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MEMORANDUM

To: **CPR and HAB Coalition Members**

From: **Peter Thomas and Michael Barnett**

Date: **July 6, 2026**

Subject **Summary of Final Rule: HHS Notice of Benefit and Payment Parameters**

On May 15, 2026, the U.S. Department of Health and Human Services ("HHS"), through the Centers for Medicare and Medicaid Services ("CMS"), published the HHS Notice of Benefit and Payment Parameters ("NBPP") for 2027 Final Rule[1] to the Federal Register. This rule finalizes the 2027 benefit and payment parameters, provisions related to Essential Health Benefits ("EHBs"), qualified health plans ("QHPs"), risk adjustment, and the operation of Federally-Facilitated Exchanges ("FFEs") and State-based Exchanges ("SBEs"), as well as many other policies implementing the Affordable Care Act ("ACA").[2]

Overall, the Final Rule finalizes as proposed many of the major provisions on which the Coalition to Preserve Rehabilitation ("CPR") and the Habilitation Benefits ("HAB") Coalition commented in its joint comment letter. Of note, the Final Rule does not address several issues that were addressed in our comment letter, including: the need for *separate* service caps for rehabilitation and habilitation therapy benefits—if the plan uses benefit caps at all—under the ACA. The rule does, however, finalize the proposed state defrayal policy that the CPR and HAB Coalition strongly opposed in our joint comment letter that will impact the scope of essential health benefits available to plan enrollees in the states.

This memorandum summarizes the key provisions finalized in the 2027 NBPP that are most relevant to CPR and HAB Coalition members and highlights where CMS did—or did not—respond to the concerns raised in our joint comment letter.

I. Essential Health Benefits and Rehabilitation/Habilitation Coverage

The CPR and HAB Coalitions have previously approached the Center for Consumer Information and Insurance Oversight ("CCIIO") on multiple occasions—both in-person and virtually—to discuss ways to improve rehabilitative and habilitative benefits by separating and limiting the

[1] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program,* 91 Fed. Reg. 29,526 (May 20, 2026) (to be codified at 42 C.F.R. pt. 600 and 45 C.F.R. pts. 153–58). https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf

[2] *Id*. at Section 1302.

impact of the therapy caps associated with both benefits, which the vast majority, if not all, ACA plans employ. Both Coalitions have also submitted extensive written comments on this specific topic in response to previous annual Notice of Benefit and Payment Parameters proposed rules. Furthermore, both Coalitions also jointly responded to CMS' Request for Information ("RFI") on Essential Health Benefits ("EHBs") in January 2023 stressing similar points.

During our most recent joint meeting with CCIIO in December 2025, we reiterated that our number one goal is to eliminate arbitrary therapy caps under ACA and private plans across-the-board for medically necessary care, especially for rehabilitative and habilitative services and devices. However, given the ACA's statutory allowances of non-dollar caps in benefits, and in light of our previous advocacy efforts with CCIIO on this issue that have not generated regulatory interest in this approach, we believe an exceptions process similar to the one imposed by Congress on the Medicare program is a meaningful alternative worthy of serious consideration for ACA plans. While we were hopeful CMS would have addressed some of these concerns mentioned in response to the 2023 EHB RFI or issue a new RFI, we encouraged the Agency to move forward with addressing this issue, and our recommendations, as expeditiously as possible. However, we are disappointed that, once again, neither CMS nor CCIIO have meaningfully addressed this issue in any written regulatory activity.

The final rule, as in years past, again does not address the arbitrary therapy caps in ACA marketplace plans nor does it include new enforcement mechanisms or compliance standards specifically targeting discriminatory benefit design related to habilitation and rehabilitation therapy services. This increased enforcement and compliance would pressure-test some of these plans to make sure they are meeting patient needs, especially in light of the pervasive lack of clinical evidence for therapy caps. The outright omission of mention of this issue in this year's proposed or final rules is significant given the extensive concerns raised by both Coalitions regarding discriminatory and non-evidence-based therapy limitations that disproportionately impact individuals with significant injuries, chronic conditions, developmental disabilities, neurologic impairments, and other complex medical needs.

II. Catastrophic Plan Eligibility Expansion

One of the most consequential provisions in the final rule is CMS's decision to move forward with substantially expanding catastrophic plan eligibility. Section 1302(e)[3] of the ACA narrowly limits catastrophic plan eligibility to individuals under age 30 and those who qualify for hardship or affordability exemptions. Congress designed catastrophic plans as a narrow, short-term option—not as a mainstream alternative to bronze coverage. This final rule expands access to catastrophic plans beyond these traditional categories and finalizes broader eligibility pathways tied to income-related circumstances.

CPR and the HAB Coalition strongly opposed his proposal in our joint comment letter, arguing that catastrophic plans provide limited practical coverage for individuals with serious rehabilitation and habilitation needs because services generally are not covered until the enrollee reaches the plan deductible and maximum out-of-pocket ("MOOP") threshold. We noted in our joint comments that Congress intentionally limited eligibility for catastrophic coverage, and that

[3] 42 U.S.C. § 18022(e)

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expanding it broadly without congressional authorization risks steering patients into plans that appear affordable initially but leave them exposed to severe financial hardship when health needs arise, particularly needs involving access to rehabilitation therapies and other forms of post-acute care. We argued that expanding catastrophic coverage would increase the rate of individuals who are underinsured, expose patients with disabling conditions to substantial financial risk, encourage enrollment in high-deductible coverage with limited upfront benefits, undermine meaningful access to medically necessary rehabilitation and habilitation services, and potentially destabilize the broader individual market risk pool. Despite these concerns, CMS finalized this policy largely as proposed.

Higher Cost-Sharing Exposure in Catastrophic and Bronze Plans

The ACA established annual limits on cost-sharing under ACA plans to protect patients from catastrophic medical debt, and those limits are central to the law's consumer protection framework. The rule finalizes policies permitting bronze plans to exceed statutory MOOP limits and require catastrophic plans to delay coverage until patients reach 130 percent of the MOOP. In practice, this means some enrollees would need to spend more than $15,000—or far more for families—before coverage meaningfully begins. This finalized policy raises serious concerns for individuals requiring intensive rehabilitation or habilitation services, which involve recurring therapy visits, assistive technologies, specialty care, and long-term treatment.

This is particularly concerning for patients who rely on habilitative and rehabilitative services and devices, which are included in the ACA's list of EHBs. These services are not optional or discretionary. In fact, they enable children to develop speech and motor skills, allow adults to regain mobility after injury, and help individuals with disabilities maintain independence and avoid institutionalization. High upfront cost-sharing forces patients to delay or forgo medically necessary habilitation and rehabilitation therapy. Missed or delayed habilitation or rehabilitation therapy often results in permanent functional decline, preventable complications, and higher long-term costs in both Medicare and Medicaid.

CPR and the HAB Coalition warned in our joint comments that higher upfront cost-sharing obligations can delay medically necessary care, increase functional decline, worsen health outcomes, and ultimately increase downstream costs to Medicare, Medicaid, and the broader healthcare system. Nevertheless, CMS is proceeding with policies that shift greater financial liability onto enrollees before coverage meaningfully begins.

Multi-Year Catastrophic Plans Finalized

HHS is also finalizing the creation of catastrophic plans with plan terms of up to ten consecutive plan years. CPR and the HAB Coalition strongly opposed this proposal, expressing concern that multi-year catastrophic coverage could lock individuals into inadequate coverage structures even after they develop significant health conditions or disabilities.

More specifically, we noted in our joint comments that the ACA's market reforms, including guaranteed availability and annual cost-sharing protections, are structured around annual enrollment cycles for a reason. Annual reassessment allows consumers to adjust coverage as

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their medical needs evolve. The suggestion in the final rule that insurers could vary cost-sharing over time or structure higher out-of-pocket exposure in early years to incentivize long-term enrollment is particularly troubling. Such flexibility risks creating benefit designs that disadvantage individuals once they become high-cost or chronically ill. Patients with multi-year habilitation or rehabilitation needs—such as those undergoing treatment for cancer, stroke, or recovering from serious injury—could face especially high early financial burdens. The CPR and HAB Coalitions strongly urged HHS that value-based insurance design should promote access to effective care, not create new barriers to medically necessary services.

We emphasized that health status can change dramatically over time and that individuals who initially select catastrophic coverage while healthy may later experience medical events such as stroke, spinal cord injury, traumatic brain injury, progressive neurologic disease, cancer, or other disabling conditions requiring extensive rehabilitation and habilitation services. This finalized policy therefore raises ongoing concerns regarding continuity of access to comprehensive coverage and the adequacy of benefits for individuals with evolving medical and functional needs.

III. Essential Health Benefit Defrayal Policies

CMS finalized proposals related to State-required benefits and EHB defrayal obligations. "Defrayal" is a term that refers to the ACA's requirement that states contribute to the cost of premium subsidies for qualified individuals to afford ACA premiums in their state when the state enacts benefit mandates that exceed essential health benefits. CPR and the HAB Coalition expressed serious concerns in our joint comments regarding the proposed reversals of prior regulatory policy involving State defrayal requirements. Our joint comments warned that the changes could weaken consumer protections and force states to curtail access to benefits added to their EHB packages since implementation of the ACA, including rehabilitation and habilitation benefits not otherwise considered EHB in 2011. Although the final rule maintains the broader EHB framework, we remain concerned that the revised approach to defrayal could create incentives for narrower interpretation of EHB obligations over time and may undermine consistency in benefit protections across states. In some states, this new regulatory interpretation of defrayal could restrict state-enacted benefit mandates that have been considered EHB—and fully subsidized by the federal government—for several years.

In our joint comments, we strongly opposed the proposed revisions to EHB standards involving defrayal, arguing that the proposals would not only create financial instability for states but also reduce coverage protections for patients and jeopardize access to critical rehabilitative and habilitative services relied upon by individuals with disabilities and chronic conditions. We emphasized that the ACA established EHBs to ensure that health coverage in the individual and small group markets includes meaningful, comprehensive benefits and that Congress specifically required coverage of rehabilitation and habilitation services and devices as one of the ten EHB categories.

The CPR and HAB Coalitions also stressed that states relied on longstanding federal guidance confirming that benefits included in a State EHB-benchmark plan are treated as EHBs and therefore are not subject to State defrayal obligations, even where those same benefits were

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separately mandated under State law after 2011. Over time, many states updated their benchmark plans to improve coverage for services directly affecting individuals with disabilities and chronic conditions, including hearing services, durable medical equipment, habilitation therapies, autism services, and other supports and devices. These modernizations of benefit packages changed with contemporary clinical practice, recognizing the problem of locking-in a 2011 benefit design for years to come if such benefit modifications were not considered part of EHB. In most instances, states have not defrayed the cost of these modifications.

From the CPR and HAB Coalition's perspectives, the finalized policy creates two immediate risks. First, it destabilizes coverage gains that states have lawfully implemented and that patients have depended upon for years. Second, it increases the likelihood that important services and devices could be reclassified as non-EHB benefits in the near future. This distinction is highly significant because ACA consumer protections—including the prohibition on annual and lifetime dollar limits, application of annual maximum out-of-pocket protections, and eligibility for premium tax credits—apply specifically to EHBs. If services are reclassified as non-EHB, consumers will face higher premiums, increased out-of-pocket costs, and reduced financial protection and states will be required to add funding to help subsidize the cost of these benefits or delete them from the EHB in that state.

We further emphasized that these risks are particularly acute for individuals requiring medical rehabilitation therapy services following a stroke, spinal cord injury, traumatic brain injury, amputation, or progressive neurological disease, as well as children and adults who depend on habilitative therapy services and assistive technologies to maintain or improve daily functioning and independence. Reclassification of these services as non-EHB could expose patients to financial barriers that interrupt medically necessary care and produce long-term functional and financial consequences. Unfortunately, the final rule largely ignored the Coalitions' concerns and codified a new, more restrictive interpretation of defrayal of benefits which will have implications on the scope of EHB benefits in the future.

IV. Key Takeaways

The 2027 NBPP final rule reflects a continued policy direction toward increased issuer flexibility, expanded use of catastrophic coverage structures, and greater cost-sharing exposure for consumers with significant health care needs. From the CPR and HAB Coalition's perspectives, the final rule raises substantial concerns regarding affordability, nondiscrimination, and meaningful access to rehabilitation and habilitation therapy services for individuals with disabilities and chronic conditions.

CMS declined, yet again, to address longstanding concerns regarding discriminatory therapy caps and quantitative treatment limits, finalized expanded eligibility for catastrophic coverage despite significant stakeholder concerns regarding underinsurance and delayed access to medically necessary care, and finalized multi-year catastrophic plan options that may leave individuals who newly acquire or develop serious disabilities or chronic illnesses locked into inadequate coverage for extended periods. Collectively, these policies risk increasing financial barriers to care and shifting greater out-of-pocket liability onto patients who rely on intensive, ongoing rehabilitation and habilitation therapy services to maintain function, independence,

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health, and community participation. The final rule also fails to establish stronger rehabilitation- and habilitation-specific enforcement safeguards within EHBs implementation, leaving continued uncertainty regarding compliance with federal nondiscrimination and parity requirements.

The CPR and the HAB Coalitions remain deeply concerned that these policy changes may further erode access to medically necessary rehabilitation and habilitation services at a time when many individuals with disabilities already face significant coverage limitations, utilization management barriers, and unaffordable cost-sharing obligations. Moving forward, we will continue engaging with CMS, CCIIO, Congress, state regulators, and other stakeholders to advocate for stronger consumer protections and more meaningful enforcement of rehabilitation and habilitation coverage requirements. We will also continue monitoring implementation of this final rule and evaluating potential legislative, regulatory, and oversight opportunities to mitigate policies that may undermine access to care for people with disabilities and complex medical needs.

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