Top 10 FY27 ACA Marketplace Program Changes

Source document: CMS-9883-F, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule, available at https://www.cms.gov/files/document/cms-9883-f-patient-protection.pdf; 1121 pages.

Overview

This rule is likely to make the individual-market Marketplace more operationally restrictive for some subsidized enrollees, while giving issuers and states more flexibility in plan design, network oversight, and catastrophic/high-deductible products.

At-a-Glance Business Impact

Change	Primary Business Risk	Functions Most Affected
Immigration-related APTC/BHP eligibility limits	Coverage loss; uncompensated care	Finance, revenue cycle, community health
Low-income noncitizen APTC changes	Uninsured growth among very low-income patients	ED, ambulatory, safety-net access
1-year tax filing and reconciliation rule	Subsidy loss; enrollment churn	Eligibility, financial counseling
Income verification and data matching	Enrollment friction; documentation delays	Patient access, revenue cycle
SEP restrictions and verification	Fewer mid-year coverage opportunities	Access, population health, enrollment assistance
Catastrophic coverage hardship pathway	More insured-but-underinsured patients	Finance, contracting, collections
Bronze and catastrophic plan flexibility	Higher patient cost-sharing exposure	Revenue cycle, service-line planning
State network adequacy flexibility	Potentially narrower QHP networks	Managed care, strategy
State ECP/provider-access reviews	More state-specific oversight	Government affairs, contracting
Non-network QHP certification pathway	New contracting and payment dynamics	Managed care, legal, revenue cycle

Top 10 Changes and Business Implications

1. Tighter eligibility for premium tax credits for certain lawfully present noncitizens

What changed: CMS aligns Marketplace advance premium tax credit eligibility with new statutory limits by narrowing eligibility for certain lawfully present noncitizens. CMS also states that Federal Basic Health Program payments to states will cease for BHP enrollees who are lawfully present but do not meet the new eligibility standard.

Health system impact: This is one of the most important coverage-risk provisions. Hospitals and ambulatory networks in markets with meaningful immigrant populations should anticipate potential Marketplace coverage

loss, churn, affordability problems, and bad-debt exposure. The impact may be concentrated in emergency departments, safety-net clinics, women's health, pediatrics, behavioral health, and primary care.

2. Elimination of APTC eligibility for certain lawfully present noncitizens below 100% FPL

What changed: CMS finalizes conforming changes so that premium tax credits are no longer available for certain lawfully present noncitizens who are ineligible for Medicaid because of immigration status and have income below 100% of the federal poverty level. CMS also indicates this will affect Federal BHP payments for such individuals.

Health system impact: This could move some very low-income patients from subsidized coverage into uninsured or unstable coverage status. Health systems should model likely effects by geography, payer mix, and service lines serving low-income immigrant communities.

3. Faster loss of APTC for failure to file and reconcile taxes

What changed: CMS finalizes a 1-year failure-to-file-and-reconcile policy. Exchanges on the Federal platform will apply it beginning in plan year 2027. State Exchanges may use either a 1-year or 2-year policy in 2027 but must use the 1-year policy beginning in 2028.

Health system impact: This is a coverage-churn provision. Patients who remain financially eligible for subsidized coverage may nonetheless lose affordability support because of tax-filing noncompliance. Health systems should expect more patients with terminated subsidies, premium nonpayment risk, delayed care, and confusion at registration.

4. More income-verification friction and data-matching issues

What changed: CMS continues income-verification policies in plan year 2027 and beyond, including creating income data-matching issues when trusted data sources show projected income below 100% FPL. CMS also removes the requirement to accept a household income attestation when no tax data is returned.

Health system impact: This could increase administrative friction for patients trying to enroll in or retain subsidized coverage. For providers, the operational effect may show up as delayed coverage, eligibility denials, and more patients needing financial counseling or documentation assistance.

5. Elimination of the 150% FPL special enrollment period and broader SEP verification

What changed: CMS finalizes removal of the 150% FPL special enrollment period and broader SEP verification, requiring Exchanges on the Federal platform to conduct SEP verification for at least 75% of new enrollments.

Health system impact: The 150% FPL SEP has been an important pathway for low-income people to enroll outside open enrollment. Removing it and increasing SEP verification may reduce mid-year coverage opportunities, leaving more patients uninsured until the next open enrollment period.

6. Expanded access to catastrophic coverage for people ineligible for subsidies

What changed: CMS finalizes hardship-exemption changes allowing individuals who are ineligible for APTC or cost-sharing reductions because projected household income is below 100% FPL or above 250% FPL to qualify for a hardship exemption. Individuals age 30 and older who receive the exemption can enroll in catastrophic coverage if otherwise eligible.

Health system impact: This may reduce the number of completely uninsured patients, but it may also increase the number of patients with very high deductibles and limited first-dollar coverage. Catastrophic coverage is

better than no coverage, but it can still create high patient balances, delayed elective care, and collection challenges.

7. New flexibility for bronze and catastrophic plan designs, including higher cost-sharing exposure

What changed: CMS finalizes new bronze-plan cost-sharing flexibility beginning in plan year 2027, allowing certain individual-market bronze plans to exceed the standard annual limitation on cost sharing by up to 130% of the standard limit. CMS also finalizes multi-year catastrophic plans with terms of up to 10 consecutive plan years beginning in 2027.

Health system impact: The business risk is not simply whether patients are insured, but whether they are underinsured. Higher out-of-pocket exposure can translate into bad debt, delayed care, more charity-care screening, and added pressure on revenue-cycle operations.

8. State Exchanges and SBE-FPs no longer must use quantitative network-adequacy reviews as stringent as FFE standards

What changed: CMS removes the requirement that State Exchanges and State-based Exchanges on the Federal platform impose quantitative time-and-distance standards at least as stringent as Federally-facilitated Exchange standards and removes the requirement that they conduct quantitative network-adequacy reviews before QHP certification. They must still ensure sufficient provider access under applicable standards.

Health system impact: This gives states more discretion and may create more variation in network adequacy enforcement. Health systems should watch for QHPs proposing narrower networks or more aggressive contracting positions in states where oversight becomes less prescriptive.

9. FFE states may conduct their own provider-access and ECP reviews

What changed: CMS finalizes a framework allowing Federally-facilitated Exchange states to conduct provider-access reviews if they demonstrate sufficient authority and technical capacity. CMS also finalizes a new Effective Essential Community Provider Review Program allowing FFE states to conduct their own ECP certification reviews. Non-network plan provisions in this area are generally implemented beginning in 2028.

Health system impact: Oversight of QHP networks and ECP participation may become more state-specific. Safety-net hospitals, children's hospitals, cancer centers, academic medical centers, FQHC-affiliated systems, and rural providers should track state-level implementation because it could influence whether issuers must include them in QHP networks.

10. Non-network QHPs can be certified beginning in 2028

What changed: CMS removes the requirement that all QHPs use a provider network and creates a pathway for non-network plans to receive QHP certification beginning in plan year 2028. These plans must demonstrate sufficient choice of providers that accept the plan's benefit amount as payment in full and reasonable access to ECPs that accept that payment amount.

Health system impact: This is potentially significant for provider contracting. Non-network products could weaken traditional network contracting dynamics if issuers try to steer patients into plans built around fixed benefit amounts rather than negotiated contracts. Hospitals should evaluate whether these products could increase patient billing complexity, create pressure to accept plan-set payment amounts, or generate payment disputes.

Other Notable Provisions

- CMS finalizes 2027 user fee rates of 1.9% for Federally-facilitated Exchanges and 1.5% for State-based Exchanges on the Federal platform.
- CMS removes standardized plan option requirements and non-standardized plan limits beginning in 2027.
- CMS prohibits routine non-pediatric dental services from being included as essential health benefits.
- CMS requires QHP issuers to submit quality improvement strategies addressing any two of the five statutory QIS topic areas beginning in 2027.