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HHS Proposes Rule Restricting Marketplace Enrollment, Eligibility, and Benefits

On March 10, the Department of Health and Human Services (HHS) released its first [major healthcare regulation](#) of the Trump Administration. The proposed rule makes several changes to marketplace coverage, including to enrollment processes, benefits, and income verification for premium tax credits (PTCs) and cost sharing reductions (CSRs). If finalized, many of the proposed changes will go into effect starting in January 2026, but some of the changes, including to special enrollment periods, would go into effect this year. A full summary of the proposed rule is [available here](#). Read on for the highlights of the rule and to learn about how certain provisions could impact access to care for people with chronic and complex conditions.

Enrollment Changes

The rule makes a number of changes that could make it more difficult for individuals to enroll in marketplace coverage. These changes threaten the historic enrollment numbers achieved over the past several years, including an [all-time high](#) for 2025 coverage.

- The rule proposes to **shorten the marketplace annual open enrollment period to 45 days**, shrinking the amount of time people have to enroll in new coverage or make changes to their plan selection. Starting with the open enrollment period for the 2026 plan year, people will have from November 1 to December 15 to enroll in coverage. Under the Biden Administration, the open enrollment period was extended to 75 days, from November 1 to January 15.
- The rule proposes to **remove the monthly “low-income special enrollment period” (SEP)** (in place since 2021) that allowed consumers with incomes below 150 percent of the federal poverty level (FPL) to enroll in marketplace coverage all-year round (the SEP is available monthly). The SEP was aimed at ensuring that low-income, uninsured people who were eligible for subsidized marketplace coverage had limited barriers to enrollment.
- The rule **makes it harder for consumers to demonstrate they are eligible for an SEP** by requiring more documentation. The Biden Administration had allowed consumers to self-attest to eligibility for most SEPs, removing administrative and paperwork barriers to enrollment. The proposed rules takes away

How To Submit Federal Comments

- Organizations should consider submitting comments to the rule and letting the Administration know the impact that proposed changes will have on people living with chronic and complex conditions.
- Comments can be submitted [HERE](#) and are due on April 11, 2025.

the self-attestation option, requiring the marketplace to verify that the enrollee is eligible for the SEP before they are allowed to enroll in coverage.

- The rule will make reenrollment more difficult for marketplace enrollees by **charging fully subsidized enrollees enrolled in \$0 premium plans a \$5 premium to reenroll** (which then would be eliminated after the enrollee confirmed their eligibility). The stated purpose of this change is to cut down on fraudulent enrollments by requiring the enrollee to pay a nominal premium amount to confirm that they are aware they are covered and to stay enrolled. There is a concern that the premium requirement will confuse potential enrollees who are expecting to stay in a \$0 premium plan.

Benefits Changes

While the rule largely leaves ACA benefits alone, HHS has singled out gender affirming care. In keeping with the recent spate of executive orders, the rule proposes to prohibit coverage for these services as part of the ACA's

What is EHB?

- The ACA requires individual market and small group plans to cover a set of [ten Essential Health Benefits \(EHB\)](#).
- States may choose a "[benchmark plan](#)" to set the scope of coverage for each of the ten EHB categories. The benchmark plan is meant to reflect the scope of coverage typically included in an employer plan.
- If a state mandates coverage beyond EHB, the state must "defray" the additional costs of those services.

Essential Health Benefits (EHB). Using language that is scientifically inaccurate, the rule refers to these services as "sex-trait modification" services and prohibits coverage for these services as part of EHB starting in 2026.

HHS relies heavily on its uncited assertion that gender affirming care is not typically covered by employer plans, and therefore should not be considered EHB, to justify the proposed prohibition on coverage. The Preamble also justifies its exclusion based on the fact that gender affirming care does not fall cleanly into any one EHB benefits category. Instead, gender affirming care crosses multiple categories, including prescription drug benefits, mental and behavioral health care, hospital care, and ambulatory care. The proposed exclusion for this coverage is unlike any other benefits exclusion in that it goes after a

group of consumers (transgender and nonbinary people) and their ability to access what are otherwise covered services.

Deferred Action for Childhood Arrivals (DACA) Changes

[DACA recipients](#) are individuals who came to the United States as children, are undocumented, but who are protected from removal proceedings. Despite President Trump's campaign promises to protect DACA and the over 500,000 people who rely on the program, the proposed rule would eliminate the Biden era expansion of marketplace coverage and subsidies to DACA recipients. Up until fall of 2024, DACA recipients were excluded from marketplace coverage, including subsidies. Recognizing the unfairness of this exclusion and the impact on health care access for DACA recipients locked out of coverage options, the Biden Administration finalized a rule last fall that expanded marketplace coverage to this group. Despite [ongoing litigation](#), DACA recipients had begun to enroll in marketplace coverage for the 2025 plan year. The proposed rule would eliminate the Biden era policy, once again prohibiting DACA recipients from enrolling in marketplace coverage.

Premium Hikes

The proposed rule would revert back to a previous calculation used to determine the out-of-pocket maximum for individual and small group plans. The out-of-pocket maximum is an important backstop on what a consumer pays out-of-pocket in cost sharing and deductibles (excluding premiums) each plan year. The result of this proposed change is that the out-of-pocket maximum for the 2026 plan year could go up to \$10,600 for self-only coverage, a 15% from 2025.

What's Next

Many of the Biden-era changes that this new rule rolls back contributed to [record high ACA enrollment rates](#) in 2025. If the new rule is implemented, up to [2 million individuals](#) could lose their coverage in 2026, mostly concentrated in Southern states such as Mississippi and North Carolina.

Some of the changes implemented in this new rule could limit individuals' ability to qualify for and enroll in marketplace plans. Other changes limit the usefulness of marketplace coverage by limiting what is covered. It is important for individuals living with chronic illnesses and other conditions to understand how these changes might impact their ability to find meaningful health care coverage.

The comments to the rule are due April 11, 2025. This is a fairly short turn around for public feedback, and individuals and groups should make sure to understand the impact the proposed rule would have on their health care access and to communicate any concerns they have to their elected officials and to HHS.

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