The Marketplace Final Rule Rolls Back Access to Marketplace Coverage and Affordability

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On June 20, 2025, the Department of Health and Human Services (HHS) finalized a **marketplace rule**, hereinafter referred to as the Marketplace Final Rule, that restricts access to marketplace coverage and affordability programs under the Affordable Care Act (ACA). Discussed below are the key eligibility, enrollment and affordability provisions of the Marketplace Final Rule; the rule is not discussed in its entirety.

The Marketplace Final Rule was published just over a week before enactment of the 2025 budget reconciliation bill, otherwise known as the "One Big Beautiful Bill" Act or "OBBBA."[1] Alongside devastating cuts to Medicaid, SNAP, and other programs, the bill also represents an existential threat to the future of Marketplace coverage. The overlapping policy goals and unusual patchwork of sunset dates and implementation deadlines in the Marketplace Final Rule signal that CMS was closely involved with OBBBA as the legislation evolved. While HHS finalizes a number of Marketplace Final Rule provisions on a short-term basis, that was likely done for purposes of budgetary savings during OBBBA debate. Now that OBBBA is law, it is very possible that HHS will extend these provisions or make them permanent in future rulemaking. Through the Marketplace Final Rule and OBBBA, federal policymakers have set in motion a series of policy changes designed to diminish access to Marketplace coverage.

Past-Due Premium Lockout (45 C.F.R. § 147.104(i))

A central tenet of the ACA is the requirement that a health insurance issuer that offers health insurance coverage in the individual market must accept "every … individual in the State that applies for such coverage."[2] This principle of "guaranteed availability" levels the playing field between individuals and insurance issuers, ensuring that any individual in a state can enroll in any health insurance coverage offered for sale in the relevant market. The Marketplace Final Rule erodes this key principle by allowing issuers to condition new coverage on payment of premiums for old policies.

As early as 2012, HHS noted that the guaranteed issue provision of the ACA "does not include an exception allowing issuers to refuse to cover individuals with histories of non-payment under other policies either with the same issuer or other issuers."[3] HHS later issued guidance

[1] Pub. L. No. 119-21, § 71304 (2025) ["OBBBA"].
[2] 42 U.S.C. § 300gg-1(a); 42 C.F.R. § 147.104(a).
[3] *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 77 Fed. Reg. 70584, 70599 (Nov. 26, 2012).

explicitly prohibiting issuers from applying the first month's premium payment for a new policy (the "binder payment") to past-due premiums for previous coverage with the same issuer, and then refusing to effectuate the new enrollment based on failure to pay premiums. HHS correctly determined that such action constituted a violation of the ACA's guaranteed availability provisions under a plain reading of the statute.[4]

This interpretation was reversed by the first Trump Administration in its 2017 Market Stabilization Rule, which allowed issuers to require an individual or employer to pay all past-due premiums owed to that issuer (or any other issuer that is a member of the same controlled group) in the prior 12-month period in order to effectuate new coverage, provided the issuer met specified notice requirements.[5] Five years later, HHS dismantled this barrier to coverage and returned to its original interpretation of guaranteed issue, promulgating a rule that any issuer that conditioned coverage on payment of a past-due premium was out of compliance with guaranteed issue requirements.[6]

In the Marketplace Final Rule, HHS has not only reinstated that barrier, but has finalized a past-due premium policy with none of the limited safeguards implemented in the first Trump Administration.[7] Effective August 25, 2025, the Marketplace Final Rule removes the federal prohibition on attributing payments for new coverage to past-due premiums. To the extent permitted by state law, issuers are once again allowed to condition coverage under a new policy on payment of a premium balance for an old policy owed to the same issuer or any

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[4] Ctrs. for Medicare & Medicaid Srvs., Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual, Section 6.3, "Terminations for Non-Payment of Premiums," 114 (July 19, 2016), **https://wayback.archive-it.org/2744/20200125160955/https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf**; *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18346, 18349 (Apr. 18, 2017).

[5] 82 Fed. Reg. 18346, 18351 (Apr. 18, 2017).

[6] 45 C.F.R. § 147.104(i). In its preamble to the 2023 Notice of Benefit and Payment Parameters, the agency explained that the rule would "remove an unnecessary barrier and make it easier for consumers to enroll in coverage." *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023*, 87 Fed. Reg. 27208, 27218.

[7] 82 Fed. Reg. 18346, 18349-18353 (Apr. 18, 2017).

other issuer in the same controlled group.[8] Unlike the 2017 policy, the 2025 rule change would not limit the policy to past-due premium amounts accruing over the prior 12 months.[9] In other words, an issuer can apply new premium payments for a 2025 policy to *any* amount of past-due premium from *any* date in the past. Moreover, the issuer can do so without any advance notice to the enrollee.[10] Notably, an issuer cannot deny coverage on the basis of non-payment of past premiums to an unrelated issuer.[11] HHS is implementing this policy on a permanent basis.

In its justification for reversing current policy and removing 45 C.F.R. § 147.104(i), HHS claims the policy will reduce adverse selection and encourage people to maintain continuous coverage throughout the year. The agency offers no evidence for either of these conclusions, other than obliquely referencing "recent enrollment data [that] suggest people are manipulating guaranteed availability and grace periods to time enrollment in coverage to when they need health care services."[12]

This proposed policy will be particularly harmful for low-income people, as well as those living in markets with limited issuer competition who may have no choice but to seek coverage from the same issuer or controlled group. It will also unfairly penalize individuals whose past-due premiums were outside of their control (for example, because an agent or broker failed to make a payment or because of slow processing time by an issuer or Marketplace). As HHS itself admits in the preamble, the version of the policy implemented in the Marketplace Final Rule – which lacks consumer notice and lookback limits – is likely to be even more harmful to low-income people than the 2017 past-due premium lockout.[13]

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[8] A "controlled group" means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the IRS Code, or a narrower group as may be provided by applicable state law. 45 C.F.R. § 147.106(d)(4).
[9] *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 27074, 27084 (June 25, 2025).
[10] *Id.* at 27085.
[11] *Id.* at 27090.
[12] *Id.* at 27085.
[13] *Id.* at 27087-27088 ("In neither the proposed rule nor this final rule do we deny that the past-due premium policy as finalized in this rule will possibly have at least some negative impacts on low-income individuals. Nor does the change in policy in this final rule rely on any belief or assertion that low-income individuals will be less harmed by this policy, as compared to the [2017] policy…"

Although removal of the regulation prohibiting issuers from imposing a past-due premium barrier is contrary to federal law and harmful to individuals, states can still choose to protect their residents and uphold the principle of guaranteed availability of coverage. As HHS repeatedly mentions in the preamble to the Marketplace Final Rule, the removal of federal protections means that a state is merely permitted – but not required — to allow issuers operating in its borders to condition enrollment on payment of old premium debts.[14] States that do choose to implement some form of past-due premium penalty can mitigate its effects in a number of ways: requiring clear advance notice of the past-due premium penalty and potential for coverage lockout, extending grace periods, offering alternative repayment plans, permitting enrollment after partial repayment, and providing income-based exemptions.[15]

Excluding DACA Recipients Will Harm Individuals, Families, and the Marketplace (45 C.F.R. § 155.20)

The ACA extends access to qualified health plans (QHPs) and insurance affordability programs to U.S. citizens and nationals, and those "lawfully present" in the United States.[16] The Marketplace Final Rule modifies the definition of "lawfully present" to exclude recipients of "Deferred Action for Childhood Arrivals" (DACA). As a result, effective August 25, 2025, DACA recipients will no longer be able to enroll in a QHP with or without premium tax credits (PTCs) or Cost-Sharing Reductions (CSRs); or in a Basic Health Program (BHP) in states that elect to operate a BHP. In a clearly political move aligned with this Administration's other attacks on immigrants' access to health care, this change shuts DACA recipients out of Marketplace and BHP coverage after just a few months in which they could enroll in such plans. HHS is implementing this policy on a permanent basis.

When the DACA program was first established in 2012, existing HHS policies would have classified DACA recipients as "lawfully present," making them eligible to enroll in QHPs, BHPs,

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[14] *See, e.g., id.* at 27086 ("This final rule removes the Federal prohibition on attributing payments for new coverage to past-due premiums owed for prior coverage and leaves it to States to determine whether to permit the practice), and if permitted, any restrictions on the practice.").

[15] *See* National Health Law Program, *Comments to HHS Re: RIN 0938-AV61; CMS-9894-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (*June 10, 2025), **https://healthlaw.org/resource/nhelp-comments-on-notice-of-proposed-rulemaking-regarding-marketplaces** [hereinafter, NHeLP Marketplace Comments].

[16] 42 U.S.C. § 18001(d)(1).

and Medicaid or the Children's Health Insurance Program (CHIP) in states that have opted to cover "lawfully residing" pregnant people and children through the CHIPRA 214 option.[17] But almost immediately after the Department of Homeland Security began accepting requests for consideration of DACA status in August 2012, HHS issued guidance and regulations that excluded DACA recipients from the definition of "lawfully present" for purposes of Medicaid, CHIP, and Marketplace coverage.[18] This exclusion negatively impacted health outcomes and financial well-being for DACA recipients and their families, increased overall healthcare system costs, and exacerbated health inequities.[19]

On May 3, 2024, HHS issued a final rule that included DACA recipients among those "lawfully present" individuals that meet other eligibility requirements to enroll in a QHP (with or without PTCs or CSRs) or a BHP, effective November 1, 2025. HHS anticipated that allowing DACA recipients to enroll in Marketplace or BHP coverage would increase insurance coverage, reduce delays in care, improve the ACA's risk pool, and make DACA recipients more productive members of society.[20] Unfortunately, many DACA recipients were blocked from accessing affordable coverage before realizing any such positive benefits, first as a result of a November 2024 court ruling that blocked DACA recipients in 19 states from enrolling in Marketplace

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[17] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #10-006: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (Jul. 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.
[18] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #12-002: Individuals with Deferred Action for Childhood Arrivals* (Aug. 28, 2012), **https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf;** *Pre-Existing Condition Insurance Plan Program (PCIP)*, 77 Fed. Reg. 52614, 52615-52616 (Aug. 30, 2012); *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, 77 Fed. Reg. 18310, 18314 (Mar. 27, 2012) (adopting by cross-reference the PCIP definition of "lawfully present").
[19] Nat'l Immigr. Law Ctr., *DACA Recipients' Access to Health Care: 2023 Report* (May 2023), **https://www.nilc.org/news/special-reports/daca-recipients-access-to-health-care-2023-report.**
[20] Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program, 89 Fed. Reg. 39392, 39428 (May 8, 2024).

coverage and now because the Marketplace Final Rule excludes DACA recipients from eligibility for coverage.[21]

Excluding DACA recipients from Marketplace and BHP coverage does nothing to reduce their need for health care. As a group, DACA recipients are healthy, young adults whose admission to the individual market risk pool would likely have lowered costs across the board.[22] However, access to comprehensive coverage remains crucial for all people, in order to ensure that access to preventive services and care for specific conditions remains available, reducing the need for emergency care or avoidable services that arise from delaying or forgoing less-costly care.[23]

Increased paperwork requirements will drive hundreds of thousands of people to lose access to affordable coverage (45 C.F.R. §§ 155.320(c)(3)(iii); 155.320(c)(5); and 155.315)

The Marketplace Final Rule finalizes three changes to verification standards that HHS estimates will drive a combined 749,000 people to lose eligibility for Advance Premium Tax Credits (APTCs) or have APTCs reduced, potentially to zero.[24] By temporarily removing the

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[21] *See Kansas v. United States*, Case No. 1:24-cv-00150, 2024 WL 5220178 (D.N.D. Dec. 9, 2024)

[22] *See* U.S. Citizenship & Immigr. Srvs., Active DACA Recipients – December 16, 2024 (Mar. 28, 2025), **https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf** (finding that most DACA recipients are between the ages of 21 and 40 with an average age of 29); KFF, Key Facts on Deferred Action for Childhood Arrivals (DACA) (Feb. 11, 2025), **https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca** ("Among individuals who are likely eligible for DACA, nearly two-thirds (64%) report their health as excellent or very good, while an additional 28% report their health as good. In comparison, 71% of U.S.-born individuals ages 15-41 report being in excellent or very good health, with an additional 22% reporting being in good health. These findings reflect that younger individuals tend to be healthy.").

[23] NHeLP Marketplace Comments at 5.

[24] 90 Fed. Reg. 27074, 27199-27200 (June 25, 2025).

ability of applicants to attest to their income in certain circumstances where data is unavailable or conflicting, and permanently reducing the amount of time that all individuals have to resolve data inconsistencies, HHS's new standards will disproportionately affect low-income people who rely on APTCs and CSRs to afford coverage. Without access to subsidies – which 92% of Marketplace enrollees receive – many of these households will be forced to drop coverage they are eligible for because paperwork hurdles have rendered it unaffordable.[25] When an individual applies for Marketplace coverage, the information they provide on their application is verified against Internal Revenue Service, Social Security Administration, and current income data sources.[26] If information such as family size or income data is inconsistent with these records, the mismatch triggers a "data matching issue" (DMI) that may require an applicant to provide supplemental documentation to address the inconsistency.[27] Such discrepancies can occur for a variety of reasons including a change in income since the person's last tax return, an error by an applicant or their agent or broker on an application, or a data lag between the government records systems against which applicant attestations are verified. Once a DMI is triggered, consumers are generally in for a long process: HHS noted in the preamble to the Marketplace Proposed Rule that close to 60% of consumers who ultimately resolved their DMIs successfully took more than 90 days to do so.[28]

The Marketplace Final Rule turns back the clock on recent reforms and reinstates policies that will cause coverage to drop as applicants and enrollees struggle to respond to millions of additional DMIs. Specifically, the Marketplace Final Rule 1) reinstates a 2019-era rule that Marketplaces must generate a DMI if an applicant reports income above 100% FPL when trusted data sources show income below that level; 2) rescinds a rule that allowed individuals to self-attest to income if IRS data is unavailable; and 3) removes an automatic 60-day extension for individuals to resolve inconsistencies, reducing the resolution period to the statutory minimum of 90 days.

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[25] Ctrs. for Medicare & Medicaid Srvs., Health Insurance Exchanges 2025 Open Enrollment Report 15, **https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf**

[26] 42 U.S.C. § 18081(e)(4); 45 C.F.R. § 155.305(f)-(g).

[27] *See Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 12942, 12957 (Mar. 19, 2025); 42 U.S.C. § 18081(c)(4); Healthcare.gov, "How do I resolve an inconsistency?", **https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency**

[28] 90 Fed. Reg. 12942, 12963 (Mar. 19, 2025).

First, effective August 25, 2025, Marketplaces must generate a DMI when an enrollee reports income over 100% FPL if IRS data indicates income below that level. In its justification for this policy, HHS claims that the prior policy under 45 C.F.R § 155.320(c)(5), which requires Marketplaces to accept an individual's self-attested income in certain cases, induces individuals under 100% FPL to overstate their projected income in order to qualify for premium subsidies under false pretenses.[29] As a result of this policy change, which HHS estimates will cost enrollees and Marketplaces nearly $77 million by the end of 2026, HHS estimates that 81,000 fewer people will receive APTCs across federal and state Marketplaces – many of whom will have no choice but to drop coverage that is unaffordable without subsidies.[30] By reviving a policy that the first Trump Administration was forced to vacate after a court challenge in 2021, HHS is undermining access to care for low-income people without providing any compelling evidence that improper enrollments are widespread or that this policy would address them if they were.[31] This policy sunsets at the end of 2026.

Second, the Marketplace Final Rule rescinds a policy that required Marketplaces to accept an applicant's attestation of annual income when IRS tax return data is unavailable, thereby requiring Marketplaces to generate a DMI in each such circumstance, effective August 25,

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[29] The agency admits it lacked "firm data" when it finalized a similar policy in 2019, and now relies on a 2024 paper to support its claims that "potentially millions of applicants are inflating their incomes or having applications submitted on their behalf with inflated incomes." 90 Fed. Reg. 27074, 27121 (June 25, 2025), citing Benjamin Hopkins, Jessica Banthin, and Alexandra Minicozzi, *How Did Take Up of Marketplace Plans Vary with Price, Income, and Gender?*, AM. J. HEALTH ECON. (Dec. 2019), **https://www.journals.uchicago.edu/doi/abs/10.1086/727785?journalCode=ajhe.** But HHS fails to acknowledge the public comment submitted by one of this paper's authors in response to its inclusion in the Proposed Rule. In her comment, the author cautions that the article "refrained from concluding there was improper enrollment, with the exception of one state (Florida)," points out that individuals who report that they anticipate earning higher income in the future compared to the prior tax year are neither committing fraud nor behaving improperly, and highlights "major methodological flaws" in a separate report on which CMS relies heavily in the Proposed and Final Rules rule to support its assertions that increased verification processes are necessary in the face of widespread fraud. *See* Jessica Banthin, *Comments to HHS re: Re: RIN 0938-AV61, CMS-9884-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 2-3 (Apr. 11, 2025) **https://www.regulations.gov/comment/CMS-2025-0020-24021**

[30] 90 Fed. Reg. 27074, 27199-27200 (June 25, 2025),

[31] *City of Columbus v. Cochran,* 523 F. Supp. 3d 731 (D.Md. 2021).

2025. As HHS itself noted in 2024 when it first implemented the self-attestation policy that has now been reversed, IRS data may be unavailable in many circumstances, including name changes, demographic updates or mismatches, or household composition changes due to birth or change in marital status.[32] Unsurprisingly, considering the numerous legitimate situations in which the IRS is unable to return consumer data, the agency estimates that this requirement will generate a staggering $2.77 million new DMIs at a cost of over $235 million to consumers and Marketplaces by the end of 2026. HHS does not provide an exact estimate of the number of people who will become uninsured as a result of this policy change, but acknowledges that APTCs will be reduced, "potentially to zero," for 407,000 people. Particularly for low- and middle-income people, loss of APTCs is the functional equivalent of loss of coverage as many of these people will be unable to absorb the cost of an unsubsidized plan. This policy sunsets at the end of 2026.

Despite its claims that it is necessary to rescind these current policies immediately to limit the effects of "millions" of improper enrollments, HHS has also determined that they will sunset both policies in the Marketplace Final Rule after just one full plan year, on December 31, 2026. According to the agency, fully-subsidized plans available to some consumers who qualify for enhanced APTCs (eAPTCs), as well as "predatory agents, brokers, and web brokers", are the primary incentives to use false income attestations to enroll in $0 premium plans.[33] Not only does such a short duration essentially double system build costs, to account for their almost

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[32] 88 Fed. Reg. 25740, 25818-25820, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024* (Apr. 27, 2023), codifying 45 C.F.R. § 155.315(f)(7). Note that after implementation of this policy, the federal Marketplace continued to generate income DMIs when IRS tax data were available and the attested projected household income amount was more than a reasonable threshold below the income amount returned by the IRS, and other sources cannot provide income data within the reasonable threshold; or when IRS tax data cannot be requested because an applicant did not provide sufficient information and other sources could provide income data within a reasonable threshold. State-based Marketplaces also continued to have the flexibility to use alternative electronic databases to generate income DMIs when the IRS was unable to return data.

[33] Congress first passed temporary enhancements to existing subsidies as part of the American Rescue Plan Act of 2021, then extended them for an additional 3 years under the Inflation Reduction Act of 2022. The enhanced subsidies increase financial support for enrollees in QHPs by lowering the amount an enrollee must pay towards the cost of the second lowest-cost silver plan in their market. Enrollees with incomes under roughly 150% FPL who are eligible for eAPTCs can enroll in fully-subsidized plans, but will be required to pay 2-4% of their income if eAPTCs expire. *See* 26 U.S. Code § 36B(b)(3)(A)(i) and (iii).

immediate dismantling, the Marketplace Final Rule fails to provide an adequate or even logical policy justification for the sunset policy, though HHS may decide to extend these policies through future rulemaking. In the Marketplace Final Rule, HHS anticipates that eAPTCs will expire on December 31, 2025, just four months after the two new verification policies go into effect.[34] The agency fails to explain why these enhanced verification policies are necessary in 2026 if the alleged risks posed by eAPTCs will end in 2025; or specifically how they will compel the market to "shed excess improper enrollments" over the course of the 2026 plan year in which eAPTCs will not be available.[35]

Finally, effective August 25, 2025, the Marketplace Final Rule permanently removes an automatic 60-day extension for individuals to resolve a DMI, reducing the resolution period from 150 days to the 90-day statutory minimum unless the individual requests and the agency grants an individualized exception.[36] In its reversal, HHS now claims that the extension does not conform with statutory requirements, pointing to language in the ACA that allowed HHS to extend the response period in 2014 as proof that Congress did not intend the Department to provide such extensions in any other year. HHS uses its new statutory interpretation to implement the policy immediately and permanently. It also deflects critical public comments on the basis of this statutory argument, suggesting that its hands are legally tied despite the negative impacts on consumers, particularly those with multiple sources of income or with inconsistent hours arising from gig work, seasonal work, or self-employment; and the resulting adverse effects on the individual market risk pool.[37]

HHS anticipates that the removal of the 60-day automatic extension will result in 226,000 enrollees losing APTCs despite continuing to have access to the ad hoc discretionary extension process. For most consumers, loss of tax credits is the functional equivalent of losing

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[34] *Id*. at 27074-27075.
[35] *Id.* at 27124.
[36] Beginning in 2024, HHS authorized an automatic 60-day extension "to allow applicants sufficient time to provide documentation to verify household income," noting that the 90 days required under statute (42 U.S.C. § 18081(e)(4)(A)(ii)(II)) was often insufficient for applicants to provide income documentation, particularly in cases where multiple household members needed to report projected income that could include multiple sources of income, seasonal income, or self-employment. *See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024,* 88 Fed. Reg. 25740, 25819 (Apr. 27, 2023), codifying 45 C.F.R. § 155.315(f)(7).
[37] *See* 90 Fed. Reg. 27199, 27120-27121 (June 25, 2025).

coverage, and the removal of the 60-day automatic extension will drive most affected individuals to become uninsured.[38]

The $5 Premium Penalty for Certain Automatically Re-Enrolled Consumers (45 C.F.R. § 155.335(a) and (n))

The Marketplace Final Rule prohibits automatic re-enrollment in fully-subsidized ($0 premium) Marketplace coverage for individuals who do not actively confirm their eligibility. For the 2025 coverage year, enrollees in $0 premium plans who do not apply for an updated eligibility determination by December 15, 2025 will have their Advance Premium Tax Credits (APTCs) reduced by $5 every month until they confirm their eligibility. The enrollee may be eligible for a partial or full refund of the penalties the next time they reconcile their APTCs. If the enrollee fails to pay the $5 premium penalty for two consecutive months they will be placed in a three-month grace period and will face coverage termination. This new requirement also intersects with the Marketplace Final Rule's changes at 45 C.F.R. § 147.104(i), which permits issuers to require that enrollees pay past-due premium amounts to effectuate new coverage.[39] This provision applies to the Federally-facilitated Marketplace (FFM), including State-based Marketplaces (SBMs) using the federal platform. It sunsets at the end of 2026.

HHS justifies the $5 premium penalty by asserting that recent coverage gains are the result of fraudulent actions of agents, brokers, and web-brokers. HHS broadly accuses them of improperly enrolling individuals into fully-subsidized plans without their knowledge to obtain ill-gotten commission payments from issuers, and asserts that the $5 premium penalty is needed to "shed" what HHS believes are inappropriate enrollments.[40] In HHS's view, implementing this penalty will combat widespread fraud in the Marketplace.

Importantly, there is little evidence suggesting that individuals enrolling in plans are the ones committing fraud. Although HHS generally conflates what it calls "improper enrollment" in the

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[38] *Id.* at 27199.
[39] *See* Alicia Emanuel & Shandra Hartly, *The Punitive ACA Marketplace Rule Rolls Back Progress Toward Marketplace Access and Affordability*, Nat'l Health Law Prog. (Jun. 25, 2025), https://healthlaw.org/the-punitive-aca-marketplace-rule-rolls-back-progress-toward-marketplace-access-and-affordability/
[40] 90 Fed. Reg. 27074, 27103 (Jun. 25, 2025).

Marketplace with fraud, they are not the same thing.[41] Individuals with low incomes, who are more likely to work in volatile jobs with unpredictable schedules or limited formal payment documentation, may have more difficulty accurately predicting their future income.[42] But this does not mean they are defrauding the Marketplace. Additionally, to the extent there *is* legitimately fraudulent action occurring in the Marketplace, the blame lies almost entirely with brokers and agents – not individual enrollees.[43] But even if HHS's fraud assertions were supported by the evidence, it still had numerous options for less burdensome interventions, such as income verification, periodic data matching, and APTC reconciliation.[44]

The $5 premium penalty is likely to create significant confusion for individuals and result in coverage loss. Individuals who understood themselves to be enrolled in a fully-subsidized plan will be surprised to receive a bill for a premium penalty. Crucially, such confusion and administrative burden has been linked to coverage loss; even small burdens impact people's ability to get and keep health insurance.[45] Premiums are a hassle in and of themselves that

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[41] Kaye Pestaina, et al., *Fraud in Marketplace Enrollment and Eligibility: Five Things to Know*, KFF (Jun. 30, 2025), **https://www.kff.org/patient-consumer-protections/issue-brief/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/**

[42] *See, e.g.*, Kristin F. Butcher and Diane Whitmore Schanzenbach, *Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs*, Ctr. on Budget and Pol'y Priorities (Jul. 24, 2018), **https://www.cbpp.org/research/food-assistance/most-workers-in-low-wage-labor-market-work-substantial-hours-in-volatile/** (volatile jobs); Liz Ben-Ishai, *Volatile Job Schedules and Access to Public Benefits*, CLASP (Sept. 16, 2015), **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf** (unpredictable schedules); Dory Thrasher, *Making Supplemental Nutrition Assistance Program Enrollment Easier for Gig Workers*, 113 Am. J. Pub. Health S210, S211 (2023), **https://pmc.ncbi.nlm.nih.gov/articles/PMC10733874/** (limited formal payment documentation); *see also* Pestaina, *supra* note 41.

[43] *See, e.g.*, Stacey Pogue, et al., *Federal Efforts Ostensibly Aimed at Marketplace "Fraud" Ignore Obvious Strategies to Counter Broker Misconduct*, CHIRblog (Jun. 10, 2025), **https://chirblog.org/federal-efforts-ostensibly-aimed-at-marketplace-fraud-ignore-obvious-strategies-to-counter-broker-misconduct/**; *see also* Pestaina, et al., *supra* note 41.

[44] 90 Fed. Reg. 27074, 27107 (Jun. 25, 2025).

[45] Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies—Important Tools for Preventing Coverage Loss*, 386 New Eng. J. Med. 408, 408 (2022), **https://pmc.ncbi.nlm.nih.gov/articles/PMC9597888/**

impact the take-up and the retention of health coverage.[46] Additionally, in terms of cost, even small premiums can discourage enrollment in and retention of coverage for low-income populations.[47] Administrative barriers to enrollment also disproportionately screen out low-risk individuals who would be more likely to passively re-enroll in coverage, stabilizing the risk pool and lowering costs for everyone.[48]

Individuals who are automatically re-enrolled into new plans following discontinuation of their old plans also risk coverage loss. If they are enrolled into a new fully-subsidized plan but do not verify their information, the $5 premium penalty effectively becomes a binder payment. If the enrollee does not make the binder payment, their coverage does not effectuate. Moreover, they likely will not realize they are not covered until they attempt to use their coverage.

Elimination of the Automatic Re-Enrollment Hierarchy (45 C.F.R. § 155.335(j)(4))

The Marketplace Final Rule eliminates the automatic enrollment hierarchy that allows Marketplaces to move enrollees from bronze to silver qualified health plans (QHPs) if a silver QHP is available in the same product, with the same provider network, and with a net premium lower than or equivalent to the bronze plan. SBMs are prohibited from retaining the automatic re-enrollment hierarchy, but they still have the option to request to use alternative re-enrollment procedures.[49] This policy does not sunset.

HHS frames the automatic re-enrollment hierarchy as a problematic policy that permits Marketplaces to end coverage that an enrollee has obtained through a bronze QHP without the enrollee's knowledge or input, undermining their choices.[50] This is not an accurate representation. The automatic re-enrollment hierarchy improves enrollee experience by

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[46] *See* Keith Marzilli Ericson, et al., *Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment* at 3 (Nat'l Bureau of Econ. Research, Working Paper No. 30885, 2023), **https://sacarny.com/wp-content/uploads/2024/06/ELMS-Admin-Barriers-2024-05.pdf**
[47] *See, e.g.*, Betsy Cliff, et al., *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, Nat'l Bureau of Econ. Research (2021), **https://www.nber.org/system/files/working_papers/w28762/w28762.pdf**
[48] Mark Shepard, et al., *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Review 772, 776 (2025), **https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20231133**
[49] *See* 45 C.F.R. § 155.335(a)(2)(iii).
[50] 90 Fed. Reg. 27074, 27078, 27110 (Jun. 25, 2025).

providing more comprehensive coverage for the same or lesser cost. Health insurance decisions are complex and can be confusing. Eliminating the automatic re-enrollment hierarchy shifts the burden onto enrollees to understand the complexities of plan selection, including actuarial values, cost-sharing, co-payments, and deductibles. The new policy also risks increasing out-of-pocket costs for enrollees who do not understand all of the available options since bronze plans offer less coverage at higher costs.

Shortening the Federal Open Enrollment Period and Limitations on State-based Marketplaces Flexibility (45 C.F.R. § 155.410)

The Marketplace Final Rule shortens the federal open enrollment period (OEP) to 45 days starting with the 2027 plan year. Starting in 2026, the OEP on the FFM will take place from November 1 to December 15.[51] While SBMs retain some flexibility to determine the duration of their OEP, the rule requires that OEPs in states running SBMs run only between November 1 and December 31, are nine weeks or shorter, and allow for plan selection to be effective as of January 1.[52] Importantly, the rule does not specify a minimum required OEP length, opening the door for an even shorter OEP. This policy does not sunset.

Except during the first Trump administration, the FFM has always run at least a 75-day OEP.[53] HHS asserts that it is necessary to shorten the OEP to lessen confusion, reduce casework volumes and unintentional enrollment in two plans, and accommodate enrollees who are accustomed to the December 15 deadline to enroll in coverage.[54] HHS also cites fraud as a catalyst for these changes, accusing agents and brokers of switching or updating enrollees' plans without their knowledge for commission payments, and contending that a sufficient number of enrollees are inappropriately switching their plans between December 15 and January 15 to necessitate shortening the OEP. Yet, instead of holding brokers and agents accountable, HHS erects another barrier to access for enrollees that will cause coverage loss.

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[51] 90 Fed. Reg. 27074, 27135 (Jun. 25, 2025).
[52] This policy will force 19 of 20 SBMs to truncate their OEPs. *See* Emanuel & Hartly, *supra* note 39.
[53] 90 Fed. Reg. 27074, 27136 (Jun. 25, 2025).
[54] 90 Fed. Reg. 27074, 27136 (Jun. 25, 2025).

Holding the OEP in the middle of the holiday season requires consumers to make complex health insurance decisions during a time of added financial and psychological stress.[55] Individuals are forced to prioritize in a way that may result in them dropping their coverage. Additionally, a shorter OEP risks screening out younger, healthier consumers, increasing the likelihood of adverse selection and inflated costs for those who retain coverage.[56] Shortening the OEP will also impact enrollment assisters' work by leaving them with less time to reach all who need assistance.[57] This issue will be compounded by recent massive cuts to the federal Navigator program.[58] With enrollment assisters having fewer resources and less time, individuals will inevitably be left behind.

One-Year "Failure to File and Reconcile" Policy (45 C.F.R. § 155.305(f)(4))

Historically, Marketplace enrollees must file a tax return and "reconcile" the APTC they *actually* received with the APTCs they *should have* received and repay any excess, subject to repayment limits, to maintain eligibility for subsidized coverage.[59] If they do not complete this process, they risk losing APTCs for their "failure to file and reconcile" (FTR).[60] The current two-

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[55] Katherine Swartz & John A. Graves, *Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices*, 30 Health Affairs 1286, 1287 (2014).
[56] 90 Fed. Reg. 27074, 27138 (Jun. 25, 2025); *see also, e.g.*, Covered California, *Data Snapshot: Covered California Open and Special Enrollment Periods* (Apr. 3, 2025), **https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf**
[57] *See* Families USA, *Navigators Help Open the Door to Health Coverage During Open Enrollment* (Jan. 3, 2023), **https://familiesusa.org/resources/navigators-help-open-the-door-to-health-coverage-during-open-enrollment/**
[58] *See* Kaye Pestaina, *A 90% Cut to the ACA Navigator Program*, KFF (Feb. 14, 2025), **https://www.kff.org/quick-take/a-90-cut-to-the-aca-navigator-program/**
[59] 26 U.S.C. § 36B(f). Note that OBBBA will eliminate limits on APTC recapture for most populations starting in 2026.
[60] 81 Fed. Reg. 94058, 94123 (Dec. 22, 2016); *see also* Katie Keith, *HHS Finalizes ACA Marketplace Rule, Part 2: Income And SEP Verification, 'Failure to Reconcile,' And More*, Health Affairs Forefront (Jun. 27, 2025), **https://www.healthaffairs.org/content/forefront/hhs-finalizes-aca-marketplace-rule-part-2-income-and-sep-verification-failure-reconcile**

year FTR policy was adopted in the 2024 NBPP.[61] HHS adopted the two-year policy based on its experience with the one-year policy, which, among other issues, caused confusion for enrollees and tax preparers, and generated significant costs associated with FTR-related appeals.[62] Additionally, delays in IRS data due to long processing times created issues associated with the one-year FTR policy.[63] HHS determined that a two-year FTR process would eliminate these issues.

The Marketplace Final Rule revokes the two-year FTR policy, and requires Marketplaces to deny APTCs for people who fail to file and reconcile for one year. SBMs also must implement a one-year FTR process. This policy is effective only for the 2026 plan year. However, OBBBA reinstates the one-year FTR policy starting in plan year 2028.

The Marketplace Final Rule also implements the following notice requirements for the FFM (SBMs retain existing notice flexibilities):

FTR Recheck Notices and Timing[64]

Notices	Timing
Enrollees with FTR status receive ***Marketplace Open Enrollment Notice (MOEN) with FTR language*** and tax filers receive OE FTR ***direct notice***	Fall (prior to OEP beginning)
Tax filers receive FTR Recheck ***direct notice*** and enrollees receive FTR Recheck ***Indirect Notice*** upon completion of FTR Recheck	Early winter (shortly after OEP ends)
Upon final recheck, enrollees losing APTC receive updated ***Eligibility Determination Notice (EDN)*** and tax filers receive Stop APTC ***direct notice***	Spring

[61] 88 Fed. Reg. 25740, 25815-16 (Apr. 27, 2023).
[62] 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023).
[63] Nat'l Health Law Prog., *Comments on RIN 0938-AU97; CMS-9899-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024*, 7 (Jan. 30, 2023), https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act/
[64] 90 Fed. Reg. 27074, 27118 (Jun. 25, 2025) (emphasis added).

HHS estimates that 210,000 people will lose coverage under the one-year FTR policy.[65] As with many of the Marketplace Final Rule's other changes, these widespread coverage losses increase the risk of adverse selection in the market and raise costs for everyone who retains coverage. These coverage losses will also likely be concentrated among people with lower incomes, who have greater difficulty predicting and verifying their income.[66]

Removal of Low-Income Special Enrollment Period (45 C.F.R. § 155.420(d))

In 2021, HHS introduced a special enrollment period (SEP) for individuals eligible for advance premium tax credit with incomes at or below 150% of the federal poverty line (FPL) (hereafter "the 150% FPL SEP").[67] The 150% FPL SEP aimed to help more people in the U.S. access affordable and quality health care coverage, especially in light of the coverage disruptions and the health inequities exposed by the COVID-19 pandemic.[68] It was a targeted intervention to support lower-income individuals who benefit from more enrollment flexibility.[69]
The 150% FPL SEP has played an important role in reducing health disparities for many underserved populations by increasing access to coverage.[70] HHS has previously stated that it has been especially helpful for those transitioning from Medicaid or aging out of CHIP.[71] It has been critical for people in non-expansion states, since many people with incomes at or below 150% FPL in those states would be eligible for year-round Medicaid based on their income if

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[65] 90 Fed. Reg. 27074, 27198 (Jun. 25, 2025).
[66] *See* Pestaina, et al., *supra* note 41.
[67] 86 Fed. Reg. 53412, 53503-04 (Sept. 27, 2021). Though the SEP was optional for state-based exchanges, by 2025 all but two states with their own exchanges had adopted it. Rachel Swindle et al., *ACA Marketplace Models and Key Policy Decisions*, The Commonwealth Fund (last visited July 24, 2025), **https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions**.
[68] 86 Fed. Reg. 53412, 53412-13 (Sept. 27, 2021).
[69] 86 Fed. Reg. 53412, 53435-36 (Sept. 27, 2021).
[70] Katie Keith, *New Special Enrollment Period for Low-Income People Could Boost Coverage*, The Commonwealth Fund (Sept. 7, 2021), **https://www.commonwealthfund.org/blog/2021/new-special-Enrollment-period-low-income-people-could-boost-coverage**.
[71] 89 Fed. Reg. 26218, 26320-21 (Apr. 15, 2024).

they lived in an expansion state.[72] This SEP has increased access for people with disabilities and/or limited English proficiency (LEP) who may encounter barriers attempting to sign up during OEP, especially considering cuts to funding for navigators that have reduced assistance to individuals enrolling in Marketplace coverage. Finally, it has expanded access to coverage for many recent lawfully present immigrants earning 0-150% FPL, given the five-year bar on Medicaid eligibility.[73]

The Marketplace Final Rule temporarily eliminates the 150% FPL special enrollment period. This provision goes into effect on August 25, 2025, the soonest possible effective date, and sunsets at the end of 2026.[74] HHS asserts that the 150% FPL SEP needs to be eliminated because it leads to adverse selection and improper enrollments.[75] HHS argues that the 150% FPL SEP encourages people to wait to enroll in coverage until they are sick, but HHS does not point to any direct evidence that the 150% FPL SEP has led to this result.[76] HHS also claims that the 150% FPL SEP, in combination with the availability of eAPTCs, increases opportunities for improper enrollments. [77] However, the elimination of the 150% FPL SEP does not sunset until a full year after the eAPTCs are set to expire, making HHS' logic flawed. Despite HHS' arguments, it is clear that the true purpose of revoking the 150% FPL SEP is to reduce enrollment.

It is important to note the interaction between the Marketplace Final Rule and a provision in OBBBA that makes individuals who enroll through an income-based SEP ineligible for premium tax credits (PTCs).[78] Few individuals who would be eligible for the 150% FPL SEP could afford to enroll without PTCs and although the rule sunsets after one year, the permanent prohibition on extending PTCs to people who enroll via an income-based SEP will effectively eliminate the 150% FPL SEP as well as any other future low-income SEP. By sunsetting the rule after one

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[72] *See, e.g.*, *Marketplace Plan Selections by Household Income*, KFF, https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-household-income-2/ (last visited July 27, 2025) (showing that the seven states with the highest levels of Marketplace enrollments for those in the 100%-150% FPL category are non-expansion states).
[73] 8 U.S.C. §1613.
[74] 90 Fed. Reg. 27074, 27144 (June 25, 2025).
[75] 90 Fed. Reg. 27074, 27140 (June 25, 2025).
[76] 90 Fed. Reg. 27074, 27142 (June 25, 2025).
[77] 90 Fed. Reg. 27074, 27141-42 (June 25, 2025).
[78] Pub. L. No. 119-21, § 71304 (2025) ["OBBBA"].

year, lawmakers can claim that savings arising from this effective prohibition on SEPs are due entirely to their bill, rather than a combination of the bill and the rule.

Eliminating the 150% FPL SEP will lead to many low-income individuals being unable to access health coverage and care when they need it, as the SEP serves as an additional pathway for low-income individuals to enroll in free or low-cost coverage. This policy change will likely result in more emergency room utilization, uncompensated care, and worse health outcomes among already vulnerable populations.[79] Increased levels of uninsurance have predictable negative impacts on community health, public health, and the stability of hospital and health provider systems.[80]

Pre-Enrollment Verification for Special Enrollment Periods (45 C.F.R. § 155.420(g)

The Marketplace Final Rule finalizes amendments to § 155.420(g). By doing so, HHS imposes two requirements on the FFM and SBMs using the federal platform to verify eligibility for special enrollment periods (SEPs). Beginning with the 2026 plan year, the FFM is required to conduct pre-enrollment verification for all types of SEPs.[81] The FFM is also required to conduct pre-enrollment verifications for at least 75% or more of new SEP enrollments.[82] Individuals applying through the FFM will have their eligibility verified electronically, or will be asked to submit documentation to confirm eligibility for the SEP. This process must be completed before coverage takes effect.

Notably, unlike the proposed rule, SBMs are not subject to this provision. HHS acknowledges in the preamble to the Marketplace Final Rule that improper enrollment is concentrated in

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[79] 90 Fed. Reg. 27074, 27145 (June 25, 2025).
[80] KFF, *The Uninsured Population and Health Coverage* (May 28, 2024), **https://www.kff.org/health-policy-101-the-uninsured-population-and-health-coverage/**.
[81] 90 Fed. Reg. 27074, 27079 (June 25, 2025). HHS explains that prior to the 2023 Payment Notice, Marketplaces on the Federal platform conducted manual verification for five SEPs: marriage, adoption, moving to a new coverage area, loss of minimum essential coverage (MEC), and Medicaid/CHIP denial. By removing the provision that limits pre-enrollment verifications to the loss of MEC SEP, HHS is reinstating pre-enrollment verification for these SEPs on the Federal platform that were in place prior to the 2023 Payment Notice.
[82] *Id.*

Marketplaces using the federal platform, so the burden of extending this provision to SBMs will not reap the benefit.[83] Yet another deviation from the proposed rule is that this provision will take place during the 2026 plan year only. So, the FFM will need to set up functional changes in the system for 2026, just to have it stopped in 2027.

HHS justifies this policy change by stating it is necessary to increase program integrity and address improper enrollments. Specifically, HHS cites "misuse and abuse of SEPs to gain coverage."[84] However, it is unclear how imposing pre-enrollment verifications on *new* enrollment address what HHS presents as high levels of improper enrollment among *current* enrollees. This is especially perplexing given that HHS asserts that expiration of enhanced federal subsidies (eAPTCs) will curtail future improper enrollments and eAPTCs are set to expire at the end of 2025.

The burden of imposing pre-enrollment verification requirements on individuals and families seeking Marketplace coverage outweighs HHS's concern about fraudulent enrollment and program integrity. Despite HHS' assertion that documentation to verify SEPs is easily accessible, SEP proofs (like paperwork confirming an adoption or marriage), are often difficult to track down from government agencies and county offices. Obtaining proofs can also take time to process and mail to the individual. Once the individual submits their proofs to their Marketplace, incorrect information and errors in processing documents can cause delays in proving eligibility for the SEP. All of these administrative barriers delay enrollment, and can deter enrollment altogether.

It is well documented that the use of SEPs is grossly underutilized, so the additional administrative burden of pre-enrollment verifications will only further deter individuals from Marketplace enrollment. One study which relied on CMS data found that fewer than 15% of uninsured SEP eligible individuals enroll in coverage.[85] Individuals may not be enrolling due to factors like lack of awareness, affordability concerns, or because of the difficulty of the

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[83] 90 Fed. Reg. 27074, 27151.
[84] *Id* at 27079.
[85] Matthew Buettgens et al., More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods, Urban Inst. (Nov. 20, 2015), **https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-MillionUninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf**.

enrollment and SEP verification process.[86] Regardless, the underutilization of SEPs contributes to annual enrollment declines, which ultimately results in a higher uninsured rate. Individuals and families will only be more deterred from enrolling in Marketplace coverage through SEPs once this provision is implemented.

Requiring SEP pre-enrollment verifications will likely deter healthy individuals and families from enrolling when they are eligible for a SEP. Data indicates that younger, healthier individuals submit SEP verification requirements at much lower rates than older individuals.[87] This is in part why the 2023 Final Regulations removed SEP verification requirements for all SEPs except loss of minimum essential coverage (MEC) for new consumers.[88] HHS also acknowledges in the preamble to the Marketplace Final Rule that verifications can undermine the risk pool by "imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling."[89] Overall, imposing pre-verification requirements for more SEPs will negatively impact the risk pool and adversely impact premium rates.

Limiting Coverage of "Sex-Trait Modification" Services as an Essential Health Benefit (42 C.F.R. §§ 156.115; 156.400)

The Marketplace Final Rule introduced a significant limitation on coverage of services in the Marketplace by prohibiting coverage of "specified sex-trait modification procedures" as essential health benefits (EHBs). EHBs are the primary mechanism that the ACA established to ensure that enrollees would have access to a comprehensive set of covered benefits. All non-grandfathered individual and small-group market plans are required to cover EHBs.[90] This coverage requirement also extends to Medicaid Alternative Benefit Plans (ABPs), such as those used to cover the Medicaid expansion population.[91] In addition, while large group plans are not required to cover EHBs, the ACA prohibits them from imposing annual and lifetime limits on all services considered EHBs and establishes a maximum-out-pocket limit that applies to EHBs.[92]

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[86] *Id.*
[87] 87 Fed. Reg. 27208, 27278 (May 6, 2022).
[88] *Id.*
[89] 90 Fed. Reg. 27074, 27148 (June 25, 2025).
[90] 42 U.S.C. § 300gg-6; 42 U.S.C. § 18022.
[91] 42 U.S.C. § 1396u-7(b)(5) (added by ACA § 2001(c)(3) (referencing 42 U.S.C. § 18022).
[92] 42 U.S.C. § 300gg-11; 42 U.S.C. § 300gg-6(b).

The ACA gave HHS the authority to define EHBs and to ensure that the scope of services covered as EHBs are equal to the scope of services covered in a typical employer plan. HHS, in turn, passed on this authority to define EHBs to the states in the form of a benchmarking process, whereby each state selects a benchmark or model plan that includes all the benefits that plans within that state are required to cover as EHBs.[93] This deferential treatment towards states has been in place since HHS first implemented the ACA's coverage requirements in 2011 and, since then, HHS has increased state flexibility through rulemaking by allowing them to expand the number of services covered as EHBs as long as the resulting benchmark plan meets certain actuarial requirements. HHS has nonetheless exercised its authority to define EHBs to fill gaps in coverage that persist across states.[94] HHS also excluded certain services that have traditionally been offered as excepted benefits (such as adult vision services and long-term care) from being covered as EHBs.[95]

The Marketplace Final Rule undercuts state flexibility to define EHBs in an unprecedented way by prohibiting issuers from covering "specified sex-trait modification procedures" as EHBs.[96] The designation of "specified sex-trait modification procedures" as non-EHB services means that state regulators and insurers must:

- Exclude "sex-trait modification procedures" from state EHB benchmark plans;[97]
- Ensure that PTCs do not pay for "specified sex-trait modification procedures;"[98]

[93] For information on the EHB benchmarking process and selected benchmark plans by state, see CMS, Information on Essential Health Benefits (EHB) Benchmark Plans (last visited July 28, 2025), **https://www.cms.gov/marketplace/resources/data/essential-health-benefits**.
[94] *See, e.g.*, 45 C.F.R. § 156.122 (establishing a national standard for prescription drug coverage); § 156.115(a)(5)(defining habilitative services)
[95] *See* Dep't of Health and Hum. Srvs., Patient Protection and Affordable Care Act, *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012); 78 Fed. Reg. 12845. Codified at 45 C.F.R § 156.115(d).
[96] 90 Fed. Reg. 27223, to be codified at 45 C.F.R §§ 156.115(d); 156.400.
[97] *Id.*
[98] 26 U.S.C. § 36B(b)(3)(D).

- Remove the estimated cost of "specified sex-trait modification procedures" when determining PTC amounts for Marketplace enrollees,[99] and
- Disregard cost sharing for "specified sex-trait modification procedures" when calculating maximum out of pocket costs.[100]

In addition, insurers offering individual and small group plans, as well as large employer plans, may choose to impose annual or lifetime limits on "specified sex-trait modification procedures" since they are designated as non-EHB.[101]

The Marketplace Final Rule defines "specified sex-trait modification procedures" as:

> Any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) Intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) Intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.[102]

"Sex-trait modification procedures," a term that has no basis in science or medicine, represents HHS's attempt to restrict access to gender-affirming care for individuals with gender dysphoria. Highlighting the intent to target transgender individuals, in fact, the Marketplace Final Rule clarifies that the term does not extend to gender-affirming care services that are provided for treatment of a "disorder of sexual development" or for a different purpose that is not attempting to align an individual's body with their asserted identity.[103] As such, the rule effectively bars coverage as EHBs of certain services when provided for the purpose of "sex-trait modifications," but permits coverage of the same

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[99] *Id*. *See also* 90 Fed. Reg. 27205, "Given that a QHP's percentage of premium attributable to the EHB is used to determine the amount of available tax credits under the ACA, we expect an impact on the amount of available PTC."
[100] 42 U.S.C. § 18022(c)(3). 90 Fed.Reg.27204 "the prohibition on annual and lifetime dollar limits and requirement to accrue enrollee cost sharing towards the annual limitation on cost sharing will not apply to specified sex-trait modification procedures to the extent such care is included in health plans as non-EHB, including in large group market and self-insured group health plans."
[101] 42 U.S.C. § 300gg-11.
[102] 90 Fed. Reg. 27223, to be codified at 45 C.F.R § 156.400.
[103] *Id.*

services as EHBs when provided to treat other conditions. This prohibition is the first time since the ACA's enactment that HHS has used its authority to define EHBs in order to restrict access to certain services based on a diagnosis or the purpose for which they are being provided.

Importantly, the Marketplace Final Rule does not prohibit issuers from covering so-called "sex-trait modification procedures" as non-EHBs. However, because the ACA ties payment of PTCs to costs associated with provision of EHBs, plans that do cover "sex-trait modification" services would have to segregate funding for these services in order to avoid using federal funds for covering such services. This segregation of funding is likely to be particularly burdensome for plans as they would have to segregate funds for certain services when provided for a particular purpose, but are permitted to use APTC dollars to cover the same services when provided for non-sex-trait modification purposes.

Similarly, states may continue to require coverage of "sex-trait modification procedures" as non-EHB coverage mandates. However, to comply with the ACA's limit on additional state-level coverage mandates, states would have to defray the costs of such services when used for "sex-trait modifications." States may still require plans to cover the same services, as EHBs, when provided for other purposes without having to defray the costs of the services in those instances. However, because defrayal only applies to QHPs, states can continue requiring non-QHPs, including plans outside of the Marketplace and Medicaid ABPs, to cover services that fall under the definition of "sex-trait modification procedures" without having to defray.[104]

Many questions remain about how HHS will implement and enforce this new rule restricting access to "sex-trait modification procedures" as EHBs, which the Marketplace Final Rule makes effective starting January 2026.[105] We expect HHS to provide clarity on these questions in the coming months and, similarly, expect states to provide guidance to issuers as they face

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[104] 42 U.S.C. § 18031(d)(3)(B)(ii); 45. C.F.R. § 155.170. The Marketplace Final Rule's prohibition on "sex-trait modification procedures" as EHB should not impact coverage of such services in Medicaid. As mentioned above, Medicaid Alternative Benefit Plans (ABPs), which provide coverage to Medicaid expansion adults and other populations, must meet EHB coverage standards. However, states may provide additional benefits beyond those in the benchmark coverage. 42 U.S.C. § 1396u-7(b)(5) (added by ACA § 2001(c)(3) (referencing 42 U.S.C. § 18022).; 42 U.S.C. §§ 1396u-7(a)(1)(B), 1396a(k)(1) (requiring states to cover the expansion population using benchmark or benchmark equivalent plans); 42 C.F.R. § 440.360. 42 U.S.C. § 1396u-7(a)(1)(C); 42 C.F.R. §§ 440.335, 440,360 (setting forth requirements for providing additional services).

[105] 90 Fed. Reg. 27223, to be codified at 45 C.F.R § 156.115(d).

uncertainty regarding which services to provide coverage for, in which circumstances, and using which types of funding.

Conclusion

Clearly, the Marketplace Final Rule will have devastating effects on individuals and families attempting to access Marketplace coverage, and on the integrity of the Marketplaces and the ACA. In combination with OBBBA and the anticipated expiration of eAPTCs, coverage will become more expensive, less valuable, and harder to obtain. Healthier people may be compelled to drop their coverage in 2026, discouraged by more limited, burdensome enrollment processes and sharply increased premiums and out-of-pocket costs. People who remain covered despite higher costs and more burdensome requirements are likely to be those who anticipate needing health insurance to defray the costs of serious health conditions. The resulting smaller, sicker risk pool will drive insurance plans to increase their premiums in future years, further squeezing individuals and families who may be forced to drop coverage over time as costs continue to increase. As some policies in the Marketplace Final Rule sunset, permanent changes to the law under OBBBA will come into effect, making it unlikely that the individual markets will rebound as Marketplace Final Rule provisions expire. And if history is any indication, Republicans will not hesitate to point to the predictable outcomes of their own attacks on the ACA to further diminish the law, including by promoting junk plans and health-related tax benefits for the rich as alternatives to comprehensive and affordable private insurance coverage.