SUMMARY OF PROVISIONS OF HHS' PROPOSED 2026 NOTICE OF BENEFIT AND PAYMENT PARAMETERS AND OTHER KEY REGULATIONS

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On October 4, 2024, the Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (proposed Payment Notice) for 2026.[1] *The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in 2025 and beyond. This paper summarizes key provisions of the proposed notice and maximum out of pocket information*[2] *recently released by HHS. Comments are due within 30 days of publishing in the Federal Register.*

Overview

The following highlights the key changes included in the 2026 proposed Payment Notice. More information on these and other proposed changes follow.

1. **User Fees:** HHS proposes to increase user fees to 2.5 percent for issuers in the Federally-facilitated Marketplace (FFM) from 1.5 percent and to 2.0 percent from 1.2 percent for issuers in state-based Marketplaces operated by HHS (SBM-FPs). However, the user fee rate is subject to change should Congress authorize enhanced subsidies for the 2026 benefit year before April 2025.
2. **Preventing Unauthorized Marketplace Activity Among Agents and Brokers:** HHS proposes several policies to reduce the amount of noncompliance and unauthorized agent/broker activity.
3. **Standard Plans:** HHS proposes to continue to require issuers operating on the Healthcare.gov platform to offer standard plans. Standardized options would be required for every network type, metal, and throughout every service area where an issuer offers a non-standardized product on-

[1] Department of Health and Human Services, "Proposed Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026", https://public-inspection.federalregister.gov/2024-23103.pdf

[2] https://www.cms.gov/files/document/2026-PAPI-Parameters-Guidance-2024-10-08.pdf

Exchange. HHS also proposes to reintroduce a meaningful difference standard for FFMs to reduce consumer confusion by ensuring plans are different enough from one another.

4. **Silver Loading:** HHS solicits feedback to determine if it should codify silver-loading in regulation.
5. **Updating Premium Payment Thresholds**: HHS seeks comments on ways it can work with state insurance departments and other entities to reduce the risk of issuer insolvency.
6. **Risk Adjustment:** HHS proposes several updates to the risk adjustment model. This includes updates to the data used to recalibrate the model, the risk adjustment coefficients, and the risk adjustment user fee. Additionally, it proposes to create a new component, namely the Affiliated Cost Factor (ACF) to reflect costs that are not related to active medical conditions. Consequently, HHS proposed the use of ACF for enrollees that use PrEP. Finally, HHS requests comment on if the time value of money should be taken into account for collection and remittance of State transfers.
7. **Risk Adjustment Data Validation (RADV):** HHS proposes several changes to the RADV audit including changes to members included in the initial validation audit (IVA) sampling, sampling adjustments for small issuers, and methodology used for the secondary validation audit (SVA).
8. **Medical Loss Ratio** HHS proposes to change the MLR formula by shifting risk adjustment from the numerator to the denominator in the MLR formula for issuers for who receive large risk adjustment payments (over 50% of premiums).
9. **Maximum Out of Pocket:** The maximum out of pocket increased 10.3% to $10,150 for an individual or $20,300 for a family.
10. **Basic Health Plan (BHP) Methodology –** HHS proposes a payment methodology to handle situations in which states implement a BHP part way through the year.
11. **Actuarial Value Calculator:** HHS announced that it would no longer be releasing both a proposed and final Actuarial Value Calculator (AVC). Instead, it would only release a final AVC each year and use comments from the final AVC to update next year's AVC. At the time of this publication, the 2026 AVC has not yet been released.

The following provides more detail on each of the items summarized above.

User Fees

HHS proposes to increase user fees in 2026 compared to 2025 for issuers in states that utilize Healthcare.Gov. In particular, HHS proposes for 2026 benefit year FFM and SBM-FP user fee rates equal to 2.5 percent and 2.0 percent of total monthly premiums, respectively. In 2025 user fee rates were 1.5 percent for FFMs and 1.2 percent for SBM-FPs. However, if the enhanced premium tax credit (PTC) subsidies as currently enacted or at a higher level are extended through the 2026 benefit year by March 31, 2025, HHS proposes a 2026 benefit year FFE user fee rate range between 1.8 and 2.2 percent of total monthly premiums and a 2026 benefit year SBE-FP user fee rate range between 1.4 and 1.8 percent. Consequently, the final 2026 user fee rate may be unknown until March 31 of next year.

Preventing Unauthorized Marketplace Activity Among Agents and Brokers:

HHS proposes a number of key changes to regulations involving agents and brokers for Healthcare.gov states. HHS has dealt with an increase in unauthorized changes in consumers' enrollments by agents and brokers in the past year. While they have enacted some operational changes to address this issue[3], CMS feels that regulatory changes are also necessary.

To increase oversight on agents/brokers, HHS proposes to hold "lead agents" (i.e., directors of agency) accountable for any findings of noncompliance in addition to the agent/broker in question. It also clarified its authority to suspend agents or brokers. The regulation also proposes to increase training requirements as well as transparency requirements, such a model consent form.

Standard Plans and Limitations on Non-Standard Plans

Standard Plan Options (SPOs)

HHS proposes to continue requiring QHP issuers operating on the Healthcare.gov platform to offer standard plans. The standardized option rules only apply to states using the federal platform (FFE and SBE-FP) and is not required for state Marketplaces. States on the federal platform who already have standardized plan requirements as of January 1, 2020 are exempt (and will use the state rule). Standardized options would be required for every network type, metal, and service area for which the issuer offers a non-standardized product. 2026 SPOs are intended to remain consistent with 2025 SPOs, with minor differences. The exact plan designs can be found in the Notice of Benefit and Payment Parameters (Tables 11 and 12). HHS proposes to continue the limitation on non-standardized plan options per product network type, metal level, and inclusion of dental, pediatric dental, and/or adult vision.

Additional Limitations

HHS has observed that some insurers are offering standardized plan options that are too similar and may cause consumer confusion. Consequently, HHS is proposing to reintroduce meaningful difference standard. Plans must be different enough for these plans to be accepted for issuers operating in Healthcare.gov states. These differences include different provider networks, formulary, deductible type, in-network tiers, a $500 or more difference in maximum out of pocket cap or a $250 or more difference in deductible. A full listing of acceptable differences can be found in the Payment Notice.

[3] https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity

Silver Loading

HHS requested comments on whether to formalize current guidance in regulation to allow for silver-loading. Issuers currently offset additional costs related to cost-sharing reductions by increasing silver premiums. While there is guidance that allows for silver-loading (as opposed to loading these costly broadly across all premiums not just silver), there is no regulation that permits it. Codifying (e.g., putting into formal regulation) silver-loading would make it harder for a future administration to disallow the practice.

Updating Premium Payment Thresholds

HHS proposes to allow issuers greater flexibility in waiving minimal amounts of unpaid member premiums. Currently after an enrollee pays his/her binder payment (initial premium amount), issuers can set a "reasonable" net premium threshold by which a member can avoid a grace period without paying the full amount of premiums owed. CMS proposes to allow issuers either a threshold of at least 95 percent of the net premium or a fixed-dollar premium threshold, which can be no more than $5. This increased flexibility is expected to slightly increase enrollment (the impact analysis estimates APTC transfers to increase by $481 million dollars).

Reducing Issuer Insolvency Risks

In recent years, several issuers insolvencies have caused disruptions to the individual market. HHS seeks comment on ways that it can help reduce the risks of insolvency, especially for issuers that operate on Healthcare.gov. HHS notes that it could increase coordination with state departments of insurance and the National Association of Insurance Commissioners (NAIC). It could also request additional financial data and if specific issuers are at risk, HHS could act to cap enrollment, deny QHP certification, or take other actions to reduce disruptions.

Risk Adjustment

HHS proposes several updates to the risk adjustment program in the Payment Notice.

Sequestration

The risk adjustment program will be sequestered at a rate of 5.7% for funds collected during fiscal year 2025. These sequestered amounts will be available to issuers in fiscal year 2026 (i.e., there's a delay in payment for some risk adjustment payments). The Infrastructure Investment and Jobs Act extended the 5.7% sequestration through fiscal year 2031.

Risk Adjustment Model Recalibration & Changes

HHS proposes to recalibrate the 2026 benefit year risk adjustment models using the 2020, 2021, and 2022 enrollee-level EDGE data. HHS also proposes to begin phasing out the market adjustment for Hepatitis C drugs which accounts for the introduction of new and generic Hepatitis C drugs.

HHS is also proposing to add a new type of factor – Affiliated Cost Factor (ACF) - to the adult and children models starting in 2026. ACF would be for specific services that do not indicate a specific active medical condition but may explain significant cost differences. They propose to incorporate a pre-exposure prophylaxis (PrEP) as the first ACF in 2026. HHS also indicates that cost of gene therapies could be a future ACF. Given that the data on gene therapies is limited and the cost varies substantially, HHS noted that gene therapies may not be appropriate to include otherwise.

HHS requests comment on if the time value of money should be taken into account for collection and remittance of State transfers. This has the potential for increasing transfers if finalized.

Risk Adjustment User Fee

HHS proposes a risk adjustment user fee of $0.18 per member per month (PMPM) for the 2026 benefit year. This is a decrease from the prior year, a contrast to Healthcare.gov user fee rates.

Risk Adjustment Data Validation (RADV)

HHS proposes several changes to the RADV sampling methodology. Changes impact both the initial and second validation audits (IVA and SVA).

Beginning with the 2025 HHS-RADV year, HHS proposes to exclude enrollees without HCCs from the IVA sample. This change is intended to better align the sampled population with the 2019 NBPP change of applying HHS-RADV error rates to only the HCC-portion of PLRS. HHS also proposes to remove the Finite Population Correction which adjusts sample population for issuers with less than 4,000 members. HHS proposes instead to sample 200 members with HCCs for each HIOS ID. For HIOS IDs with less than 200 members with HCCs, all members with HCCs will be sampled. HHS also proposes to replace the source of the Neyman allocation data with the three most recent years of consecutive HHS-RADV data instead of its current MA-RADV proxy data.

Beginning with the 2024 HHS-RADV year, HHS proposes to modify the SVA to use a bootstrapped 90 percent confident interval and to increase the SVA subsample size to 24 enrollees (previously 12).

Beginning with the 2023 HHS-RADV year, HHS proposes to add a new materiality threshold for HHS-RADV appeals and rerunning with an impact to State transfers of at least $10,000.

Medical Loss Ratio Changes

HHS is also proposing a change to the MLR formula. For issuers and only for issuers, whose risk adjustment receipts exceed 50 percent of premium revenue, the MLR formula would subtract risk adjustment from the denominator rather than the numerator (which is what currently occurs). This change makes it easier for issuers to meet the MLR standard and would be effective for the 2026 MLR reporting year. HHS also solicits comments to make the change for all issuers (i.e., all issuers would subtract risk adjustment from the denominator for purposes of MLR calculations). HHS cautions this would make it harder for issuers that owe large risk adjustment charges to meet MLR standards and consequently prefers the more limited change to the MLR formula.

In a simplified example, for issuers with large receipts, if premium revenue equals $850 PMPM, claim costs $1,100 PMPM, and risk adjustment receipts $450 PMPM, under the current formula the MLR would be 76.5% and under the proposed formula equal to 84.6%. Should CMS not finalize its proposed approach but instead select a broader approach, the formula change would apply in all situations to all issuers. For example, for issuers with large payables, if premium revenue equals $600 PMPM, claim costs $200 PMPM, and risk adjustment payments $300 PMPM, under the current formula the MLR would be 83.3% and under the proposed formula equal to 66.7%.

Maximum Out of Pocket Updates

HHS no longer publishes maximum out-of-pocket (MOOP) amounts in the Payment Notice, but instead will finalize the values via guidance. HHS published guidance[4] finalizing the MOOP amounts for non-CSR plans[5] and cost-sharing variations for 2026. The MOOP will be **increasing** 10.3% from the 2024 amounts of $9,200/$18,400 (single/family

- Non-CSR Plans: $10,150/$20,300 (single/family)
- 100%-150% FPL: $3,350/$6,700. In 2025 these amounts were $3,050/$6,100 (single/family) so 2026 represents a significant increase relative to last year's value.
- 150%-200% FPL: $3,350/$6,700 (single/family). Similarly, 2026 represents an increase relative to 2025's value of $3,050/$6,100 (single/family).
- 200%-250% FPL: $8,100/$16,200 (single family). This amount is an increase from 2025 levels, which was set at $7,350/$14,700 (single/family).

[4] https://www.cms.gov/files/document/2026-PAPI-Parameters-Guidance-2024-10-08.pdf

[5] Standard plans include platinum, gold, silver non-cost sharing variation, enhanced bronze metal offerings as well as catastrophic plans.

- The catastrophic plan's deductible and MOOP will be set to $10,150/$20,300 (single/family). This is a significant increase relative to 2024's value of 9,200/$18,400 (single/family).

Basic Health Plan Methodology Chage

HHS proposes a change to the BHP payment methodology. The Federal BHP payment amount must equal 95 percent of the value of the PTC and CSRs that would have been paid on behalf of BHP enrollees if they enrolled in a QHP through an Exchange. There are currently two states that have implemented BHP. A change to the premium adjustment factor (PAF) is proposed to calculate the adjusted reference premium (ARP) used to calculate the BHP payment starting in program year 2026. The PAF accounts for the premium increases in other States that took effect after discontinuing payments to issuers for CSRs provided to enrollees in QHPs offered through Exchanges and depends on the timing of BHP of implementation.

If a State uses second lowest cost silver plan (SLCSP) premiums from a premium year in which BHP was partially implemented (for a part of the premium year), the PAF value is calculated to reflect the partial year CSR load filed by the issuers for the premium year. This approach is based on the premium year, not necessarily the program year.

Finally, the proposed guidance in the technical clarification for calculating BHP payment in cases of multiple SLCSP in a rating area (which typically occurs when if QHPs have plan offerings in only a part of the county instead of the entire county). For such cases, starting with the program year 2026 payment methodology, the proposed approach is to use the premium of the SLCSP applicable to the part of the county with the largest total population.

The 2026 Actuarial Value Calculator (AVC)

HHS also notes that it would no longer be releasing both a draft and final AVC. Instead, it would only release a final AVC. Any comments on the final AVC would be used to update the next year's AVC. HHS made this change to speed up the release of the final AVC and therefore make it easier on states creating standard plans as well as issuers by having a final AVC sooner. HHS notes that it does not expect any major changes in the 2026 AVC relative to the 2025 AVC.

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.

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

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Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.