NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

2027 Notice of Benefit and Payment Parameters Final Rule

On May 15, 2026, the Centers for Medicare & Medicaid Services (CMS) finalized the 2027 Notice of Benefit and Payment Parameters (NBPP) Rule, which sets standards for Marketplace plans, Exchanges, issuers, agents, brokers, and web-brokers. The rule includes changes related to plan design, eligibility verification, network and Essential Community Provider (ECP) standards, consumer protections, and Marketplace oversight. **Review CMS' factsheet on the rule here.**

Many CHC patients rely on Marketplace coverage and need affordable, comprehensive plans that include access to their CHC providers. **Review NACHC's comment letter on the 2027 NBPP proposed rule here.**

CONSUMER IMPACTS

Essential Community Provider (ECP) Standards

Essential Community Providers (ECPs) are safety-net providers, such as CHCs, that primarily serve medically underserved, low-income populations, such as uninsured individuals and Medicaid enrollees. Under the Affordable Care Act (ACA), health insurance marketplaces require these specialized providers to be included in plan networks to ensure access. In the CY27 NBPP final rule, CMS ultimately retained the ECP contracting threshold, keeping it at 35% instead of reducing it to 20% as initially proposed.

Issuers must continue contracting with at least 35% of available ECPs within their service area, including separate thresholds applicable to CHCs and family planning providers. ***CMS specifically cited stakeholder concerns that lowering the threshold could disrupt continuity of care, narrow provider networks, and reduce access for low-income and medically underserved patients. They state:***

> "We agree with commenters that FQHCs and family planning providers continue to serve as important safety-net providers within their community and provide an array of services to cater to a variety of health needs…Additionally, we understand commenters' concerns that FQHCs and family planning providers currently face significant financial strain, and we agree that these are important issues to address. Therefore, after consideration of these comments, we are not finalizing this proposal."

CMS also eliminated the requirement that issuers submit a written narrative justification when they fail to satisfy the ECP contracting standard and seek a certification exception and revised certain administrative and reporting requirements related to ECP compliance.

For more information, please contact regulatoryaffairs@nachc.org

Network Adequacy

CMS finalized a new framework that allows Federally Facilitated Exchange (FFE) states to conduct their own ECP certification and network adequacy reviews if CMS determines that the state has sufficient legal authority and technical capacity. This is the first time CMS has broadly delegated ECP certification authority to qualifying FFE states. States may also propose alternative review methodologies if they demonstrate that enrollees will continue to have reasonable access to ECPs. CMS also removed the requirement that State Exchanges and SBE-FPs use quantitative time-and-distance standards at least as stringent as federal standards.

- Maintaining the 35% ECP threshold is a significant win for patient access. However, increased state flexibility could create variation in how access standards are reviewed and enforced across states. ***CHCs should monitor whether Marketplace plans maintain meaningful access to CHCs, especially in rural and medically underserved areas.***

Adult Dental Coverage and Essential Health Benefits (EHBs)

EHBs are the core categories of services that Marketplace plans must cover, such as primary care, prescription drugs, maternity care, behavioral health services, and pediatric dental and vision care. Benefits designated as EHBs receive important consumer protections, including limits on annual and lifetime coverage caps and requirements that cost-sharing count toward a patient's annual out-of-pocket maximum.

Beginning plan year 2028, CMS finalized the following policies:

- **Adult Dental Services as an EHB:** CMS finalized a prohibition on including routine non-pediatric (adult) dental services as an EHB. This reverses a policy finalized in the 2025 NBPP that gave states flexibility to include adult dental services in their EHB benchmark plans. This change will likely affect patient access to oral health services for medically underserved populations.
- **Additional EHB Changes:** Beginning in 2028, certain state-mandated benefits enacted after December 31, 2011, may be considered benefits "in addition to EHBs," even if they are currently incorporated into a state's EHB benchmark plan. If a benefit is classified as exceeding EHB requirements, states may be required to defray the cost of that benefit for Marketplace enrollees or repeal the mandate as it applies to QHPs.
    - CMS has not yet identified which states will be subject to defrayal. Examples of additional services that could trigger state defrayal requirements include in vitro fertilization (IVF) procedures, state-mandated adult dental coverage, hearing aids, non-routine vision care, chiropractic care, expanded cancer screenings, or expanded behavioral health services.

Agent, Broker, and Consumer Protection Requirements

CMS finalized several new consumer protection and oversight provisions designed to address misleading marketing practices, unauthorized enrollments, and consumer confusion in the Marketplace. These include:

- Misleading Marketing Practices: CMS finalized new restrictions on marketing practices by agents, brokers, and web-brokers effective June 2026, including:
    - Offering cash, gift cards, rebates, or other cash-equivalent incentives to encourage enrollment in a Marketplace plan.

- Advertising that consumers are guaranteed to receive "$0 premiums" or "$0 health insurance" when eligibility depends on individual circumstances.
- Misrepresenting enrollment deadlines or creating false urgency to pressure consumers into enrolling.
- Using misleading information about available benefits, costs, or financial assistance.

- **Consumer Consent and Application Review Requirements:** Beginning with plan years on or after January 1, 2028, agents, brokers, and web-brokers will be required to use standardized HHS-approved consent and eligibility review forms.
- **Increased Oversight:** CMS finalized additional oversight requirements for enrollment transactions conducted by agents, brokers, and web-brokers.

Other Provisions

CMS decided against finalizing two proposals to better preserve the enrollment experience, making it easier for patients to compare coverage options, access financial assistance, and receive support from trusted enrollment assisters.

CMS opted not to finalize:

- **The State Exchange Enhanced Direct Enrollment (SBE-DE) option, which would have allowed SBEs to use private web-broker platforms.** State Exchanges must continue operating centralized eligibility and enrollment functions.
- **Removing the requirement that State Exchanges operate a centralized consumer-facing eligibility and enrollment website.**

MARKETPLACE ENROLLMENT & ELIGIBILITY VERIFICATION

CMS finalized several new eligibility and enrollment verification requirements intended to strengthen program integrity. Many of these provisions were originally finalized in the 2025 Marketplace Integrity and Affordability Rule but were subsequently subsequently struck down in the courts. The 2027 NBPP permanently reinstates several of these requirements beginning January 1, 2027, including updated income verification requirements when:

Income Verification When Data Indicates Income Below 100% FPL

Exchanges must generate a Data Matching Issue (DMI) when an applicant projects annual household income above 100% of the Federal Poverty Level (FPL), but trusted data sources indicate their income is below that threshold.

- Individuals with fluctuating or difficult to document income, such as self-employed workers, seasonal workers, gig workers, and hourly employees, may be more likely to receive a DMI and be required to submit additional documentation. This is a significant change because eligibility for premium tax credits is tied to income.
- CMS also removed a previously established sunset date, making this ***a permanent requirement***.

Income Verification When IRS Tax Data is Unavailable

Exchanges are no longer required to accept a household's self-attestation of income when Internal Revenue Service (IRS) tax data is unavailable.

- Historically, consumers could rely on their income attestation if IRS records lacked sufficient information. Beginning January 1, 2027, consumers will need to provide additional documentation to verify their income.
- ***CHC Outreach & Enrollment (O&E) staff may need to help patients resolve more data-matching issues, which could delay coverage and increase the risk of coverage gaps.***

Pre-Enrollment Special Enrollment Period (SEP) Verification

Beginning January 1, 2027, Exchanges will now need to verify eligibility for at least 75% of new SEP enrollments on the Federal platform before coverage can take effect. This policy applies to several common SEP categories, including:

- Loss of minimum essential coverage
- Marriage
- Birth, adoption, or placement for adoption
- Permanent move to a new service area
- Medicaid or CHIP eligibility determinations

CHC O&E staff may need to help patients obtain documentation and navigate enrollment delays, particularly for patients with urgent health care needs. If the correct documentation is not submitted and verification is not completed, the plan selection may be canceled and coverage will not begin. CMS finalized this requirement without a sunset provision, making it ***permanent***.

Failure to File and Reconcile Advanced Premium Tax Credits (APTCs)

Under the ACA, consumers receiving APTCs must file a federal income tax return and reconcile the amount of subsidy received with the amount they were actually eligible for based on annual income. In the final NBPP rule, CMS finalized new requirements to tighten enforcement of tax filing and reconciliation for individuals receiving APTCs. Failure to complete this process can result in a loss of future premium assistance. Specifically;

- Beginning in plan year 2028, all Exchanges must deny APTCs to individuals who failed to file a federal tax return and reconcile for a single prior year.
- For plan year 2027, State-Based Exchanges (SBEs) may choose to apply either a one-year or a two-year standard, while HealthCare.gov will implement a one-year standard.
- Consumers who lose eligibility for APTCs may still enroll in Marketplace coverage but would be responsible for the full premium amount.
- CMS also finalized new consumer notice requirements, including more urgent warning language that notifies consumers they are at imminent risk of losing financial assistance. Consumers will receive both direct and indirect notices reminding them of their obligation to file and reconcile.

Patients who miss tax filing or reconciliation requirements may lose financial assistance more quickly, making coverage less affordable and increasing the risk of becoming uninsured. ***CHC patients experiencing homelessness, housing instability, or limited access to tax preparation assistance may be disproportionately affected.***

Eligibility For Lawfully Present Immigrants

CMS finalized changes implementing provisions of **H.R. 1**, the budget reconciliation bill that restricts eligibility for Marketplace APTCs and cost-sharing reductions (CSRs) for certain lawfully present immigrants:

- **Medicaid-Related Immigration Exception:** Effective immediately, lawfully present immigrants who are ineligible for Medicaid because of their immigration status can no longer qualify for Marketplace subsidies through the longstanding exception for individuals below 100% FPL.
- **New Eligibility Restrictions:** Beginning in 2027, Marketplace financial assistance will generally be limited to lawful permanent residents (green card holders), certain Cuban and Haitian immigrants, and individuals residing in the U.S. under a Compact of Free Association. Many other lawfully present immigrants who previously qualified for subsidies will no longer be eligible.
- **Enhanced Verification Requirements:** Federal and State Exchanges must now verify that an individual is lawfully present and meets the new "eligible noncitizen" definition for premium subsidy eligibility. Immigration status will be verified through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) system or related federal verification services. Applicants whose status cannot be verified electronically may be required to submit additional documentation.

QUALIFIED HEALTH PLAN (QHP) DESIGN UPDATES

Expansion of Hardship Exemptions

CMS finalized an expansion of hardship exemption eligibility effective immediately. Individuals ineligible for APTCs or cost-sharing reductions because their projected household income falls below 100% FPL or exceeds 250% FPL may now qualify for a hardship exemption allowing enrollment in catastrophic coverage. This policy expands access to catastrophic plans regardless of age and in all states.

Multi-Year Catastrophic Plans

Catastrophic health plans are low-premium health insurance plans designed primarily to protect consumers from very high medical costs in the event of a serious illness or injury. These plans typically have very high deductibles and out-of-pocket costs, meaning consumers generally pay most routine health care expenses out of pocket before coverage begins. They cover the same 10 essential health benefits as other Marketplace plans, including preventive services at no cost.

In the final rule, CMS finalized standards that allow insurers to offer catastrophic plans with terms of up to 10 consecutive plan years, starting in 2027. Individuals who enroll in a multi-year catastrophic plan will not need to re-establish eligibility annually and may remain enrolled for multiple years if they were eligible when initially enrolled. ***However, deductibles and maximum out-of-pocket limits will continue to reset annually.***

Higher Cost-Sharing Limits

CMS also finalized changes to the permissible cost-sharing parameters, effective in 2027. For some Bronze plans, annual maximum out-of-pocket (MOOP) limits could reach approximately $15,600 for individual coverage and $31,200 for family coverage. Beginning in 2028, catastrophic plans will be permitted to have MOOP limits equal to 130% of the statutory ACA maximum.

Consumers may be drawn to lower-premium catastrophic and bronze plans without fully understanding the significantly higher financial exposure associated with these plans. While lower-premium plans may appear attractive to patients, they can carry very high deductibles and out-of-pocket expenses. ***CHC enrollment assisters should help patients understand the tradeoffs of enrolling in a Bronze or Catastrophic plans, especially for patients with chronic conditions, prescriptions, or ongoing care needs.***

Standardized Plan Requirements

CMS finalized the removal of the federal requirement that issuers in Federally Facilitated Exchanges (FFE) and State-Based Exchanges on the Federal Platform (SBE-FPs, such as the ones in Arkansas & Oregon) offer standardized plan options.

- Standardized plans required insurers to use uniform deductibles, copayments, and cost-sharing structures, making it easier for consumers to compare plans. CMS also eliminated the preferential display of standardized plans on HealthCare.gov.

Non-Standardized Plan Limits

CMS also removed limits on the number of non-standardized plans that issuers may offer within a service area. The final rule eliminates both the cap on non-standardized plans and the exceptions process that previously governed additional plan offerings. As a result, consumers may see more plan options available on HealthCare.gov beginning in 2027. ***Eliminating both standardized plans and plan quantity limits may increase consumer confusion and make it more difficult to identify plans that include CHCs and provide affordable access to care.***

Non-Network Qualified Health Plan (QHP) Certification

Unlike traditional Marketplace plans that contract with a defined network of providers, non-network plans do not maintain provider networks. Instead, they establish a payment amount for covered services and rely on providers' willingness to accept it as payment in full. These plans are intended to offer consumers greater flexibility in provider choice, but they may also make it more difficult to determine where care can be obtained and what costs may be incurred.

Beginning in plan year 2028, CMS finalized a new pathway allowing non-network plans to be certified as Qualified Health Plans (QHPs). Plans will have to go through several steps to obtain certification, including demonstrating sufficient access to a range of providers and providing clear information on participating providers and anticipated costs. Find more information here. ***Ultimately, these plans may create confusion for patients because they do not use traditional provider networks. Patients may need help understanding whether their CHC and other providers will accept the plan's payment amount as payment in full.***