

A Physician's Guide to Recent Changes to ACA Marketplace Affordability

Initial data for the Affordable Care Act (ACA) marketplaces for 2026 show at least a 5 percent enrollment drop, or about 1.2 million fewer enrollees than last year. But many stakeholders believe the early figures are undercounting disenrollments and estimate that enrollment will decline by about 20 percent, dropping to around 19 million enrollees from 24 million. Due to recent federal changes (including the expiration of additional, enhanced premium tax credits that made premiums more affordable), many people did not sign up or renew coverage this year, and, for those who did, many face sharply higher out-of-pocket premiums for 2026 and beyond. As a result of these increased premiums, it is expected that more enrollees than usual will stop premium payments due to cost and drop coverage during the year. Beyond showing fewer patients with marketplace coverage, early data indicates that the decline in premium affordability resulted in a significantly higher proportion of families “buying down” their coverage by enrolling in plans with lower net premiums but significantly higher deductibles.

Physicians should be aware of the implications of these marketplace changes on their practices and patients and be prepared to answer patients' questions about cost and coverage.

I. WHAT MARKETPLACE POLICY CHANGES ARE IMPACTING PATIENTS' COSTS AND COVERAGE?

Three developments have raised out-of-pocket premiums and changed rules in the health insurance marketplaces for 2026, although additional changes that will further impact costs and access are likely soon.

- **[Expiration of enhanced premium tax credits \(PTCs\)](#):** PTCs are available in advance to low- and moderate-income households to offset the cost of monthly premiums. COVID-era laws increased the value of those subsidies, further lowering premium costs and making people at higher income levels newly eligible for help. The increased affordability led to growth in the number of people enrolled in the marketplaces from 12 to 24 million individuals. While PTCs are still available for many, the enhanced PTCs that so dramatically increased affordability expired on December 31, 2025, more than doubling the average marketplace premium for a formerly subsidized person who is no longer eligible for PTCs.
- **[H.R. 1, the One Big, Beautiful Bill Act](#):** H.R. 1 eliminated marketplace subsidies for certain very low income lawfully present non-U.S. citizens beginning in 2026. Beginning in 2027, additional categories of lawfully present non-U.S. citizens (including refugees, asylees, and Temporary Protected Status recipients) will lose access to marketplace subsidies.
- **[Changes to federal ACA rules](#):** Recent federal rules, including the Marketplace Integrity and Affordability final rule, have increased marketplace verification procedures, mostly for low-income people; limited the circumstances in which individuals can enroll mid-year; allowed health insurers to pay a smaller share of overall plan costs; and changed a formula underlying the PTC calculation that increased the share of the total premium a patient must pay and raised their out-of-pocket expenses. Other new rules expand access to non-comprehensive coverage and could reduce the breadth of provider networks.

II. HOW WILL PATIENTS' COVERAGE CHANGE?

Broadly, these policy changes, and others, will lead to fewer people enrolling in coverage, more patients disenrolling from coverage throughout the year, and patients choosing plans with greater cost sharing that leave them exposed to high costs if they get sick.

- 1. *More Patients Enrolled in Plans with High Deductibles:*** Higher marketplace premiums are leading more people to choose plans with higher deductibles and lower premiums. Nationwide, for the lowest income enrollees, moving from a Silver plan to a Bronze plan means an increase in deductible from an average of \$80 to nearly \$7,500. A healthy patient who needs few medical services may save money overall with a high-deductible plan, especially if paired with a health savings account (HSA), which allows tax-free savings that can be used to pay for medical expenses (except premiums). However, most marketplace enrollees switching to or purchasing a plan with a higher deductible are unlikely to be able to afford a HSA, and for patients with ongoing or unexpected health needs, higher deductibles can create substantial financial and access barriers.
- 2. *More Patients Enrolled in Catastrophic Plans:*** Catastrophic plans are one type of lower-premium, high-deductible plan that is becoming more popular as premiums rise. Enrollment in this type of plan was limited under the ACA statute—only people under age 30 and those of any age qualifying for a hardship exemption could enroll. However, the Centers for Medicare & Medicaid Service (CMS) expanded eligibility for hardship exemptions in 2025 to include anyone ineligible for a PTC or cost-sharing reductions, opening up an avenue for anyone with income below 100% or over 250% of the federal poverty level to qualify for catastrophic coverage enrollment. Enrollment in Catastrophic plans has historically been very low (roughly 50,000 lives across the nation in 2025), but these recent changes are increasing their popularity. In 2026, deductibles for catastrophic plans equal the out-of-pocket maximum allowed under the ACA—\$10,600 for an individual and \$21,200 for family coverage.
- 3. *More Patients Enrolled in Off-Marketplace “Junk” Plans:*** People who cannot afford a health plan with higher premiums may choose—or, without full knowledge, be persuaded to enroll in—short-term, limited duration insurance (STLDI) or similar “junk” insurance with lower premiums but tight restrictions. This coverage is not required to comply with the ACA’s consumer protection rules. It does not include free preventive care or essential health benefits, can discriminate based on pre-existing conditions, can deny coverage for certain conditions or types of medical care, and is not required to have an annual limit on out-of-pocket cost sharing. Historically, patients have not understood the limitations of these plans before purchasing them and needing care.
- 4. *Patients Facing Mid-Year Coverage Loss:*** The extra financial help from the enhanced PTCs kept enrollment stable during the year because premiums were affordable, often as low as zero dollars a month. However, this year, without the enhanced PTCs, attrition in marketplace coverage is likely to continue throughout the year, chipping away at the enrollment topline. Within-year coverage loss will occur for a few different reasons: failure to pay the initial premium, failure to pay the premium for three consecutive months (the length of the nonpayment grace period), and actively terminating coverage.
- 5. *More Patients who are Uninsured:*** Overall, more patients will be uninsured due to the policy changes described above. This creates ethical and financial implications for physicians.

III. HOW WILL THESE CHANGES IMPACT PHYSICIAN PRACTICES AND WHAT CAN THEY DO TO PREPARE?

As patients move to less comprehensive coverage and potentially no coverage at all, physician practices will have to carefully navigate these changes from a financial perspective for their practice, as well as with an understanding of the impact on their patients and their relationships with patients. For example:

- ***With new coverage limitations, patients may choose not to seek medically necessary care due to cost.*** Some patients enrolled in high-deductible plans may delay or forego needed care if they cannot afford to pay for medical services before their higher deductibles are met. Patients enrolled in STLDI or similar “junk” plans may not realize that free preventive care or pre-deductible coverage of certain benefits are not guaranteed, as they are under marketplace plans. Many patients may not discover the limitations of their coverage until they seek medical services, leaving physician practices to explain the limitations while helping patients triage their care according to cost.
- ***Physician practices will have to verify insurance information prior to scheduling appointments and at the point of care.*** Due to the aforementioned policy changes, patients may have switched their marketplace plans since their last visit or dropped their insurance altogether. Additionally, practices should be cognizant that some patients may have claims pended if they are behind on premium payments. If patients do not pay their premiums in full by the end of a three-month grace period, it will be up to the physician practice to bill for any care rendered in the second and third months of nonpayment. Physician practices may incur greater costs for debt collections, and the patient-physician relationship may be strained, when patients receive unexpected bills from physician practices.
- ***Physician practices are likely to face greater uncompensated care costs.*** Avoiding uncompensated care costs may require practice changes, such as increasing insurance eligibility checks, requiring deposits, collecting amounts due from patients in advance or at the time of service, keeping a patient’s credit card on file, or requiring patients to sign forms acknowledging their responsibility for payment in full. Ultimately, this may also mean more debt collection for practices.
- ***Physician practices should be prepared to provide patients with cost estimates and discuss the value of services and prescriptions.*** Patients will be more price-sensitive and more likely to ask for prices up-front to make decisions based on cost. Physicians should be transparent about pricing and may need to work with patients to determine a care plan and/or payment plan that fits a patient’s budget.
- ***Physician practices should help patients use the benefits they do have, especially preventive care.*** All marketplace plans, including Bronze and catastrophic plans, require that most preventive services receive first-dollar coverage. Therefore, it will be important for physicians to remind patients about the availability of no-cost preventive services. Certain other services may also be available at no cost, based on the state and plan. For example, in California, all Bronze plan enrollees can get three non-primary care visits that are not subject to the deductible.

IV. HOW CAN PHYSICIAN PRACTICES HELP PATIENTS?

Help patients understand their benefits. Patient awareness of marketplace policy changes, and their impact on coverage and costs may be limited. Some patients may not fully understand their covered medical benefits, including free preventive care, or their financial responsibilities, including the impact of high deductibles.

- Patients may misunderstand the scope of their coverage or the extent of their financial responsibility, and this may lead to an inability to pay for care they receive. Helping patients understand their financial obligations up front can help them avoid unanticipated financial obligations that may damage the patient-physician relationship.
- Proactive messaging around the importance of insurance (see talking points below) can help encourage patients to keep or gain comprehensive coverage even when upfront premiums are rising.

Communicate with patients about the importance of comprehensive coverage. While physician practices should not be the sole source of answers on health insurance options, they are often called on as trusted advisors. Here are some messages that respond to the types of questions patients may ask:

- **Comprehensive coverage is important.** If you have income that is too high for Medicaid but do not have other insurance options, you may be eligible for marketplace coverage and financial help to afford it.
- **When shopping for coverage, consider the amount you are willing to pay up-front against the amount you may need to pay to receive care, such as a deductible.** Paying a slightly higher monthly premium could significantly lower the total amount you pay for health services if you get sick. Conversely, you could be responsible for very high deductible amounts if you choose a plan with the lowest monthly premium.
- **In the marketplace, many people with low incomes qualify for help paying out-of-pocket costs.** When shopping for coverage, look for Silver-level plans, which may have special discounts and cost-sharing assistance.
- **If you have a high-deductible health plan, consider signing up for a health savings account (HSA).** Money you put into an HSA is not taxed if you use it for health care expenses. Beginning in 2026, all Bronze and catastrophic plans are eligible to be paired with an HSA.
- **With any comprehensive health plan, free preventive care is available prior to paying your deductible.** Check your coverage to see if other benefits, such as physician or specialist visits, are also available prior to paying your deductible.
- **Beware of coverage you are offered as an individual that is outside of the marketplace.** Plans called short-term, limited duration plans, health care sharing ministries, or some plans offered by associations or farm bureaus, do not need to follow most insurance rules. They can deny your medical claims or raise your premiums if you have a pre-existing condition, often have no limits on the amount you pay if you get sick, and may not have free preventive care.

If possible, help patients obtain medically necessary care by navigating charitable or financial assistance programs. Some patients will have difficulty affording their medical care, especially if their coverage is less comprehensive than it was last year. If possible, physician practices should share tools and resources that can help patients manage the cost of their care.

- **Let patients know about patient assistance programs.** Consumer assistance programs are offered by a range of nonprofit organizations and corporations. If possible, physician practices should provide patients with contact information for medication assistance and/or copay programs as well as patient foundations or

other nonprofit organizations that provide financial assistance to patients. Additionally, most states have prescription discount programs that are available to eligible residents.

- **Have an established payment policy in place that is presented to all patients.** In addition to when and how payments are collected, practices should let patients know whether they offer flexible payment plans, medical financing, or need-based discounts on certain medical services. Patients should be informed when medical financing products, such as medical credit cards and installment plans, are being serviced through third-party financial services companies.
- **If the practice has a financial assistance policy, it should be shared with patients upfront or at the time of service.** When patients do not pay outstanding bills, practices should try to manage medical debt with patients directly; for example, by offering payment extensions or forgiveness of debt, if that is possible. If unpaid accounts need to be turned over to a third-party collection agency, practices should be mindful to select agencies that charge reasonable fees and do not engage in wage garnishment and property liens being placed on lower-income patients.