AMENDMENT

OFFERED BY MR. FITZPATRICK OF PENNSYLVANIA

At the end of title II, add the following new sections:

SEC. 203. EXTENSION AND MODIFICATION OF ENHANCED PREMIUM TAX CREDIT.

(a) EXTENSION AND MODIFICATION OF RULES TO INCREASE PREMIUM ASSISTANCE AMOUNTS.—Section 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986 is amended to read as follows:

''(iii) TEMPORARY RULES FOR 2026 AND 2027.—In the case of any taxable year beginning after December 31, 2025, and before January 1, 2028—

''(I) TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 150 PERCENT OF POVERTY LINE.—With respect to any taxpayer whose household income does not exceed 150 percent of the poverty line for such taxable year—

''(aa) the applicable percentage for such taxpayer shall be 0%, and

''(bb) the premium assistance amount (determined after application of clause (aa)) with respect to any coverage month shall not exceed the excess of the amount described in paragraph (2)(A) over $5.

''(II) TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 200 PERCENT OF POVERTY LINE.—With respect to any taxpayer whose household income exceeds 150 percent of the poverty line but does not exceed 200 percent of the poverty line for such taxable year, the premium assistance amount determined under paragraph (2), with respect to any coverage month, shall be the amount such that the premium assistance amount for such a taxpayer shall decrease, on a sliding scale in a linear manner, from—

"(aa) the premium assistance amount which would be determined under subclause (I) if the household income of such taxpayer were 150 percent of the poverty line, to

"(bb) the premium assistance amount which would be determined under paragraph (2) if subparagraph (B)(ii) thereof were applied by substituting '2 percent' for 'the applicable percentage'.

"(III) TAXPAYERS WHOSE HOUSEHOLD INCOME EXCEEDS 200 PERCENT OF POVERTY LINE.—With respect to any taxpayer whose household income exceeds 200 percent of the poverty line for such taxable year, clause (ii) shall not apply and the applicable percentage for such taxable year shall be the percentage such that the applicable percentage for such a taxpayer whose household income is within an income tier specified in the

following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

''In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
200% up to 250%	2.0%	4.0%
250% up to 300%	4.0%	6.0%
300% up to 400%	6.0%	8.5%
400% up to 600%	8.5%	8.5%
600% up to 700%	8.5%	9.25%''.

(b) EXTENSION AND MODIFICATION OF RULE TO ALLOW CREDIT TO TAXPAYERS WHOSE HOUSEHOLD INCOME EXCEEDS 400 PERCENT OF POVERTY LINE.—Section 36B(c)(1)(E) of such Code is amended to read as follows:

''(E) TEMPORARY RULE FOR 2026 AND 2027.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, subparagraph (A) shall be applied by substituting 'but does not exceed 700 percent' for 'but does not exceed 400 percent'.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 204. GUARDRAILS TO PREVENT FRAUD IN EXCHANGES.

(a) REDUCTION OF FRAUDULENT ENROLLMENT IN QUALIFIED HEALTH PLANS.—

(1) PENALTIES FOR AGENTS AND BROKERS.—Section 1411(h)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(h)(1)) is amended—

(A) in subparagraph (A)—

(i) by redesignating clause (ii) as clause (iv);

(ii) in clause (i)—

(I) in the matter preceding subclause (I), by striking ''If—'' and all that follows through the ''such person'' in the matter following subclause (II) and inserting the following: ''If any person (other than an agent or broker) fails to provide correct information under subsection (b) and such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such person''; and

(II) in the second sentence, by striking ''For purposes'' and inserting the following:

''(iii) DEFINITIONS OF NEGLIGENCE, DISREGARD.—For purposes'';

(iii) by inserting after clause (i) the following:

''(ii) CIVIL PENALTIES FOR CERTAIN VIOLATIONS BY AGENTS OR BROKERS.—If any agent or broker fails to provide correct information under subsection (b) or section 1311(c)(8) or other information, as specified by the Secretary, and such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such agent or broker shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than $10,000 and not more than $50,000 with respect to each individual who is the subject of an application for which such incorrect information is provided.''; and

(iv) in clause (iv) (as so redesignated), by inserting ''or (ii)'' after ''clause (i)''; and

(B) in subparagraph (B)—

(i) by striking ''Any person'' and inserting the following:

''(i) IN GENERAL.—Any person''; and

(ii) by adding at the end the following:

''(ii) CIVIL PENALTIES FOR KNOWING VIOLATIONS BY AGENTS OR BROKERS.—

''(I) IN GENERAL.—Any agent or broker who knowingly provides false or fraudulent information under subsection (b) or section 1311(c)(8), or other false or fraudulent information as part of an application for enrollment in a qualified health plan offered through an Exchange, as specified by the Secretary, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $200,000 with respect to each individual who is the subject of an application for which such false or fraudulent information is provided.

''(II) PROCEDURE.—The provisions of section 1128A of the Social

Security Act (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty under subclause (I) in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.''.

(2) CONSUMER PROTECTIONS.—

(A) IN GENERAL.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)) is amended by adding at the end the following new paragraph:

''(8) AGENT- OR BROKER-ASSISTED ENROLLMENT IN QUALIFIED HEALTH PLANS IN CERTAIN EXCHANGES.—

''(A) IN GENERAL.—For plan years beginning on or after such date specified by the Secretary, but not later than January 1, 2029, in the case of an Exchange that the Secretary operates pursuant to section 1321(c)(1), the Secretary shall establish a verification process for new enrollments of individuals in, and changes in coverage for individuals under, a qualified health plan offered through such Exchange, which are submitted by an agent or broker in

accordance with section 1312(e) and for which the agent or broker is eligible to receive a commission.

''(B) REQUIREMENTS.—The enrollment verification process under subparagraph (A) shall include—

''(i) a requirement that the agent or broker provide with the new enrollment or coverage change such documentation or evidence (such as a standardized consent form) or other sources as the Secretary determines necessary to establish that the agent or broker has the consent of the individual for the new enrollment or coverage change;

''(ii) a requirement that any commissions due to a broker or agent for such new enrollment or coverage change are paid after the enrollee has resolved all inconsistencies in accordance with paragraphs (3) and (4) of section 1411(e);

''(iii) a requirement that the information required under clause (i) and, as applicable, the date on which inconsistencies are resolved as described in clause (ii), is

accessible to the applicable qualified health plan through a database or other resource, as determined by the Secretary, so that any commissions due to a broker or agent for such enrollment can be effectuated at the appropriate time;

''(iv) a requirement that individuals are notified of any changes to enrollment, coverage, the agent of record, or premium tax credits in a timely manner and that such notice provides plain language instructions on how individuals can cancel unauthorized activity;

''(v) a requirement that individuals be able to access their account information on a website or other technology platform, as defined by the Secretary, when used to submit an enrollment or plan change, in lieu of the Exchange website described in subsection (d)(4)(C), including information on the agent of record, the qualified health plan, and when any changes are made to the agent of record or the qualified health plan, on a consumer-facing website or through a toll-free telephone hotline; and

"(vi) a requirement that the agent or broker report to the Secretary any third-party marketing organization or field marketing organization (as such terms are defined in section 1312(e)) involved in the chain of enrollment (as so defined) with respect to such new enrollment or coverage change.

"(C) CONSUMER PROTECTION.—The Secretary shall ensure that the enrollment verification process under subparagraph (A) prioritizes continuity of coverage and care for individuals, including by not disenrolling individuals from a qualified health plan without the consent of the individual, regardless of whether the broker, agent, or qualified health plan is in violation of any requirement under this paragraph.".

(B) REQUIRED REPORTING.—Section 1311(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)) is amended—

(i) in subparagraph (H), by striking "and" at the end;

(ii) in subparagraph (I), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(J) report to the Secretary the termination (as defined in section 1312(e)(1)(C)) of an issuer.''.

(3) AUTHORITY TO REGULATE FIELD MARKETING ORGANIZATIONS AND THIRD-PARTY MARKETING ORGANIZATIONS.—Section 1312(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(e)) is amended—

(A) by redesignating paragraphs (1) and (2) as subclauses (I) and (II), respectively, and adjusting the margins accordingly;

(B) in subclause (II) (as so redesignated), by striking the period at the end and inserting ''; and'';

(C) by striking the subsection designation and heading and all that follows through ''brokers—'' and inserting the following:

''(e) REGULATION OF AGENTS, BROKERS, AND CERTAIN MARKETING ORGANIZATIONS.—

''(1) AGENTS, BROKERS, AND CERTAIN MARKETING ORGANIZATIONS.—

''(A) IN GENERAL.—The Secretary shall establish procedures under which a State may allow—

''(i) agents or brokers—''; and

(D) by adding at the end the following:

''(ii) field marketing organizations and third-party marketing organizations to participate in the chain of enrollment for an individual with respect to qualified health plans offered through an Exchange.

''(B) CRITERIA.—For plan years beginning on or after such date specified by the Secretary, but not later than January 1, 2029, the Secretary, by regulation, shall establish criteria for States to use in determining whether to allow agents and brokers to enroll individuals and employers in qualified health plans as described in subclause (I) of subparagraph (A)(i) and to assist individuals as described in subclause (II) of such subparagraph and field marketing organizations and third-party marketing organizations to participate in the chain of enrollment

as described in subparagraph (A)(ii). Such criteria shall, at a minimum, require that—

''(i) an agent or broker act in accordance with a standard of conduct that includes a duty of such agent or broker to act in the best interests of the enrollee;

''(ii) a field marketing organization or third-party marketing organization agree to report the termination of an agent or broker to the applicable State and the Secretary, including the reason for termination; and

''(iii) an agent, broker, field marketing organization, or third-party marketing organization—

''(I) meet such marketing requirements as are required by the Secretary;

''(II) meet marketing requirements in accordance with other applicable Federal or State law;

''(III) does not employ practices that are confusing or misleading, as determined by the Secretary;

''(IV) submit all marketing materials to the Secretary for, as determined appropriate by the Secretary, review and approval;

''(V) is a licensed agent or broker or meets other licensure requirements, as required by the State;

''(VI) register with the Secretary; and

''(VII) does not compensate any individual or organization for referrals or any other service relating to the sale of, marketing for, or enrollment in qualified health plans unless such individual or organization meets the criteria described in subclauses (I) through (VI).

''(C) DEFINITIONS.—In this paragraph:

''(i) CHAIN OF ENROLLMENT.—The term 'chain of enrollment', with respect to enrollment of an individual in a qualified health plan offered through an Exchange, means any steps taken from marketing to such individual, to such individual making

an enrollment decision with respect to such a plan.

''(ii) FIELD MARKETING ORGANIZATION.—The term 'field marketing organization' means an organization or individual that directly employs or contracts with agents and brokers, or contracts with carriers, to provide functions relating to enrollment of individuals in qualified health plans offered through an Exchange as part of the chain of enrollment.

''(iii) MARKETING.—The term 'marketing' means the use of marketing materials to provide information to current and prospective enrollees in a qualified health plan offered through an Exchange.

''(iv) MARKETING MATERIALS.—The term 'marketing materials' means materials relating to a qualified health plan offered through an Exchange or benefits offered through an Exchange that—

''(I) are intended—

''(aa) to draw an individual's attention to such plan or the premium tax credits or cost-sharing

reductions for such plan or plans offered through an Exchange;

''(bb) to influence an individual's decision-making process when selecting a qualified health plan in which to enroll; or

''(cc) to influence an enrollee's decision to stay enrolled in such plan; and

''(II) include or address content regarding the benefits, benefit structure, premiums, or cost sharing of such plan.

''(v) TERMINATION.—The term 'termination', with respect to a contract or business arrangement between an agent or broker and a field marketing organization, third-party marketing organization, or health insurance issuer, means—

''(I) the ending of such contract or business arrangement, either unilaterally by one of the parties or on mutual agreement; or

''(II) the expiration of such contract or business arrangement that is

not replaced by a substantially similar agreement.

''(vi) THIRD-PARTY MARKETING ORGANIZATION.—The term 'third-party marketing organization' means an organization or individual that is compensated to perform lead generation, marketing, or sales relating to enrollment of individuals in qualified health plans offered through an Exchange as part of the chain of enrollment.''.

(4) TRANSPARENCY.—Section 1312(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(e)), as amended by paragraph (3), is further amended by adding at the end the following new paragraphs:

''(2) AUDITS.—

''(A) IN GENERAL.—For plan years beginning on or after such date specified by the Secretary, but not later than January 1, 2029, the Secretary, in coordination with the States and in consultation with the National Association of Insurance Commissioners, shall implement a process for the oversight and enforcement of agent and broker compliance with this section

and other applicable Federal and State law (including regulations) that shall include—

''(i) periodic audits of agents and brokers based on—

''(I) complaints filed with the Secretary by individuals enrolled by such an agent or broker in a qualified health plan offered through an Exchange;

''(II) an incident or enrollment pattern that suggests fraud; and

''(III) other factors determined by the Secretary; and

''(ii) a process under which the Secretary shall share audit results and refer potential cases of fraud to the relevant State department of insurance.

''(B) EFFECT.—Nothing in this paragraph limits or restricts any referrals made under section 1311(i)(3) or any enforcement actions under section 1411(h).

''(3) LIST.—The Secretary shall develop a process to regularly provide to qualified health plans, Exchanges, and States a list of suspended and terminated agents and brokers.''.

(b) REMOVAL OF DECEASED INDIVIDUALS FROM EXCHANGE PLANS.—

(1) IN GENERAL.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(9) REMOVAL OF DECEASED INDIVIDUALS FROM EXCHANGE PLANS.—

''(A) IN GENERAL.—Not later than January 1, 2027, and on a biannual basis thereafter, the Secretary shall conduct a check of the Death Master File (as defined in section 203(d) of the Bipartisan Budget Act of 2013) for purposes of identifying individuals enrolled in a qualified health plan through an Exchange who are deceased.

''(B) PROCESS.—The Secretary shall establish a process to verify that an individual identified pursuant to a check described in subparagraph (A) is deceased and, in the case such individual is verified as being deceased—

''(i) if such individual is enrolled in self-only coverage, require an Exchange to

terminate such individual's enrollment under a qualified health plan; and

''(ii) if such individual is enrolled in coverage other than self-only coverage, require an Exchange to notify any individuals remaining on the qualified health plan of the deceased individual of the need to update coverage information under such plan.''.

(2) MANDATORY SPECIAL ENROLLMENT PERIOD.—The Secretary of Health and Human Services shall revise section 155.420(d)(2)(ii) of title 42, Code of Federal Regulations (or a successor regulation) to ensure that, for plan years beginning on or after January 1, 2027, a special enrollment period is required to be provided under all Exchanges established under title I of the Patient Protection and Affordable Care Act (Public Law 111–148) for individuals experiencing an event described in such section.

(c) STANDARD OF PROOF FOR TERMINATING AGENTS AND BROKERS.—Section 1312(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(e)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(4) STANDARD FOR TERMINATION FOR CERTAIN EXCHANGES.—In the case of an agent or broker with an agreement in effect with an Exchange operated by the Secretary pursuant to section 1321(c) to perform activities described in paragraph (1)(A)(i) with respect to such Exchange, the Secretary may terminate such agreement for cause if the Secretary finds, based on a preponderance of the evidence, that such agent or broker has violated such agreement, otherwise applicable law, or any other requirement applicable to such agent or broker.''.

(d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIVIDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section 1412(c)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) EXCHANGE RESPONSIBILITIES.—Beginning January 1, 2027, if an Exchange is notified under paragraph (1) of an advance determination under section 1411 with respect to the eligibility of an individual for a premium tax credit under section 36B of the Internal Revenue Code of 1986, the Exchange shall, prior to enrolling such individual in a qualified health

plan, clearly notify such individual of the amount of such tax credit.''.

SEC. 205. EXTENDING ANNUAL OPEN ENROLLMENT PERIOD FOR EXCHANGES FOR PLAN YEAR 2026.

The Secretary of Health and Human Services shall revise section 155.410(e) of title 45, Code of Federal Regulations (or any successor regulation) to provide that the annual open enrollment period determined for plan year 2026 pursuant to section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) shall begin on November 1, 2025, and end on March 1, 2026.

SEC. 206. QUALIFIED EXCHANGE ENROLLEES ELIGIBLE TO ESTABLISH HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(i) QUALIFIED EXCHANGE ENROLLEES ELIGIBLE TO ESTABLISH HEALTH SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—For purposes of this section, an individual who is a qualified Exchange enrollee for any month during a taxable year shall be treated as an eligible individual for each of the months in such taxable year and each taxable year thereafter. Notwithstanding the previous sentence,

any individual who elects to make an advance premium payment under section 1412(c)(2)(C) of the Patient Protection and Affordable Care Act with respect to any month during a taxable year shall not be treated as an eligible individual for such month or any other month during such taxable year.

''(2) QUALIFIED EXCHANGE ENROLLEE.—For purposes of this subsection, the term 'qualified Exchange enrollee' means, with respect to any month during a taxable year, any individual if, as of the 1st day of such month, such individual is enrolled in a qualified health plan in the individual market through an Exchange established under the Patient Protection and Affordable Care Act that is—

''(A) the lowest cost bronze plan available to such individual through such Exchange, or

''(B) in the case that, for any month during the preceding taxable year, such individual was enrolled in a qualified health plan in the individual market through such an Exchange (referred to in this paragraph as the 'previous plan'), such a qualified health plan for which the monthly premium is lower than the monthly premium that was in effect for the previous plan.

''(3) APPLICATION OF MONTHLY LIMITATIONS FOR CONTRIBUTIONS.—In the case of an individual who is treated as an eligible individual under paragraph (1), subsection (b)(2) shall be applied as if each reference to 'high deductible health plan' were a reference to 'a qualified health plan in the individual market that was enrolled in through an Exchange established under the Patient Protection and Affordable Care Act'.

''(4) COORDINATION WITH CONTRIBUTIONS OF PARTIAL ADVANCE PREMIUM TAX CREDIT.—

''(A) IN GENERAL.—The limitation which would (but for this paragraph) apply under subsection (b) for any taxable year to an individual who is treated as an eligible individual under paragraph (1) shall be reduced (but not below zero) by the aggregate amount contributed to health savings accounts of such individual for such taxable year under section 1412(f) of the Patient Protection and Affordable Care Act (and such amount shall not be allowed as a deduction under subsection (a)).

''(B) EXCLUSION FROM GROSS INCOME.—Any amount contributed during a taxable year to a health savings account of an eligible indi-

vidual under section 1412(f) of the Patient Protection and Affordable Care Act shall not be included in the gross income of such individual for such taxable year. For purposes of subsection (f)(3) and section 4973(g), any amount excluded from gross income under this subparagraph shall be treated in the same manner as an amount excluded under section 106(d).

''(5) ALLOWING HEALTH INSURANCE TO BE PURCHASED FROM ACCOUNT.—In the case of an individual who is treated as an eligible individual under paragraph (1), subsection (d)(2) shall be applied without regard to subparagraphs (B) and (C) thereof.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 207. OPTION TO PREPAY ANNUAL PREMIUM; OPTION TO DIRECT PARTIAL ADVANCE PAYMENT OF PREMIUM TAX CREDIT INTO HSA.

(a) OPTION TO PREPAY ANNUAL PREMIUM.—Section 1412(c)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(c)(2)) is amended—

(1) in subparagraph (B)(i), by inserting '', and, in the case of an individual who elects to make an

advance premium payment under subparagraph (C), further reduce such premium by $5'' before the semicolon;

(2) by redesignating subparagraph (C), as added by section 3(d), as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) INDIVIDUAL OPTION TO PREPAY ANNUAL PREMIUM.—Beginning with plan years beginning in 2026, in the case of an individual with respect to whom an advance determination has been made under section 1411 that such individual is eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986, if the premium assistance amount under subsection (b)(2) of such section is determined with respect to such individual in accordance with subsection (b)(3)(A)(iii)(I) of such section, such individual may elect to make an advance premium payment to the issuer of the qualified health plan in which such individual is enrolled in an amount equal to $5 multiplied by—

''(i) in the case that the advance determination of eligibility was made during

the annual open enrollment period for such plan year, 12; or

''(ii) in the case that the advance determination of eligibility was made during an open enrollment period other than the annual open enrollment period for such plan year, the number of months remaining in such plan year.''.

(b) OPTION TO DIRECT PARTIAL ADVANCE PAYMENT OF PREMIUM TAX CREDIT INTO HSA.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended—

(1) in subsection (c)(2)—

(A) in subparagraph (A), by striking ''The'' and inserting ''Subject to subsection (f), the''; and

(B) in subparagraph (B), by inserting ''(including such a payment made in accordance with subsection (f))'' after ''an advance payment''; and

(2) by adding at the end the following new subsection:

''(f) OPTION TO DIRECT PARTIAL ADVANCE PAYMENT OF PREMIUM TAX CREDIT TO HSA.—

''(1) IN GENERAL.—Beginning with plan years beginning in 2026, at the election of an eligible enrolled individual described in paragraph (2), the advance payment of the premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 shall be made as follows:

''(A) The Secretary of the Treasury shall make advance payment of 50 percent of such premium tax credit to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

''(B) The Secretary of the Treasury shall make advance payment of 50 percent of such premium tax credit into a health savings account (as defined in section 223(d) of the Internal Revenue Code of 1986) of such individual (as designated by such individual) on the same basis provided for under subparagraph (A), but only to the extent that the aggregate amount of such payments does not exceed the limitation under section 223(b) of such Code (determined without regard to this subsection) which is applicable to such individual for the taxable year in which such payments are made.

"(2) ELIGIBLE ENROLLED INDIVIDUAL.—For purposes of this subsection, the term 'eligible enrolled individual' means, with respect to a plan year (starting with 2026), an individual—

"(A) with respect to whom an advance determination has been made under section 1411 that such individual is eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986;

"(B) who is, for the first month of such plan year, a qualified Exchange enrollee (as defined in section 223(i) of the Internal Revenue Code of 1986); and

"(C) who does not elect to make an advance premium payment under subsection (c)(2)(C).".

SEC. 208. REPORT.

Not later than one year after the date of the enactment of this Act, the Secretary of the Treasury and the Secretary of Health and Human Services shall jointly submit to Congress a report on the implementation of sections 206 and 207 and any recommendations on expanding accessibility of health savings accounts.

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