintains an Effective Rate Review Program, which would be a change in precedent from CMS's traditional practice of deferring rate review to states.

In addition, CMS could exercise its authority in states lacking and Effective Rate Review Program (e.g., Wyoming, Oklahoma, and Tennessee)[3] to determine methodologies the agency deems unreasonable, which could lead to withholding of Qualified Health Plan (QHP) certification for such plans.

Regarding next steps, the rule further noted that the actuarial memorandum—rather than the Unified Rate Review Template (URRT)—is the appropriate place to include detailed discussions of CSR load data, and more information on rate filing instructions will be forthcoming. CMS will also require issuers to use the standard methodology for estimating historical CSR payments. For example, issuers this year will need to provide estimates on what CMS would have paid for CSR variants in 2025. Implementing the standard methodology may be burdensome to issuers.

[2] § 154.301(a) and (b)

[3] Centers for Medicare & Medicaid Services. State Effective Rate Review Programs. Available at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet.

Essential Health Benefits

The final rule changes Essential Health Benefits (EHBs) defrayal policies. The final rule pushed the effective date from 2027 in the proposed to 2028, but maintained a requirement that states defray treatment of state-mandated benefits "in addition to EHB" for required care, treatment, and services provided in the individual and small group markets post-December 31, 2011. These benefits are not required for federal compliance, even if they are embedded in the state's EHB benchmark plan.

Hence, states will be required to defray the cost of these benefit mandates for QHP enrollees, even if the benefits are included in the state's EHB benchmark plan. These states will be required to identify which state-required benefits are "in addition to EHB." The one-year delay buys states time to avoid defrayal obligations by repealing the applicable state-required benefits, though states may find it challenging to meet these time constraints given their legislative cycles.

Changes from Proposed

Several proposed provisions were delayed[4] a year or revised as noted below:

- **Non-Network Plans:** Delayed to 2028 from 2027, the policy to allow certification for non-network plans that demonstrate a sufficient choice of providers in the Federally-Facilitated Exchange (FFE) is finalized for PY 2028, not 2027 as originally proposed. SBEs and those on the federal platform (SBE-FPs) are still permitted to allow non-network plans through the Exchange for PY 2027, but given that it is already late in the plan filing timeline, these plans are unlikely to be prevalent next year.
- **State Defrayal Changes:** Delayed to 2028 from 2027. The final rule maintained a requirement for states to defray treatment of state- mandated benefits "in addition to EHB" as discussed above.
- **Consent Form:** Delayed to 2028 from 2027. The final rule included a standard eligibility application review form and consumer consent form for brokers, and clarified what constitutes a consumer "taking an action," consistent with the FAQ released in 2024.[5]
- **User Fees:** Effective 2027, CMS will decrease user fees on several programs compared with the proposed rule:
    - Reduced FFE user fees from 2.5% to 1.9%
    - Reduced SBE-FP user fees from 2.0% to 1.5%
    - Reduced risk adjustment user fees from $0.20 per member per month to $0.18

[4] See Table 13 in the final rule for a list of proposed changes and finalized effective date.

[5] Centers for Medicare & Medicaid Services. Frequently Asked Questions: Consumer Consent & Application Review Requirements. Available at: https://www.cms.gov/marketplace/agents-brokers/files/frequently-asked-questions-consumer-consent-application-review-requirements.pdf.

Not Finalized

Below are the proposed policies CMS did not finalize in the final rule:

- Removal of the requirement that SBEs must operate a centralized consumer-facing eligibility and enrollment web page on their website
- Option for State Exchange Enhanced Direct Enrollment (EDE), which would allow SBEs to rely solely on approved non-Exchange entities for consumer-facing eligibility and enrollment websites

For both provisions, CMS affirmed its support for these proposals but did not finalize them because it had limited time to address public comments. CMS indicated that it may address these proposals and comments in future rulemaking, such as the 2028 payment notice. What remains to be seen is whether CMS will propose any modifications to this proposal in response to comments.

A Mixed Approach

Certain provisions in the rule were finalized as proposed, but others were not, as follows.

Catastrophic Plans: Effective 2028, CMS is finalizing the following Catastrophic Plan policy provisions:

- Multiyear policies, up to 10 years
- Ability to provide pre-deductible coverage through value-based insurance design
- Eligibility expansion through all Exchanges via hardship exemptions for individuals based on ineligibility for CSRs/Advance Premium Tax Credit (APTC) and a household income below 100% or above 250% of the federal poverty level (FPL) as proposed
- Catastrophic plans must set their maximum out-of-pocket (MOOP) limit at 130% of the maximum allowable out-of-pocket cap

CMS did not finalize a proposed policy that would have allowed multiyear catastrophic plans to average annual MOOP over the course of their existence rather than having an annual limit, or to establish disease-specific MOOPs. This could have allowed for much higher MOOPs in the initial years of the plan or could have adversely affected specific health conditions. They also did not finalize a specific rating adjustment for multiyear catastrophic plans.

Note that for 2026, according to CMS data fewer than 0.3% of enrollees (67,489) selected a catastrophic plan.

Essential Community Provider (ECP) Review Program: Effective 2027, states can establish an effective ECP review program to evaluate provider access for network plans as proposed.

- Because non-network plan implementation was delayed to 2028 (as discussed above), the ECP review program requirement to review network and non-network plans was delayed from 2027 to 2028. CMS included that states must have a process to collect and review information from non-network plans in 2028 to meet the criteria.
- This does not impact SBEs or SBE-FPs, who can establish their own standards.

ECP Thresholds: CMS is not finalizing proposed revisions to decrease the ECP threshold from 35% to 20%; however, CMS is finalizing the requirement to remove the narrative justification requirement for ECP.

Finalized as Proposed

Below are the aspects of the rule that were finalized as proposed. Details about these provisions and their implications are available in the Health Management Associates/Wakely brief for consumers and states here, as well as implications for issuers here. An asterisk (*) indicates provisions finalized in the 2027 NBPP that were also finalized in a previous Marketplace Integrity and Affordability Rule that did not take effect because of a court stay in the City of Columbus vs. Kennedy litigation.[6]

- For 2027, implements an SEIPM program to measure improper payments of APTC administered by state Exchanges.
- For 2027, implements stronger regulations for agent/broker marketing practices with examples of prohibited marketing practices (e.g., cash, miscommunication on enrollment timelines, deadlines, and that consumers will always qualify for zero premiums). The rule also clarifies that agents, brokers, and web-brokers may be held responsible for marketing content created, written, released, or otherwise produced by an entity on their behalf.
- Effective the date of the final rule, removes the requirements in §155.222 that CMS approve vendors to facilitate annual agent and broker training for a given plan year.
- For 2027, ends the requirement for standardized plans in the FFE and SBE-FP and limits on non-standardized plans. Issuers can continue to offer these plans, but they will not

[6] The Marketplace Integrity & Affordability (MIA) rule, finalized by CMS in June 2025, has been challenged in two court cases. The City of Columbus v. Kennedy litigation resulted in a stay of several of the MIA provisions,14 (i.e., expanded Actuarial Value (AV) standards, pre-enrollment verification for SEPs prior to enrollment, declining coverage for consumers who have past due premiums, a $5 monthly premium for subsidized enrollees who fail to submit an application, and verification of income when tax return data is unavailable).

be differentially displayed. This does not impact SBEs or SBE-FPs, who can establish their own standards.

- For 2027, states can establish network adequacy standards based on sufficient choice of provider to be an Effective Provider Access Review Program; elimination of time and distance requirements for network adequacy. Again, this does not impact SBEs or SBE-FPs.
- Effective the date of the final rule, rescinds previous requirement that states transitioning to an SBE operate first as an SBE-FP for one year prior to their full transition to an SBE.
- Effective the date of the final rule, eliminates the requirement that CMS may request supplemental documentation from states as they transition to an SBE.
- For 2027, eliminates the option for issuers to include routine non-pediatric (adult) dental services as an EHB.
- For 2027, prohibits Exchanges from offering the 150% FPL special enrollment period (SEP).
- For 2027, in the FFE and SBE-FP requires verification for additional SEPs (marriage, adoption, moving to a new coverage area, and Medicaid/CHIP denial) beyond loss of minimum essential coverage, and verification for at least 75% of new enrollments through SEPs.*
- For 2027, additional verification requirements to confirm an applicant's annual household income when data sources indicate household income is under 100% of the FPL.*
- For 2027, removes the requirement for Exchanges to accept a household's income attestation when IRS returns no data for the household.*
- For 2027, limits APTC eligibility and Basic Health Plan (BHP) eligibility to eligible noncitizens. This provision also impacts BHP funding for states.
- For 2027, eliminates Premium Tax Credits (PTC) for noncitizens lawfully present in the United States who were ineligible for Medicaid due to their immigration status and have household income below 100% of the FPL. This provision also impacts BHP funding for states.
- For 2027, finalized the proposal requiring the Exchange to determine consumers ineligible for APTCs if they did not file their federal income taxes and reconciled APTC in the previous year (one year failure to file and reconcile [FTR]) in 2027. SBEs have the option in 2027 to implement the forementioned FTR policy looking back one year or to continue the two-year FTR policy.
- For 2027 and beyond, rescinds the option for issuers to implement both the fixed-dollar and gross percentage-based premium payment thresholds.

- For 2027, implemented requirement for issuers that silver load (load rates to account for unreimbursed CSRs) to submit certain information related to CSR loading as discussed above, beginning with PY 2027 rate filings.
- Effective the date of the final rule, CMS clarified its authority to audit or conduct a compliance review of an issuer offering a QHP pertaining to the APTC, CSRs, and user fee programs. Further, CMS may impose civil monetary penalties (CMPs) against issuers in SBEs and SBE-FPs for violations of Exchange requirements if the state is not—or CMS believes the state is not—adequately enforcing the requirements.

CONNECT WITH US

Health Management Associates, Inc. (HMA), and Wakely colleagues are closely tracking federal policy activity and state actions to address these challenges. Our experts support states, issuers, consumer groups, and other interest-holders to achieve success in the operation of and participation in the marketplaces. Our team has broad historical knowledge of the challenges and opportunities in this market and can support every step of the planning and execution processes to improve affordability and stability as it evolves in the coming months and years.

Contact our experts below with questions about NBPP and to discuss opportunities to address the trends and forthcoming changes in the market. For example:

- **Compliance:** HMA/Wakely can assist states grappling with compliance for EHB and SEIPM changes.
- **Policy Impacts:** Should a state have large changes to its silver load policy, HMA/Wakely can assist in modeling how those changes could impact market level morbidity.
- **State DOI:** HMA/Wakely can assist states in reviewing CSR loads and interpretation of the new URRT fields and CMS guidance.

To read more about the changes ahead, see the following reports and contact Lina Rashid, Michael Cohen, and Zachary Sherman:

- 2027 NBPP Webinar: Key Considerations
- 2027 Proposed NBPP: Analyzing State and Consumer Impacts
- Medicaid Changes in the OBBBA and Implications for the Marketplace and Individual Market in 2027
- ACA Non-Network Plans: How Big of a Disruption?

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