Summary: Changes to ACA marketplace eligibility, enrollment, and affordability

On June 25, 2025, the Centers for Medicare & Medicaid Services (CMS) finalized its ACA marketplace integrity rule (CMS Final Rule) that makes several significant changes to marketplace eligibility and enrollment. On July 4, 2025, the One Big Beautiful Bill Act (OBBBA; Public Law 119-21) was signed into law. This legislation includes several policy and operational changes to the ACA marketplace that will further impact coverage and affordability in 2026 and beyond.

In July, a group of cities and organizations representing health care professionals and small businesses filed a lawsuit (*City of Columbus v. Kennedy*, No. 25-cv-2114-BAH) against the Administration seeking a stay of certain provisions in the CMS Final Rule under the Administrative Procedure Act (APA). On August 22, 2025, the United States District Court for the District of Maryland, issued a nationwide stay on several provisions of the CMS Final Rule (i.e. suspended implementation) finding that the provisions were likely inconsistent with the text of the ACA or arbitrary and capricious.[1] The Administration has filed a notice of its intent to appeal the decision to the Fourth Circuit Court of Appeals. Below, we identify those provisions that are currently stayed.

Changes to premium tax credit (PTC) eligibility

The OBBBA did not extend the enhanced premium tax credit (EPTC) subsidies that have significantly improved the affordability of ACA marketplace plans. Since 2021, the more generous subsidies have increased tax credits for people with incomes below 400 percent of the Federal Poverty Level (FPL), allowed those above 400 percent FPL to qualify for credits, and capped premiums at 8.5 percent of income. As a result, marketplace enrollment has risen to a record high of more than 24 million people. Failure to extend the enhanced subsidies by the end of this year will lead to significantly higher premiums for all marketplace enrollees, many of whom may opt out of coverage. The Congressional Budget Office (CBO) estimates that 4.2 million enrollees will become uninsured if the EPTCs are allowed to expire.

A provision in the CMS marketplace integrity rule that will sunset after plan year 2026 bans consumers from receiving an Advance Premium Tax Credit (APTC) if they fail to file taxes and reconcile the APTC they received the prior year with the premium tax credit they were entitled to, based on their end-of-year income. (**STAYED**) Section 71305 of the OBBBA removes the cap on the amount that low-income consumers must repay if the APTCs they received were more than they should have received. Currently, repayment limits vary by income and low-income people are protected by the caps on repayment requirements. Because of these changes, some enrollees may soon have to pay past due premiums to obtain coverage or could incur unexpected tax liabilities next year.

A shorter open enrollment period

In recent years, open enrollment for ACA marketplaces began November 1 and ended January 15. CMS' final rule shortened the annual open enrollment period (OEP) for all individual market exchanges and delayed implementation for one year. Leading up to plan year 2027, CMS will run open enrollment for the federally-facilitated exchange from November 1 to December 15. State-based marketplaces will be able to set their own open enrollment dates but must begin an OEP by November 1 and end it no later than December 31 while not exceeding 9 weeks. CMS estimates it will cost state-based exchanges more than $7 million to implement the shortened open enrollment

[1] "Court Stays Major 2026 Marketplace Changes as Trump Administration Appeals," *Health Affairs*, September 2, 2025, https://www.healthaffairs.org/content/forefront/court-stays-major-2026-marketplace-changes-trump-administration-appeals.

period. Of note, the agency did not provide open enrollment dates for plan year 2026 but is expected to operate its OEP from November 1 to January 15.

Fewer special enrollment opportunities

Section 71304 of the OBBBA prohibits the receipt of PTCs by individuals who enroll in marketplace plans during the continuous special enrollment period (SEP) for individuals with incomes below 150 percent of the FPL. Beginning in 2026, this change will limit the ability of low-income people to enroll in subsidized marketplace coverage throughout the year unless they qualify for another SEP based on loss of coverage, marriage, childbirth, or other qualifying event. A provision in CMS' final rule also requires states utilizing the federally-facilitated exchange to verify eligibility for new SEP enrollees, disallowing applicants from "self-attesting" that they had experienced a qualifying life event **(STAYED).** Eligibility must be verified for at least 75 percent of all new SEP enrollments; moreover, consumers whose eligibility cannot be verified will be unable to enroll (**STAYED**). Of note, the OBBBA also prohibits people who are disenrolled from Medicaid because they failed to satisfy a community engagement (work) requirement from receiving PTCs, effectively locking them out of the ACA marketplace when they experience a loss of coverage.

Stricter income verification, documentation requirements

Section 71303 of the OBBBA ends the longstanding practice of allowing subsidized marketplace consumers to automatically reenroll in their plan, beginning in plan year 2028. This provision will require that all individuals take actionable steps to verify income and other information each year before the close of open enrollment and prior to receiving PTCs or cost-sharing reductions. Last year, more than half of marketplace enrollees auto-renewed their coverage without having to return to the marketplace. Section 71703 also ends provisional eligibility for marketplace coverage, beginning in plan year 2028. Currently, individuals can receive an ACA subsidy for a limited time while their eligibility is being verified. These changes will make it harder to reenroll in coverage, and some enrollees will likely drop coverage altogether.

Under CMS' final rule, new documentation requirements effective on August 25 require stricter income verification of marketplace applicants when tax data is not available, and when an individual attests to having income at or above 100 percent FPL but electronic data sources show lower income amounts (**STAYED**). Moreover, CMS will end the 60-day grace period that is now granted to marketplace consumers, keeping them covered while data matching issues are resolved. These provisions will sunset after plan year 2026 but, in the interim, will make it more difficult for low-income people to enroll in marketplace coverage.

$5 premiums for $0 premium plan auto-enrollees

For plan year 2026, CMS will require consumers auto-reenrolled into $0 premium plans to pay $5 per month until they actively confirm their eligibility information. This requirement applies to the federally-facilitated exchange, which will lower PTC amounts for fully-subsidized enrollees by $5 per month until the information in their marketplace account is either updated or confirmed, after which they will once again owe $0 premiums (**STAYED**).

Increased premium contributions and out-of-pocket costs

Technical changes in the CMS final rule, effective plan year 2026, are expected to increase marketplace consumers' premium contributions and out-of-pocket expenses. One provision changes the methodology for calculating the premium adjustment percentage, which is a measure of premium growth that impacts several calculations and will raise consumers' maximum out-of-pocket annual limit on cost-sharing while decreasing premium subsidy amounts.

Another change expands the flexibility allowed in setting actuarial value levels for bronze, silver, gold, and platinum plans. The current policy of narrowing the threshold range for each of the metal levels has improved premium affordability for PTC recipients, and expanding the de minimis threshold levels, which allows with lower actuarial values, is expected to increase premiums and cost-sharing for subsidized enrollees **(STAYED).**

Gender-affirming care prohibited as an EHB

The CMS final rule prohibits marketplace insurers from covering gender-affirming care, which CMS calls “sex trait modification procedures,” as an essential health benefit (EHB). The rule specifies that “sex trait modification procedures” means “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.”

Note that this summary does not include all of the changes to the ACA marketplace made by CMS and Congress.