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ACA Non-Network Plans: How Big of a Disruption?

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INTRODUCTION

On February 9, 2026, the US Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027. Under the proposed rule, non-network plans would be allowed to be certified as Qualified Health Plans (QHPs) and be able to offer Affordable Care Act (ACA) products on the Exchange starting as early as the 2027 plan year, even though they operate outside of a traditional contractual provider network. Functionally, these plans would set a fixed payment amount for each covered service, often as a percentage of Medicare or an average cash price.

To qualify as a QHP, a non-network plan must demonstrate that it offers a sufficient choice of providers who will accept these payment amounts in full, including Essential Community Providers and specialists such as mental health and substance use disorder providers. Enrollees may seek care from any provider willing to participate in the arrangement, but if the provider charges more than the fixed payment amount, the member would be responsible for paying the difference.

HHS positions non-network plans as a means of reducing overall healthcare costs. This proposal introduces considerations for state and federal regulators, operational considerations for plans and providers, and pricing implications for those who participate in the ACA Marketplace today. This paper summarizes these key concepts.

STATE AND FEDERAL REGULATORY CONSIDERATIONS

The introduction of non-network plans to the ACA market poses novel considerations for both state and federal regulators, including those summarized below.

Definition of "Sufficient Choice of Providers." HHS would require non-network plans to demonstrate reasonable access to providers that will accept the plan's payment levels in full, but it is unclear how access would be defined or measured without traditional contracted networks. Additional guidance will likely be needed on what evidence non-network issuers must provide and how HHS or states would monitor compliance.

State Oversight and Enforcement. HHS proposes that non-network plans report information to help with oversight, such as assessed percentage of available providers in each plan's service area that accepts the plan's benefit amount as payment in full but does not provide strict criteria for approval. HHS proposes allowing states to conduct their own oversight activities. Some states may perform network adequacy checks through time and distance standards, provider

ratios, and contract review. Non-network models may require states to develop new oversight frameworks, and states may vary significantly in how they review and approve these plans. This arrangement could create operational complexity and uneven adoption across markets, as it is likely that many state Departments of Insurance (DOI) will either prohibit these plans or vary widely in their approach to review and approval.

State Impacts. States will need to evaluate the feasibility and cost of programs funded through a combination of state and federal governments, such as Section 1332 waivers, buydown programs, state-based premium subsidies, or cost share reduction initiatives. Non-network plans could lower benchmark premiums, which reduces advance premium tax credit (APTC) spending and therefore federal pass-through funding for states with 1332 waivers. States may need to reduce program size, increase state funding, or discontinue them altogether.

Plan Compliance and Cost Share Protections. These plans would be required to cover Essential Health Benefits, but questions remain regarding what can be deemed in-network. Currently, cost sharing provisions such as the maximum out of pocket (MOOP) and actuarial value compliance (AVC) inputs are only in-network. Regulations would need to better define how these plans would be input into the AVC for compliance. Other open questions relate to how these plans overlap with the No Surprises Act regulation, which mandates emergency service coverage, calculation of the qualifying payment amount, patient protections such as in-network cost-sharing and balance billing, and dispute resolution. Would these requirements be extended to non-network plans? Additionally, non-network plans will likely need to offer preventive services at no member cost share.

Rate Review. States with effective rate review programs are tasked with reviewing premium rates proposed by issuers. It is challenging for states to review pricing for new entrants given lack of available data, unfamiliarity with their operating model, and difficulty in assessing certain assumptions like provider contract levels and risk adjustment. Given the significant difference in network models, reviewing non-network pricing will be especially challenging. States will need to be prepared to thoroughly review pricing adequacy, reasonability of assumptions, sustainability, and market impacts.

Presentation on Exchange Websites. States may elect to display these plans differently on Exchange websites to differentiate among traditional network plans and help avoid consumer confusion.

OPERATIONAL CONSIDERATIONS

Members, providers, and non-network plans will need to fully understand operational considerations. Key concerns are summarized below.

Member Experience and Consumer Protections. The non-network model may be confusing to consumers, particularly if disclosures and plan design details are complex. Because providers are not contractually obligated to accept payment, members may face uncertainty about provider participation and payment terms. Additionally, provider participation may vary over time. Consumers will be required to be active shoppers and confirm provider participation and cost share requirements for every service performed. Consumers may unintentionally receive care from a provider that does not participate, especially for time-sensitive services where active shopping is more challenging. This increases the risk of higher out-of-pocket costs or balance billing. If consumers enroll in a non-network plan during open enrollment without fully understanding the network dynamics or have a poor experience, they will not have an opportunity to change plans until the following open enrollment.

Provider Participation. Providers may be hesitant to accept fixed payment amounts that are non-negotiated and may be lower than typical reimbursement levels. Participation could vary significantly by specialty and geography, potentially creating access challenges, particularly for behavioral health and other high-demand services.

Provider Financial Risk. Providers who choose not to accept reimbursement levels as payment in full may attempt to collect additional amounts from patients, increasing administrative burden and potential bad debt. This dynamic might further discourage participation over time.

Non-Network Issuer Operational Complexity. Non-network issuers entering the ACA market need to be prepared to operate in a highly regulated ACA environment. Operational considerations include:

- Development of processes to administer fixed payment schedules, communicate payment levels, address billing disputes or member inquiries related to provider acceptance and balance billing.
- Building risk adjustment operations.
- Additional financial reporting requirements such as Medical Loss Ratio (MLR) reporting.
- Preparing and submitting rate filings for state review.
- Building distribution systems such as brokers.

Compared with current network build complexities, non-network plans today may realize administrative expense savings due to simplification and less requirements.

PRICING IMPLICATIONS

Non-network plans have the potential to significantly affect the ACA market. Issuers that currently participate in the market must be aware of these impacts and price accordingly. In addition, non-network plans will need to be prepared to price products based on a new regulatory framework. Below is a summary of key pricing implications for issuers.

Gross Premium, Benchmark, and Subsidy Reductions. Non-network plans may offer lower gross premiums because of reduced reimbursement levels and simplified administration. Depending on price differentials, this situation could cause a large influx of members who purchase these plans, especially in areas with higher proportions of price sensitive and lower income members. If these plans become the second lowest cost silver option in a rating area (even if few consumers enroll in these non-network plans), they could lower the benchmark premium used to calculate APTCs. A lower benchmark would reduce APTC amounts, thereby increasing net premiums for subsidized members.

State Program Impacts. As noted previously, non-network plans may affect state programs such as Section 1332 waivers. Issuers will need to be prepared to account for pricing impacts of changes in program funding and size.

Risk Adjustment Challenges.

- **Non-Network Plan Reporting.** Risk adjustment relies heavily on full and complete data capture. Any claims data that are unavailable would affect diagnosis capture and data integrity and thereby increase risk adjustment payments. The absence of provider contracts may make it more difficult for non-network plans to engage providers in diagnosis coding or medical record retrieval, potentially affecting risk score capture and increasing uncertainty about risk adjustment transfers. This may increasingly be difficult under the Risk Adjustment Data Validation (RADV) program.
- **Risk Adjustment Transfer Estimation.** For markets with take-up of these new plans, estimating risk adjustment accurately will be increasingly difficult because of notable shifts in market membership composition, morbidity, and the uncertainty regarding non-network plan operations to appropriately capture risk adjustment.
- **Change in Gross Premium and Risk Adjustment.** The introduction of non-network plans may reduce gross premiums. The risk adjustment transfer calculation is based on the statewide average premium. If consumers enroll in these non-network plans, the statewide average premium will decrease. As a result, issuers that are risk adjustment payers will pay less, while issuers that are risk adjustment receivers will receive less.

Enrollment Stability. Lower premiums may attract price sensitive enrollees initially, but access issues or unexpected out-of-pocket costs could lead to member dissatisfaction and attrition over time. There may also be impacts within a year if members drop coverage. Furthermore, enrollment in the Marketplace among consumers who do not want to enroll in a non-network plan may decline as a result of the decrease in subsidies. Enrollment stability may drive morbidity deterioration.

Entrant Dynamics. As communicated, non-network plans may significantly affect the ACA market. Issuers that now offer plans in the ACA market will more accurately price products if they know with certainty that non-network plans are entering a particular market.

CONCLUSION

We do not expect widespread adoption of non-network plans by plan year 2027. Although startups and reference-based pricing companies like Sidecar Health and Imagine360 have expressed interest, adoption among carriers and members will likely vary by region, depend on state DOI decisions, current market conditions, and the geographic footprint of participating carriers.

The model's long-term sustainability is uncertain and depends on the ability to price premium rates at a lower rate and maintain that year over year. The model may be difficult to sustain if risk adjustment cannot be operationalized, providers are unwilling to accept payment levels, and members do not perceive adequate access and value. These plans may also be subject to political dynamics and regulatory interpretation. HHS, under a previous presidential administration, deemed non-network plans noncompliant with various ACA regulations. Although the current administration appears amenable to these types of products, it is possible that a future administration will change course and once again deem these plans noncompliant.

A key question is whether issuers will pursue long-term strategies to undercut existing market competition and maintain those lower premiums while addressing the concerns outlined in this paper. Historically, the ACA market has seen startup issuers enter markets with aggressively low pricing to gain market share. Although this approach has sometimes captured significant enrollment, many of these issuers have later become insolvent or exited the market after sustaining substantial losses, suggesting that the strategy is often unsustainable. As a result, an important question remains: Can non-network plans price below the current market and attract consumers long term while sustaining those rates in a financially viable and profitable way?

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