

WHITE PAPER

Summary of Provisions in HHS's Proposed 2027 Notice of Benefit and Payment Parameters and Other Key Regulations

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INTRODUCTION

On February 9, 2026, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027.¹ The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2026 and beyond. This paper summarizes key provisions in the proposed notice and maximum out-of-pocket cost information² recently released by HHS. Comments are due no later than March 13, 2026.

OVERVIEW

The following highlights the key changes included in the 2027 proposed NBPP. This paper is intended to provide key information, especially with a lens focused on issuer pricing. Details on these and other proposed changes follow.

- 1. User Fees:** HHS proposes to keep user fees at 2.5% for issuers in the federally facilitated Marketplace (FFM) and 2.0% for issuers in state-based Marketplaces operated by HHS (SBM-FPs).
- 2. Non-Network Plans:** HHS proposes to allow non-network plans to become qualified health plans (QHPs) if states approve that the plans meet network adequacy requirements.
- 3. Ending Standard Plans:** HHS proposes that, starting in 2027, the FFM would no longer subject issuers to standard plan requirements or any limitations on the number of non-standard plans being offered.
- 4. Cost-Sharing Reduction (CSR) Reporting Requirements:** HHS proposes to require issuers to submit data on CSR paid amounts compared with revenue received as a result of the CSR load factor for both the previous year and the upcoming plan year. HHS proposes that CSR load factor only accounts for projected revenue loss of unreimbursed CSR payments.
- 5. EHB Changes:** HHS proposes to disallow states from proposing adult routine dental services to the state's Essential Health Benefits (EHB) benchmark. It also proposes to require states to defray the cost of any state mandate since December 31, 2011. HHS proposes that a state

¹ Centers for Medicare & Medicaid Services. Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program. *Federal Register*. Published February 11, 2026. Available at: <https://www.federalregister.gov/documents/2026/02/11/2026-02769/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and>.

² Centers for Medicare & Medicaid Services. Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year. January 29, 2026. Available at: <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

mandate include any ""required care, treatment, or services and not required by state action for purposes of compliance with Federal requirement."

- 6. Risk Adjustment:** HHS proposes several updates to the risk adjustment model, including updates to the data used to recalibrate the model, the risk adjustment coefficients, and the risk-adjusted user fee. It also proposes a technical change to the HHS RADV methodology.
- 7. Maximum Out of Pocket:** The maximum out of pocket (MOOP) increased 13.2% to \$10,600 for an individual or \$21,200 for a family.
- 8. Catastrophic Plan Changes:** HHS proposes extending the availability of catastrophic plans to any enrollee who is ineligible for advance premium tax credits (APTCs) or cost-sharing reductions (CSRs). It also proposes to allow catastrophic plans to have an average MOOP of up to 130% of the maximum annual limitation on cost sharing. In addition, the Department proposes to allow for multiyear catastrophic plans for up to 10 years, and to allow issuers to have flexibility in designing cost-sharing over the course of the plans' entire timeframe.
- 9. Bronze Plan Changes:** HHS proposes to allow individual market issuers to offer bronze plans with cost sharing to meet the bronze de minimis, regardless of whether those cost-sharing amounts exceed the maximum annual limitation on cost-sharing. Issuers may do so if they offer at least one bronze plan that is within the annual maximum annual limitation on cost-sharing in the service area.
- 10. Verification/Eligibility Changes:** HHS proposes to implement several eligibility changes to codify changes brought about through the Budget Reconciliation Act (P.L. 119-21, OBBA).³ It also proposes to increase verification requirements for certain consumers seeking APTCs.
- 11. Overall Impact:** HHS estimates that if the proposed rules are finalized, total Affordable Care Act (ACA) enrollment would be reduced by 1.2 to 2.0 million individuals in 2027.
- 12. Actuarial Value Calculator:** HHS has yet to release the 2027 actuarial value calculator (AVC). Wakely will issue additional analysis should the 2027 AVC prove materially different from the 2026 AVC.

³ 119th US Congress. H.R.1 - An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14. Enacted as P.L. 119-21 on July 4, 2025. Available at: <https://www.congress.gov/bill/119th-congress/house-bill/1/text>.

Following are details on each of the items summarized on the previous page.

USER FEES

HHS proposes to keep user fees at 2.5 percent for issuers in the FFM and 2.0 percent for issuers in state-based Marketplaces operated by HHS (SBM-FPs).

ALLOWING NON-NETWORK PLANS AND CHANGES IN NETWORK ADEQUACY REVIEW

HHS proposes a number of key changes to regulations around network adequacy. First, it proposes to end federal quantitative network adequacy standards (e.g., time and distance metrics) and make the review of networks the responsibility of states during rate review. Second, HHS would allow non-network plans to be certified as QHPs. Non-network plans are those that do not contract with providers and instead offer set negotiated rates for a specific services. Enrollees may choose any provider they want but are responsible for any costs incurred for that service above the set amount (i.e., potential for large balanced billing amounts). Under this framework, issuers could offer plans without contracted provider networks if they demonstrate sufficient access to providers willing to accept plan payment as payment in full (e.g., a sufficient number of essential community providers and mental health and substance use disorder providers).

ENDING STANDARD PLANS AND LIMITATIONS ON NON-STANDARD PLANS IN FFM

HHS proposes that beginning in plan year 2027, the FFM would no longer subject issuers to non-standard plan option limits, currently equal to two per product network type, metal level, and dental/vision benefit inclusion. In addition, the exception process (i.e., where issuers can have additional non-standardized plan options if they demonstrate these plans would benefit consumers with chronic and high-cost conditions) will be eliminated. Issuers have the flexibility to discontinue or continue the chronic and high-cost conditions plans with options to modify the cost-sharing structure, and enrollees would be transitioned or auto reenrolled as appropriate. Finally, standard plans would be discontinued from the FFM. It should be noted that this change is only for the FFM and does not impact individual state's ability to offer or require standardized plan options.

COST-SHARING REDUCTION REPORTING REQUIREMENTS

The 2027 NBPP proposes to codify the reporting requirements of CSR amounts. The elements that must be reported in Part I of the Unified Rate Review Template (URRT) template include:

1. Actual CSRs paid by the issuer in the previous year⁴ using the standard methodology;⁵ the standard methodology includes re-adjudicating previous claims costs
2. The amount of revenue generated by the previous year's load factors
3. Expected CSR amounts to be paid by the issuers in the upcoming plan year
4. CSR load factors for the upcoming plan year
5. The expected amount of revenue generated by the load factors for the upcoming plan year

Plans will also be expected to provide justification for the development of items 3–5 above in the URRT Part III Actuarial Memorandum. When providing information on the upcoming plan year insurers will need to include the methodology used to justify their CSR load factor (i.e., there is flexibility when estimating future CSR costs).

The intent of the reporting requirements is to provide HHS with data justifying actuarial appropriateness of the load factors being included in rate development. HHS raised concerns that CSR load factors developed from assumed member distributions can result in inflated premiums and inappropriate shifts to the silver positioning relative to other gold and bronze plans. If the assumed member distribution misaligns with actual revenue generated by the applied loads, it may exceed the expected amount of unreimbursed CSRs, leading to inflated premiums.

The explanation would allow states or HHS, as applicable, to evaluate whether the load factor is actuarially justified or excessive. HHS proposes that actuarially justified CSR loads only account for projected revenue loss of unreimbursed CSR payments. HHS is expected to release further guidance instructing issuers on how to complete the URRT.

⁴ For PY 2027 filings, the previous year expected to be reported is PY 2025.

⁵ National Archives. § 156.430 Payment for Cost-Sharing Reductions. Amended February 17, 2026. Available at: [https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-E/section-156.430#p-156.430\(c\)\(2\)](https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-E/section-156.430#p-156.430(c)(2)).

EHB CHANGES: MORE DEFRAYAL

HHS proposes several changes to EHB standards. First, HHS proposes to disallow the Biden-era change of allowing states to propose changes to their EHB benchmark that could add routine adult dental services. Under the previous policy, the earliest effective date to include dental was January 1, 2027, and no state has submitted any benchmark change that includes routine adult services.

A potentially larger impact could result from changes in defrayal. As part of the ACA, benefits mandated by states after December 31, 2011, are generally considered non-EHB, and the state must defray the costs incurred by issuers as the result of these benefit mandates. In 2025, HHS clarified that if a benchmark includes a mandate, then no defrayal is required. HHS now proposes to reverse this clarification. Any mandate—regardless of whether it was part of the EHB benchmark—would need to be defrayed. Furthermore, HHS proposes to define a state mandated benefit as any “required care, treatment, or services and not required by state action for purposes of compliance with Federal requirement.” It is unclear how many state-mandated benefits would need defrayal using this definition.

RISK ADJUSTMENT

HHS proposes the following updates to the risk adjustment program.

Sequestration

The risk adjustment program will be sequestered at a rate of 5.7% for funds collected during fiscal year (FY) 2026. These amounts will be available to issuers in FY 2027 (meaning a delay in payment for some risk adjustment payments). The Infrastructure Investment and Jobs Act extended the 5.7% sequestration through FY 2031.

Risk Adjustment Model Recalibration & Changes

HHS proposes to recalibrate the 2027 benefit year risk adjustment models using the 2021, 2022, and 2023 enrollee-level EDGE data. The Department requested comment on whether catastrophic plans should be risk adjusted with metallic tiers rather than through the current process of risk adjusting them separately.

Risk Adjustment User Fee

HHS proposes a risk adjustment user fee of \$0.20 per member per month (PMPM) for the 2027 benefit year—the same rate finalized in last year's NBPP.

Risk Adjustment Data Validation

HHS proposes a technical change in the HHS RADV error estimation methodology to account for Initial Validation Audit (IVA) sampling changes. The proposal includes a new scaling factor to account for the sampled RADV IVA enrollees, which all have Hierarchical Condition Categories (HCCs) applied to the total population, including enrollees without HCCs.

MAXIMUM OUT OF POCKET UPDATES

HHS no longer publishes MOOP amounts in the NBPP; instead it will finalize the values via guidance. HHS published guidance⁶ finalizing the MOOP amounts for non-CSR plans⁷ and cost-sharing variations for 2027. The MOOP will increase 13.2% from the 2026 amounts of \$10,600/\$21,200 (single/family) as follows:

- Non-CSR Plans: \$12,000/\$24,00 (single/family).⁸
- 100%–150% 50% FPL: \$4,000 and \$8,000 (single/family). In 2026, these amounts were \$3,350/\$6,700; 2027 represents a significant increase relative to last year's value.
- 150%–200% FPL: \$3,350/\$6,700 (single/family). Similarly, 2027 represents an increase relative to 2026's value of \$3,050/\$6,100 (single/family).
- 200%–250% FPL: \$9,600/\$19,200 (single/family). This amount is an increase from 2026 levels, which were set at \$8,100/\$16,200 (single family).

⁶ Centers for Medicare & Medicaid Services. Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year. October 8, 2024. Available at: <https://www.cms.gov/files/document/2026-PAPI-Parameters-Guidance-2024-10-08.pdf>.

⁷ Standard plans include platinum, gold, silver non-cost sharing variation, and enhanced bronze metal offerings. See the next sections on proposed changes to bronze and catastrophic plans.

⁸ Please note potential changes to standard bronze plans.

CATASTROPHIC PLAN CHANGES

HHS is proposing significant changes to catastrophic plans. First, the Department proposes to codify changes that it introduced⁹ last year to expand eligibility to catastrophic plans. In particular, HHS would allow hardship exemptions (i.e., gain eligibility for catastrophic plans) for members ineligible for APTCs or CSRs (as a result generally enrollees with incomes above 250% FPL or below 100% FPL would consequently qualify for a catastrophic plan).

Second, HHS proposes to require catastrophic plans to provide no benefits until 130% of the maximum annual limitation on cost sharing, rounded down until the next lowest multiple of \$50 is reached, beginning in the 2027 benefit year. The value was chosen to target a theoretical AV of 55%.

Finally, HHS proposes allowing issuers to offer multiyear catastrophic plans for up to 10 years. Issuers with multiyear catastrophic plans would have greater cost-sharing flexibility such as having a higher MOOP in year 1 and a lower MOOP in year 2. (The key is that the average MOOP over the life of the contract would need to equal the initial targeted MOOP.) HHS acknowledges that the multiyear concept may be difficult to align with many of the other ACA requirements, which are designed around annual contracts.

It is important to note that HHS had a number of policy questions in the preamble, including whether issuers should be required to offer catastrophic plans, if the plans should be risk adjusted with the metallic plans (i.e., no longer in their own risk pool), and whether a different AV target should be used. Consequently, extensive changes may be made to the policy at the time of finalization. Additionally, there is the potential risk of litigation given the large change from current practices.

⁹ 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 24, 2025. Available at: [guidance-hardship-exemptions.pdf](#).

BRONZE PLAN CHANGES

HHS proposes allowing issuers to offer bronze plans with MOOP amounts higher than the established maximum annual limitation (i.e., \$12,000 for self-only coverage in 2027). HHS proposes to allow individual market issuers the ability to **ignore the MOOP** in order to offer a bronze plan with cost-sharing parameters that fit within the standard de minimis range. An issuer may offer a bronze plan with an MOOP higher than the proposed limit only if it also offers a bronze plan at or below the MOOP limit within the same service area.

The MOOP amount for these bronze plans may exceed the proposed limit by increments of \$50. However, HHS is not establishing a strict dollar amount for the upper bound. Instead, it is the issuer's responsibility to determine the cost sharing required to achieve the desired AV within the standard bronze de minimis range.¹⁰ This flexibility will only be available in the individual market and does not apply to the small group market. HHS considered a similar proposal at the silver metal level but ultimately limited to bronze for 2027.

VERIFICATION/ELIGIBILITY CHANGES

HHS also proposes a number of eligibility and verification changes.

- **OBBBA¹¹ Implementation:** The NBPP proposes a number of codifications of the recently passed reconciliation bill (One Big Beautiful Bill Act or OBBBA). As part of the bill, eligibility for APTCs for certain lawfully present immigrants was removed. In 2026, lawfully present immigrants whose income is below 100% FPL and otherwise would have been eligible for Medicaid except for immigration will no longer qualify for APTCs. In 2027, APTC eligibility would be removed from 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 US through the Compact of Free Association. Finally, it also permanently ends the ability for exchanges to offer Low-income Special Enrollment Periods. Low-income special enrollment periods (SEP) were barred as part Program Integrity Rule (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 impact the 2028 plan year.

¹⁰ As a reminder the AV de minimis for bronze plans is still in litigation.

¹¹ [P.L. 119-21](#).

- **Program Integrity Rule Redux:** HHS proposes to implement in 2027 a number of provisions that were in the Program Integrity Rule¹² but were never implemented as a result of a court injunction. Provisions in the 2027 NBPP that would increase APTC eligibility verifications include:
 - Disallowing enrollees in the FFM from receiving APTCs if their household failed to file their taxes/reconcile APTC for one year (currently enrollees have two tax cycles to file taxes before losing eligibility)
 - Permitting exchanges to conduct pre-enrollment SEP verification
 - Requiring exchanges to generate data matching issues if federal data sources indicate a person's income is below 100% of the federal poverty level or if tax data was unavailable

OVERALL IMPACTS

The proposed provisions outlined in the proposed NBPP are expected to have a material effect on the individual market enrollment levels, member plan selections, premium trends, and the composition of the risk pool. The cumulative market effects will reflect the interaction among subsidy eligibility policy changes, SEP modifications, and eligibility verification requirements.

Overall, these provisions are expected to reduce total market ACA enrollment and APTC payments volume. Based on HHS's analysis, a reduction of roughly 1.2 to 2 million enrollees in 2027 can be expected relative to the baseline projection, as many consumers will lose eligibility for premium assistance (estimated at 1.1 million to 1.8 million enrollees). Consistent with past experience, it is likely that healthier and lower cost members will be the first to leave the market, which would place upward pressure on premiums.

However, HHS anticipates that the proposed changes to SEP policies—specifically, the removal of the SEP for individuals earning 150% FPL and the introduction of pre-enrollment SEP verification—would help improve the overall risk pool profile by limiting opportunities for adverse selection by encouraging more continuous coverage.

¹² Centers for Medicare & Medicaid Services. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. *Federal Register*. 2025;90(120):20704–27224. Available at: <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf>.

After accounting for both the upward and downward pressures on rates, HHS estimates a modest net premium reduction of approximately 1.5% to 1.8% relative to baseline projections before applying standard trends. In the years following 2027, HHS estimates that the market will stabilize, with enrollment declining by about 2.3% in 2028 as the full effect of subsidy expirations and SEP restrictions is realized, followed by small but positive gains in 2029 and 2030 as the market adjusts.

Though not explicitly noted in the HHS summary, we believe that the above estimates include codifying the provisions around implementing the recently passed legislation (i.e., changes in legal immigrant eligibility for APTCs). Consequently, issuers considering the overall enrollment and premium changes in 2027 relative to 2026 (or 2025) should note that the regulatory impact analyses of the proposed rule likely include the impacts related to OBBBA.

It's also unclear whether the premium reduction includes estimates of buy down or enrollees shifting to bronze or catastrophic plans. The proposed increased cost-sharing flexibilities for bronze and catastrophic plans would, if finalized as proposed, decrease premiums in these plans. Consequently, consumers may be more likely to shift from higher AV plans to these plans. This movement would have the impact of reducing average premiums, albeit with the result of higher cost sharing for enrollees.

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ABOUT WAKELY

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If you have any questions or want to follow up on any of the concepts presented here, please contact Michael Cohen, PhD, at michael.cohen@wakely.com. Special thanks to Ann Pogrebetskiy, Freddy Quiram, Karan Rustagi, Ksenia Whittal, Lisa Winters, Matt Sauter, Michelle Anderson, Ren Zhong, Taylor Gehrke, and Van Phan on their contributions to this review.

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