Long-Awaited Rule Aims To Boost ACA Choices While Embracing Higher Deductibles

New offerings include plans with 30% higher out-of-pocket costs and others with no set networks of doctors and hospitals.

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The Affordable Care Act seems to always be in a policy tug-of-war as its backers and critics spar over how it should work and who can qualify for coverage. This year is no different, with the Trump administration embracing standards it says will reduce fraud as well as steps that could further erode national enrollment.

Wide-ranging ACA changes pushed by the administration were finalized in mid-May, including new offerings such as plans with 30% higher out-of-pocket costs, and others with no set networks of doctors and hospitals.

The administration says such plans expand consumers' choices and may carry lower premiums.

The rule stated, though, that the combined effect of the new provisions could not only cost $1.3 billion each year to implement, but also reduce enrollment by up to an additional 2 million next year. That would come on top of already anticipated sign-up decreases this year because of higher premiums and smaller subsidy payments.

Over time, lower enrollment can boost premiums if insurers suspect their costs are rising because healthier people drop coverage more than sicker members do.

Some policy experts fear the changes will erode the ACA and make it more expensive, particularly for those whose subsidies have shrunk or disappeared.

"Even more people will lose coverage as healthcare costs and administrative burdens rise," said Katie Keith, director of the Center for Health Policy and the Law at the Georgetown University Law Center, who writes frequently on changes to the ACA. "All of this comes at a time when millions of consumers are already experiencing a healthcare affordability crisis."

The lengthy payment rule is an annual exercise in which the Centers for Medicare & Medicaid

Services, which oversees the ACA, can set new standards for coverage. The rule for next year is more ambitious than in past years, with changes to how plans are designed, eligibility verification, and adjustments needed to implement congressional legislation, along with technical updates.

Here are some of its biggest changes.

Non-Network Plans

Starting in 2028, some Affordable Care Act consumers may be able to pick plans that don't have dedicated networks of doctors and hospitals, which patients use to qualify for negotiated in-network payment rates.

Under this new model, enrollees would seek out providers willing to accept the amount their insurer will pay toward whatever nonemergency care they need, such as a sore throat, a doctor visit, or childbirth.

The rule requires insurers to have "a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full."

Regulators say the policy aims to reduce costs by getting consumers to "shop for lower prices and negotiate directly with providers."

But how the plans will work — and how they will be monitored for having enough practitioners — isn't yet clear, and that has raised concerns with some experts who say non-network plans might chip away at ACA safeguards intended to ensure enough medical providers are available in a given area. Patients could also find themselves on the hook financially when they find their doctor or hospital charges more than the insurer will reimburse.

Economist Matthew Fiedler, a senior fellow at the Brookings Institution, pointed out another potential pitfall with this approach.

"It may not always be obvious whether enough providers are willing to accept the plan's rates," he wrote in a comment letter to regulators. "If this is the case, non-network plans likely would offer lower premiums, mainly by paying lower prices for care and making accessing care harder."

There will likely be variation by state in how such plans must prove they have an adequate number of care providers willing to accept amounts as payment in full, said Louise Norris, a health policy analyst for healthinsurance.org, a consumer information and referral website affiliated with Trove Group.

"I would put a big buyer-beware notice on non-network plans," she told KFF Health News. "Consumers will need an understanding of how this will work, and also it puts the onus on the consumer to find out what the provider is charging."

But other viewpoints, including from the Paragon Health Institute, a conservative think tank,

consider the non-network plans a step forward for transparency and competition because they empower consumers.

“When consumers can see what the plan will pay and how provider prices vary, they have incentives to shop,” noted Paragon’s comment letter.

It will take time and more federal guidance, though, before it becomes clear what additional requirements these plans will face and how many insurers will decide to offer them. Some clues can be found in non-network plans sold by Ohio-based Sidecar Health, which offers such coverage in Ohio, Florida, Georgia, and Texas with enrollees in 48 states — but only for employer plans.

Higher Out-of-Pocket Costs

Another change coming soon is the potential for higher ACA out-of-pocket costs.

Under the final rule, insurers can set higher maximum out-of-pocket limits in two types of plans: bronze and catastrophic. That begins in 2027 for bronze plans, which already have the highest annual deductibles of all the metal-tiered plans but generally lower premiums as a result.

Starting next year, any insurer that offers at least one bronze plan with a regular out-of-pocket maximum — the total amount a consumer is responsible for in copayments and deductibles during the year — can also offer one that has up to a 30% higher maximum than otherwise allowed.

That means some bronze plan out-of-pocket maximums could be $15,600 for individual coverage or $31,200 for a family plan.

Regulators say they need to set these criteria because bronze plans increasingly can’t meet other ACA requirements without increasing those limits. Federal regulators admit the higher amounts could result in “financial challenges for some enrollees” because they might not have enough in savings to cover those costs, according to an analysis of the new rules by Keith at Georgetown.

And here’s another change: Starting in 2028, insurers offering catastrophic plans, which are available for people age 30 and under as well as people who don’t qualify for premium subsidies, will see 30% higher out-of-pocket maximums.

The thresholds may be similar to what some bronze plans offer, but there are differences. Catastrophic plans must be set at the higher levels; it’s not optional. And, in those plans, nothing except preventive services and up to three primary care visits are covered before the consumer must meet the new higher deductible amounts, the point at which insurance will kick in. Consumers cannot receive ACA subsidies to help them purchase a catastrophic plan.

While the premiums may be lower, it isn’t clear whether such plans will attract substantial numbers of enrollees, even with lower premiums. To balance the lower premiums against the higher potential out-of-pocket costs, enrollees will need to gamble that they will remain healthy or have access to savings to cover costs. Data shows that many Americans have limited savings,

with median balances ranging from $5,400 to $8,700, well below thresholds in catastrophic plans.

Beginning next year, insurers will be allowed to sell catastrophic plans that could remain in effect for years, rather than renewing annually.

The combination of the higher out-of-pocket costs, along with other legislative changes, and the increased paperwork requirements is “not ending Obamacare as we know it,” Keith said, “but will significantly erode access to the marketplaces. Fewer people will benefit.”

A few other changes are listed in the rule, some of which stem from the tax and spending bill Congress passed last year known as the One Big Beautiful Bill Act.

The measure makes permanent a previous decision to halt a special enrollment period that allowed very low-income people to sign up for ACA coverage year-round. Backers, including Paragon, say this can help cut down on fraudulent enrollments.

The new rule would put in place additional income verification requirements, including for people who say their income is above the poverty level and thus qualify for subsidies, despite federal data indicating their income might be below the poverty level.

In addition, it would require more checks on people applying for special enrollment periods — such as for loss of job-based coverage or for marriage or divorce — seeking information that they qualify. Also, premium tax credits would be denied to people who have not filed their taxes for one year, down from the current two.

Lawsuits brought by some cities and other plaintiffs challenging a 2025 rule resulted in courts placing some changes on hold. On June 12, the court made some of those temporary changes permanent. With the 2027 rule, the administration seeks to restore those provisions.

The same plaintiffs have challenged the new rule.

“Unless this gets blocked by another court case, consumers will have to provide more documentation for special enrollment eligibility verification,” Norris said.

“If they get married and want to add a spouse, for example, they’ll have to provide a copy of the marriage license,” she said. “Those factors will definitely depress enrollment because it will be more hurdles for people to jump through, but CMS also says it will save money on subsidies.”

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