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CMS Proposes Sweeping Changes to ACA Exchange Plans for 2027

On February 11, 2026, the Centers for Medicare & Medicaid Services (CMS) published its proposed Notice of Benefit and Payment Parameters (NBPP) for 2027.[1] The 577-page proposed rule represents the Trump Administration's most comprehensive restructuring of Affordable Care Act (ACA) marketplace regulations to date, proposing to eliminate standardized plan requirements, dramatically expand eligibility for catastrophic health plans, permit non-network plans to sell on exchanges, roll back network adequacy standards, and tighten income verification requirements.[2] This *Health Capital Topics* article explores the CMS proposed rule and discusses stakeholder responses.

Background

The ACA marketplace is under significant strain. ACA marketplace enrollment fell to approximately 23 million for the 2026 plan year, down from a record 24.2 million in 2025, as the enhanced premium tax credits (PTCs) provided under the Inflation Reduction Act expired on December 31, 2025.[3] The Kaiser Family Foundation (KFF) estimated that the expiration of those enhanced subsidies would, on average, increase subsidized enrollees' out-of-pocket premium burden by more than double.[4] The 2027 NBPP proposed rule arrives as enrollment attrition continues to unfold and Congress has not acted to restore enhanced subsidies, creating a distinctive policy backdrop for CMS's proposed marketplace restructuring.

Expansion of Catastrophic Plan Eligibility

The proposed rule's most prominent provisions center on catastrophic health plans. Currently, catastrophic plans are available only to individuals under age 30 or those qualifying for hardship or affordability exemptions; catastrophic plan enrollees numbered only 20,000 to 54,000 in 2025.[5] CMS proposes to dramatically expand eligibility by categorically granting hardship exemptions to individuals age 30 and older (1) with income below 100% of the federal poverty level (FPL) or (2) with income over 250% FPL who are ineligible for cost-sharing reductions (i.e., ACA subsidies that lower deductibles, copayments, and out-of-pocket maximums for silver plan enrollees with incomes between 100% and 250% FPL).[6] These changes would effectively open catastrophic plans to adults of any age.[7]

The rule also introduces a novel concept: multi-year catastrophic plans with terms of up to 10 consecutive years.[8] Plan issuers would be permitted to make plan-level adjustments to the index rate and to apply the applicable cost-sharing for each plan year in the contract on a prorated monthly basis. Multi-year catastrophic plans would also be permitted to use value-based insurance designs – benefit structures that reduce or eliminate cost-sharing for high-value preventive services – to cover preventive services beyond those currently required before an enrollee satisfies the deductible or out-of-pocket maximum.[9]

Standardized Plans Eliminated & Non-Network QHPs Introduced

Since 2022, CMS has required insurers on the federally facilitated marketplace (FFM) to offer standardized plans at each metal level, providing uniform cost-sharing structures to aid consumer comparison shopping. The proposed rule would repeal standardized plan requirements entirely from the FFM, arguing that these requirements actually increased the total number of plan options consumers are required to choose from and that it is impractical for the federal government to design uniform plans suited to diverse market conditions.[10] The simultaneous cap on non-standardized plan options – capped at two per metal level by the Biden Administration – would also be lifted, though states would retain authority to impose their own requirements.

Perhaps the most structurally significant change is CMS's proposal to allow non-network health plans to receive QHP certification for the first time. These plans would set specific benefit amounts for covered services without maintaining contracted provider networks, and if a provider charges over the plan's benefit amount, enrollees would be responsible for the balance. Consumer and provider advocates have historically cautioned that non-network arrangements make it difficult to ensure enrollees have adequate access to care.[11]

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Network Adequacy & Safety-Net Provider Standards

The proposed rule would shift primary network adequacy oversight from federal to state authority for plan year 2027, allowing federally facilitated exchange (FFE) states (those that rely on HealthCare.gov rather than a state-operated marketplace) that CMS determines have an "Effective Provider Access Review Program" to conduct their own provider access certification reviews in lieu of federal review, while CMS would continue performing reviews for states that do not qualify or do not elect to do so.[12] The essential community provider (ECP) contracting threshold – the share of safety-net providers, including federally qualified health centers (FQHCs) and family planning providers, that marketplace insurers must include in their networks – would drop from 35% to 20%, reversing the Biden Administration's increase and returning to levels established during the first Trump Administration.[13] The rule also removes the narrative justification requirement for issuers that fall short of ECP thresholds.

Income Verification and Enrollment Eligibility Changes

The proposed rule re-introduces and expands income verification requirements that had previously been stayed by federal courts.[14] When tax data shows income below 100% FPL, CMS would require additional income verification.[15] The rule also permanently eliminates the low-income special enrollment period for individuals at or below 150% FPL after plan year 2026.[16] Additionally, advanced premium tax credit repayment caps that previously shielded consumers who received excess credits are eliminated, meaning individuals would be required to repay the full excess amount.[17]

Other Proposals

Other CMS proposals include:

- Prohibiting insurers from including routine non-pediatric dental services as an essential health benefit, reversing Biden-era policy;
- Increasing the annual maximum out-of-pocket limit for 2027 by over 13%, to $12,000 for self-only coverage and $24,000 for family coverage;[18]
- Establishing a new State Exchange Improper Payment Measurement program; and
- Soliciting comment on whether to modify the federal 80% medical loss ratio (MLR) standard for the individual market.[19]

Stakeholder Reactions

CMS Administrator Mehmet Oz characterized the proposed changes as putting "patients, taxpayers, and states first by lowering costs and reinforcing accountability for taxpayer dollars."[20] Policy analysts offered a more cautious assessment. Matthew Fiedler, senior fellow at the Brookings Institution, stated that the proposed rule included numerous provisions that could "expose enrollees to much higher out-of-pocket costs," due to higher maximum out-of-pocket limits on catastrophic plans and the introduction of non-network plan designs.[21]

Conclusion

The 2027 NBPP proposed rule represents a fundamental restructuring of the ACA marketplace architecture. The elimination of standardized plans, introduction of non-network QHPs, expansion of catastrophic plan eligibility, rollback of ECP thresholds, and tightening of income verification collectively constitute a broad reorientation of how the federal government regulates and subsidizes individual market health coverage.

The rule arrives at a precarious moment: ACA marketplace enrollment has already declined from its 2025 record high following the expiration of enhanced subsidies,[22] and the proposed rule's CMS-estimated reductions in enrollment and federal spending suggest further market contraction is anticipated. With a compressed 30-day comment period (public comments are due March 13, 2026), the QHP certification window opening April 16,[23] and the November 2026 midterm elections on the horizon, whether the rule is finalized in its proposed form – and how states, insurers, and consumers will respond to such sweeping marketplace changes – remains to be seen.

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