

AMENDMENT TO H.R. 6703
OFFERED BY MR. KILEY OF CALIFORNIA

Add at the end the following new title:

1 **TITLE III—MISCELLANEOUS**

2 **SEC. 301. EXTENSION AND MODIFICATION OF ENHANCED**
3 **PREMIUM TAX CREDIT.**

4 (a) EXTENSION AND MODIFICATION OF RULES TO
5 INCREASE PREMIUM ASSISTANCE AMOUNTS.—Section
6 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986
7 is amended—

8 (1) by redesignating subclauses (I) and (II) as
9 items (aa) and (bb), respectively, and adjusting the
10 margins accordingly,

11 (2) by striking “TEMPORARY PERCENTAGES
12 FOR 2021 THROUGH 2025.—In the case of” and in-
13 serting “TEMPORARY RULES FOR CERTAIN YEARS.—

14 “(I) BEFORE 2026.—In the case
15 of”, and

16 (3) by adding at the end the following:

17 “(II) AFTER 2025 FOR TAX-
18 PAYERS WHOSE HOUSEHOLD INCOME
19 DOES NOT EXCEED 150 PERCENT OF
20 POVERTY LINE.—In the case of a tax-

1 able year beginning after December
2 31, 2025, and before January 1,
3 2028, if any taxpayer's household in-
4 come does not exceed 150 percent of
5 the poverty line for such taxable year,
6 the premium assistance amount deter-
7 mined under subsection (b)(2), with
8 respect to any coverage month, is the
9 excess of the lesser of the amount de-
10 scribed in paragraph (2)(A) or the
11 amount described in paragraph
12 (2)(B)(i), over \$5.

13 “(III) AFTER 2025 FOR TAX-
14 PAYERS WHOSE HOUSEHOLD INCOME
15 DOES NOT EXCEED 200 PERCENT OF
16 POVERTY LINE.—In the case of a tax-
17 able year beginning after December
18 31, 2025, and before January 1,
19 2028, if any taxpayer's household in-
20 come exceeds 150 percent of the pov-
21 erty line but does not exceed 200 per-
22 cent of the poverty line for such tax-
23 able year, the premium assistance
24 amount determined under subsection
25 (b)(2), with respect to any coverage

1 month, shall be such that the pre-
2 mium assistance amount for such a
3 taxpayer shall decrease, on a sliding
4 scale in a linear manner, from the
5 amount that would result if deter-
6 mined in accordance with subclause
7 (II) to the amount that would result
8 under subsection (b)(2) by sub-
9 stituting ‘2 percent’ for ‘the applicable
10 percentage’ in subparagraph (B)(ii)
11 thereof.

12 “(IV) AFTER 2025 FOR TAX-
13 PAYERS WHOSE HOUSEHOLD INCOME
14 EXCEEDS 200 PERCENT OF POVERTY
15 LINE.—In the case of a taxable year
16 beginning after December 31, 2025,
17 and before January 1, 2028, if any
18 taxpayer’s household income exceeds
19 200 percent of the poverty line for
20 such taxable year—

21 “(aa) clause (ii) shall not
22 apply for purposes of adjusting
23 premium percentages under this
24 subparagraph, and

1 “(bb) the following table
 2 shall be applied in lieu of the
 3 table contained in clause (i):

“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%”.

4 (b) EXTENSION AND MODIFICATION OF RULE TO
 5 ALLOW CREDIT TO TAXPAYERS WHOSE HOUSEHOLD IN-
 6 COME EXCEEDS 400 PERCENT OF POVERTY LINE.—Sec-
 7 tion 36B(c)(1)(E) of such Code is amended—

8 (1) by striking “TEMPORARY RULE FOR 2021
 9 THROUGH 2025.—In the case of” and inserting
 10 “TEMPORARY RULE FOR CERTAIN YEARS.—

11 “(i) BEFORE 2026.—In the case of”,
 12 and

13 (2) by adding at the end the following:

14 “(ii) AFTER 2025.—In the case of a
 15 taxable year beginning after December 31,
 16 2025, and before January 1, 2028, sub-
 17 paragraph (A) shall be applied by sub-
 18 stituting ‘but does not exceed 700 percent’
 19 for ‘but does not exceed 400 percent’.”.

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

4 **SEC. 302. GUARDRAILS TO PREVENT FRAUD IN EX-**
5 **CHANGES.**

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

8 (1) PENALTIES FOR AGENTS AND BROKERS.—
9 Section 1411(h)(1) of the Patient Protection and Af-
10 fordable Care Act (42 U.S.C. 18081(h)(1)) is
11 amended—

12 (A) in subparagraph (A)—

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

15 (ii) in clause (i)—

16 (I) in the matter preceding sub-
17 clause (I), by striking “If—” and all
18 that follows through the “such per-
19 son” in the matter following subclause
20 (II) and inserting the following: “If
21 any person (other than an agent or
22 broker) fails to provide correct infor-
23 mation under subsection (b) and such
24 failure is attributable to negligence or

1 disregard of any rules or regulations
2 of the Secretary, such person”; and

3 (II) in the second sentence, by
4 striking “For purposes” and inserting
5 the following:

6 “(iii) DEFINITIONS OF NEGLIGENCE,
7 DISREGARD.—For purposes”;

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

10 “(ii) CIVIL PENALTIES FOR CERTAIN
11 VIOLATIONS BY AGENTS OR BROKERS.—If
12 any agent or broker fails to provide correct
13 information under subsection (b) or section
14 1311(c)(8) or other information, as speci-
15 fied by the Secretary, and such failure is
16 attributable to negligence or disregard of
17 any rules or regulations of the Secretary,
18 such agent or broker shall be subject, in
19 addition to any other penalties that may be
20 prescribed by law, including subparagraph
21 (C), to a civil penalty of not less than
22 \$10,000 and not more than \$50,000 with
23 respect to each individual who is the sub-
24 ject of an application for which such incor-
25 rect information is provided.”; and

1 (iv) in clause (iv) (as so redesignated),
2 by inserting “or (ii)” after “clause (i)”;
3 (B) in subparagraph (B)—

4 (i) by inserting “including subpara-
5 graph (C),” after “law,”;

6 (ii) by striking “Any person” and in-
7 serting the following:

8 “(i) IN GENERAL.—Any person”; and

9 (iii) by adding at the end the fol-
10 lowing:

11 “(ii) CIVIL PENALTIES FOR KNOWING
12 VIOLATIONS BY AGENTS OR BROKERS.—

13 “(I) IN GENERAL.—Any agent or
14 broker who knowingly provides false
15 or fraudulent information under sub-
16 section (b) or section 1311(c)(8), or
17 other false or fraudulent information
18 as part of an application for enroll-
19 ment in a qualified health plan offered
20 through an Exchange, as specified by
21 the Secretary, shall be subject, in ad-
22 dition to any other penalties that may
23 be prescribed by law, including sub-
24 paragraph (C), to a civil penalty of
25 not more than \$200,000 with respect

1 to each individual who is the subject
2 of an application for which such false
3 or fraudulent information is provided.

4 “(II) PROCEDURE.—The provi-
5 sions of section 1128A of the Social
6 Security Act (other than subsections
7 (a) and (b) of such section) shall
8 apply to a civil monetary penalty
9 under subclause (I) in the same man-
10 ner as such provisions apply to a pen-
11 alty or proceeding under section
12 1128A of the Social Security Act.”.

13 (2) CONSUMER PROTECTIONS.—

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

18 “(8) AGENT- OR BROKER-ASSISTED ENROLL-
19 MENT IN QUALIFIED HEALTH PLANS IN CERTAIN
20 EXCHANGES.—

21 “(A) IN GENERAL.—For plan years begin-
22 ning on or after such date specified by the Sec-
23 retary, but not later than January 1, 2029, in
24 the case of an Exchange that the Secretary op-
25 erates pursuant to section 1321(c)(1), the Sec-

1 retary shall establish a verification process for
2 new enrollments of individuals in, and changes
3 in coverage for individuals under, a qualified
4 health plan offered through such Exchange,
5 which are submitted by an agent or broker in
6 accordance with section 1312(e) and for which
7 the agent or broker is eligible to receive a com-
8 mission.

9 “(B) REQUIREMENTS.—The enrollment
10 verification process under subparagraph (A)
11 shall include—

12 “(i) a requirement that the agent or
13 broker provide with the new enrollment or
14 coverage change such documentation or
15 evidence (such as a standardized consent
16 form) or other sources as the Secretary de-
17 termines necessary to establish that the
18 agent or broker has the consent of the in-
19 dividual for the new enrollment or coverage
20 change;

21 “(ii) a requirement that any commis-
22 sions due to a broker or agent for such
23 new enrollment or coverage change are
24 paid after the enrollee has resolved all in-

1 consistencies in accordance with para-
2 graphs (3) and (4) of section 1411(e);

3 “(iii) a requirement that the informa-
4 tion required under clause (i) and, as ap-
5 plicable, the date on which inconsistencies
6 are resolved as described in clause (ii), is
7 accessible to the applicable qualified health
8 plan through a database or other resource,
9 as determined by the Secretary, so that
10 any commissions due to a broker or agent
11 for such enrollment can be effectuated at
12 the appropriate time;

13 “(iv) a requirement that individuals
14 are notified of any changes to enrollment,
15 coverage, the agent of record, or premium
16 tax credits in a timely manner and that
17 such notice provides plain language in-
18 structions on how individuals can cancel
19 unauthorized activity;

20 “(v) a requirement that individuals be
21 able to access their account information on
22 a website or other technology platform, as
23 defined by the Secretary, when used to
24 submit an enrollment or plan change, in
25 lieu of the Exchange website described in

1 subsection (d)(4)(C), including information
2 on the agent of record, the qualified health
3 plan, and when any changes are made to
4 the agent of record or the qualified health
5 plan, on a consumer-facing website or
6 through a toll-free telephone hotline; and

7 “(vi) a requirement that the agent or
8 broker report to the Secretary any third-
9 party marketing organization or field mar-
10 keting organization (as such terms are de-
11 fined in section 1312(e)) involved in the
12 chain of enrollment (as so defined) with re-
13 spect to such new enrollment or coverage
14 change.

15 “(C) CONSUMER PROTECTION.—The Sec-
16 retary shall ensure that the enrollment
17 verification process under subparagraph (A)
18 prioritizes continuity of coverage and care for
19 individuals, including by not disenrolling indi-
20 viduals from a qualified health plan without the
21 consent of the individual, regardless of whether
22 the broker, agent, or qualified health plan is in
23 violation of any requirement under this para-
24 graph.”.

1 (B) REQUIRED REPORTING.—Section
2 1311(c)(1) of the Patient Protection and Af-
3 fordable Care Act (42 U.S.C. 18031(c)(1)) is
4 amended—

5 (i) in subparagraph (H), by striking
6 “and” at the end;

7 (ii) in subparagraph (I), by striking
8 the period at the end and inserting “;
9 and”; and

10 (iii) by adding at the end the fol-
11 lowing:

12 “(J) report to the Secretary the termi-
13 nation (as defined in section 1312(e)(1)(C)) of
14 an issuer.”.

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

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

23 (B) in subclause (II) (as so redesignated),
24 by striking the period at the end and inserting
25 “; and”;

1 (C) by striking the subsection designation
2 and heading and all that follows through “bro-
3 kers—” and inserting the following:

4 “(e) REGULATION OF AGENTS, BROKERS, AND CER-
5 TAIN MARKETING ORGANIZATIONS.—

6 “(1) AGENTS, BROKERS, AND CERTAIN MAR-
7 KETING ORGANIZATIONS.—

8 “(A) IN GENERAL.—The Secretary shall
9 establish procedures under which a State may
10 allow—

11 “(i) agents or brokers—”; and

12 (D) by adding at the end the following:

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

18 “(B) CRITERIA.—For plan years beginning
19 on or after such date specified by the Secretary,
20 but not later than January 1, 2029, the Sec-
21 retary, by regulation, shall establish criteria for
22 States to use in determining whether to allow
23 agents and brokers to enroll individuals and
24 employers in qualified health plans as described
25 in subclause (I) of subparagraph (A)(i) and to

1 assist individuals as described in subclause (II)
2 of such subparagraph and field marketing orga-
3 nizations and third-party marketing organiza-
4 tions to participate in the chain of enrollment
5 as described in subparagraph (A)(ii). Such cri-
6 teria shall, at a minimum, require that—

7 “(i) an agent or broker act in accord-
8 ance with a standard of conduct that in-
9 cludes a duty of such agent or broker to
10 act in the best interests of the enrollee;

11 “(ii) a field marketing organization or
12 third-party marketing organization agree
13 to report the termination of an agent or
14 broker to the applicable State and the Sec-
15 retary, including the reason for termi-
16 nation; and

17 “(iii) an agent, broker, field mar-
18 keting organization, or third-party mar-
19 keting organization—

20 “(I) meet such marketing re-
21 quirements as are required by the
22 Secretary;

23 “(II) meet marketing require-
24 ments in accordance with other appli-
25 cable Federal or State law;

1 “(III) does not employ practices
2 that are confusing or misleading, as
3 determined by the Secretary;

4 “(IV) submit all marketing mate-
5 rials to the Secretary for, as deter-
6 mined appropriate by the Secretary,
7 review and approval;

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

11 “(VI) register with the Secretary;
12 and

13 “(VII) does not compensate any
14 individual or organization for referrals
15 or any other service relating to the
16 sale of, marketing for, or enrollment
17 in qualified health plans unless such
18 individual or organization meets the
19 criteria described in subclauses (I)
20 through (VI).

21 “(C) DEFINITIONS.—In this paragraph:

22 “(i) CHAIN OF ENROLLMENT.—The
23 term ‘chain of enrollment’, with respect to
24 enrollment of an individual in a qualified
25 health plan offered through an Exchange,

1 means any steps taken from marketing to
2 such individual, to such individual making
3 an enrollment decision with respect to such
4 a plan.

5 “(ii) FIELD MARKETING ORGANIZA-
6 TION.—The term ‘field marketing organi-
7 zation’ means an organization or individual
8 that directly employs or contracts with
9 agents and brokers, or contracts with car-
10 riers, to provide functions relating to en-
11 rollment of individuals in qualified health
12 plans offered through an Exchange as part
13 of the chain of enrollment.

14 “(iii) MARKETING.—The term ‘mar-
15 keting’ means the use of marketing mate-
16 rials to provide information to current and
17 prospective enrollees in a qualified health
18 plan offered through an Exchange.

19 “(iv) MARKETING MATERIALS.—The
20 term ‘marketing materials’ means mate-
21 rials relating to a qualified health plan of-
22 fered through an Exchange or benefits of-
23 fered through an Exchange that—

24 “(I) are intended—

1 “(aa) to draw an individual’s
2 attention to such plan or the pre-
3 mium tax credits or cost-sharing
4 reductions for such plan or plans
5 offered through an Exchange;

6 “(bb) to influence an indi-
7 vidual’s decision-making process
8 when selecting a qualified health
9 plan in which to enroll; or

10 “(cc) to influence an enroll-
11 ee’s decision to stay enrolled in
12 such plan; and

13 “(II) include or address content
14 regarding the benefits, benefit struc-
15 ture, premiums, or cost sharing of
16 such plan.

17 “(v) TERMINATION.—The term ‘ter-
18 mination’, with respect to a contract or
19 business arrangement between an agent or
20 broker and a field marketing organization,
21 third-party marketing organization, or
22 health insurance issuer, means—

23 “(I) the ending of such contract
24 or business arrangement, either uni-

1 laterally by one of the parties or on
2 mutual agreement; or

3 “(II) the expiration of such con-
4 tract or business arrangement that is
5 not replaced by a substantially similar
6 agreement.

7 “(vi) THIRD-PARTY MARKETING ORGA-
8 NIZATION.—The term ‘third-party mar-
9 keting organization’ means an organization
10 or individual that is compensated to per-
11 form lead generation, marketing, or sales
12 relating to enrollment of individuals in
13 qualified health plans offered through an
14 Exchange as part of the chain of enroll-
15 ment.”.

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

21 “(2) AUDITS.—

22 “(A) IN GENERAL.—For plan years begin-
23 ning on or after such date specified by the Sec-
24 retary, but not later than January 1, 2029, the
25 Secretary, in coordination with the States and

1 in consultation with the National Association of
2 Insurance Commissioners, shall implement a
3 process for the oversight and enforcement of
4 agent and broker compliance with this section
5 and other applicable Federal and State law (in-
6 cluding regulations) that shall include—

7 “(i) periodic audits of agents and bro-
8 kers based on—

9 “(I) complaints filed with the
10 Secretary by individuals enrolled by
11 such an agent or broker in a qualified
12 health plan offered through an Ex-
13 change;

14 “(II) an incident or enrollment
15 pattern that suggests fraud; and

16 “(III) other factors determined
17 by the Secretary; and

18 “(ii) a process under which the Sec-
19 retary shall share audit results and refer
20 potential cases of fraud to the relevant
21 State department of insurance.

22 “(B) EFFECT.—Nothing in this paragraph
23 limits or restricts any referrals made under sec-
24 tion 1311(i)(3) or any enforcement actions
25 under section 1411(h).

1 “(3) LIST.—The Secretary shall develop a proc-
2 ess to regularly provide to qualified health plans,
3 Exchanges, and States a list of suspended and ter-
4 minated agents and brokers.”.

5 (b) REMOVAL OF DECEASED INDIVIDUALS FROM EX-
6 CHANGE PLANS.—Section 1311(c) of the Patient Protec-
7 tion and Affordable Care Act (42 U.S.C. 18031(c)), as
8 amended by subsection (a), is further amended by adding
9 at the end the following new paragraph:

10 “(9) REMOVAL OF DECEASED INDIVIDUALS
11 FROM EXCHANGE PLANS.—

12 “(A) IN GENERAL.—Not later than 90
13 days after the date of the enactment of this
14 paragraph, and on a quarterly basis thereafter,
15 the Secretary shall conduct a check of the
16 Death Master File (as such term is defined in
17 section 203(d) of the Bipartisan Budget Act of
18 2013) for purposes of identifying individuals
19 enrolled in a qualified health plan through an
20 Exchange who are deceased.

21 “(B) PROCESS.—The Secretary shall—

22 “(i) establish a process to verify that
23 an individual identified pursuant to a
24 check described in subparagraph (A) is de-
25 ceased; and

1 “(ii) require an Exchange to termi-
2 nate such individual’s enrollment under a
3 qualified health plan.”.

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

9 “(4) STANDARD FOR TERMINATION FOR CER-
10 TAIN EXCHANGES.—In the case of an agent or
11 broker with an agreement in effect with an Ex-
12 change operated by the Secretary pursuant to sec-
13 tion 1321(c) to perform activities described in para-
14 graph (1)(A)(i) with respect to such Exchange, the
15 Secretary may terminate such agreement for cause
16 if the Secretary finds, based on a preponderance of
17 the evidence, that such agent or broker has violated
18 such agreement, otherwise applicable law, or any
19 other requirement applicable to such agent or
20 broker.”.

21 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDI-
22 VIDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section
23 1412(c)(2) of the Patient Protection and Affordable Care
24 Act (42 U.S.C. 18082(c)(2)) is amended by adding at the
25 end the following new subparagraph:

1 “(C) EXCHANGE RESPONSIBILITIES.—Be-
2 ginning January 1, 2027, if an Exchange is no-
3 tified under paragraph (1) of an advance deter-
4 mination under section 1411 with respect to the
5 eligibility of an individual for a premium tax
6 credit under section 36B of the Internal Rev-
7 enue Code of 1986, the Exchange shall, prior to
8 enrolling such individual in a qualified health
9 plan, clearly notify such individual of the
10 amount of such tax credit.”.

11 **SEC. 303. EXTENDING ANNUAL OPEN ENROLLMENT PERIOD**
12 **FOR EXCHANGES FOR PLAN YEAR 2026.**

13 The Secretary of Health and Human Services shall
14 revise section 155.410(e) of title 45, Code of Federal Reg-
15 ulations (or any successor regulation) to provide that the
16 annual open enrollment period determined for plan year
17 2026 pursuant to section 1311(c)(6) of the Patient Pro-
18 tection and Affordable Care Act (42 U.S.C. 18031(c)(6))
19 shall begin on November 1, 2025, and end on March 1,
20 2026.

21 **SEC. 304. QUALIFIED EXCHANGE ENROLLEES ELIGIBLE TO**
22 **ESTABLISH HEALTH SAVINGS ACCOUNTS.**

23 (a) IN GENERAL.—Section 223 of the Internal Rev-
24 enue Code of 1986 is amended by adding at the end the
25 following new subsection:

1 “(i) QUALIFIED EXCHANGE ENROLLEES ELIGIBLE
2 TO ESTABLISH HEALTH SAVINGS ACCOUNTS.—

3 “(1) IN GENERAL.—For purposes of this sec-
4 tion, an individual who is a qualified Exchange en-
5 rollee for any month during a taxable year shall be
6 treated as an eligible individual for each of the
7 months in such taxable year and each taxable year
8 thereafter. Notwithstanding the previous sentence,
9 any individual who elects to make an advance pre-
10 mium payment under section 1412(c)(2)(C) of the
11 Patient Protection and Affordable Care Act with re-
12 spect to any month during a taxable year shall not
13 be treated as an eligible individual for such month
14 or any other month during such taxable year.

15 “(2) QUALIFIED EXCHANGE ENROLLEE.—For
16 purposes of this subsection, the term ‘qualified Ex-
17 change enrollee’ means, with respect to any month
18 during a taxable year, any individual if, as of the 1st
19 day of such month, such individual is enrolled in a
20 qualified health plan in the individual market
21 through an Exchange established under the Patient
22 Protection and Affordable Care Act that is—

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

1 “(B) in the case that, for any month dur-
2 ing the preceding taxable year, such individual
3 was enrolled in a qualified health plan in the in-
4 dividual market through such an Exchange (re-
5 ferred to in this paragraph as the ‘previous
6 plan’), such a qualified health plan for which
7 the monthly premium is lower than the monthly
8 premium that was in effect for the previous
9 plan.

10 “(3) APPLICATION OF MONTHLY LIMITATIONS
11 FOR CONTRIBUTIONS.—In the case of an individual
12 who is treated as an eligible individual under para-
13 graph (1), subsection (b)(2) shall be applied as if
14 each reference to ‘high deductible health plan’ were
15 a reference to ‘a qualified health plan in the indi-
16 vidual market that was enrolled in through an Ex-
17 change established under the Patient Protection and
18 Affordable Care Act’.

19 “(4) COORDINATION WITH CONTRIBUTIONS OF
20 PARTIAL ADVANCE PREMIUM TAX CREDIT.—The lim-
21 itation which would (but for this paragraph) apply
22 under subsection (b) for any taxable year to an indi-
23 vidual who is treated as an eligible individual under
24 paragraph (1) shall be reduced (but not below zero)
25 by the aggregate amount contributed to health sav-

1 ings accounts of such individual for such taxable
2 year under section 1412(f) of the Patient Protection
3 and Affordable Care Act (and such amount shall not
4 be allowed as a deduction under subsection (a)).

5 “(5) ALLOWING HEALTH INSURANCE TO BE
6 PURCHASED FROM ACCOUNT.—In the case of an in-
7 dividual who is treated as an eligible individual
8 under paragraph (1), subsection (d)(2) shall be ap-
9 plied without regard to subparagraphs (B) and (C)
10 thereof.”.

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

14 **SEC. 305. OPTION TO PREPAY ANNUAL PREMIUM; OPTION**
15 **TO DIRECT PARTIAL ADVANCE PAYMENT OF**
16 **PREMIUM TAX CREDIT INTO HSA.**

17 (a) OPTION TO PREPAY ANNUAL PREMIUM.—Section
18 1412(c)(2) of the Patient Protection and Affordable Care
19 Act (42 U.S.C. 18082(c)(2)) is amended—

20 (1) in subparagraph (B)(i), by inserting “, and,
21 in the case of an individual who elects to make an
22 advance premium payment under subparagraph (C),
23 further reduce such premium by \$5” before the
24 semicolon;

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

3 (3) by inserting after subparagraph (B) the fol-
4 lowing new subparagraph:

5 “(C) INDIVIDUAL OPTION TO PREPAY AN-
6 NUAL PREMIUM.—Beginning with plan years
7 beginning in 2026, in the case of an individual
8 with respect to whom an advance determination
9 has been made under section 1411 that such in-
10 dividual is eligible for a premium tax credit
11 under section 36B of the Internal Revenue
12 Code of 1986, if the premium assistance
13 amount under subsection (b)(2) of such section
14 is determined with respect to such individual in
15 accordance with subsection (b)(3)(A)(iii)(II) of
16 such section, such individual may elect to make
17 an advance premium payment to the issuer of
18 the qualified health plan in which such indi-
19 vidual is enrolled in an amount equal to \$5
20 multiplied by—

21 “(i) in the case that the advance de-
22 termination of eligibility was made during
23 the annual open enrollment period for such
24 plan year, 12; or

1 “(ii) in the case that the advance de-
2 termination of eligibility was made during
3 an open enrollment period other than the
4 annual open enrollment period for such
5 plan year, the number of months remain-
6 ing in such plan year.”.

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

11 (1) in subsection (c)(2)—

12 (A) in subparagraph (A), by striking
13 “The” and inserting “Subject to subsection (f),
14 the”; and

15 (B) in subparagraph (B), by inserting
16 “(including such a payment made in accordance
17 with subsection (f))” after “an advance pay-
18 ment”; and

19 (2) by adding at the end the following new sub-
20 section:

21 “(f) OPTION TO DIRECT PARTIAL ADVANCE PAY-
22 MENT OF PREMIUM TAX CREDIT TO HSA.—

23 “(1) IN GENERAL.—Beginning with plan years
24 beginning in 2026, at the election of an eligible en-
25 rolled individual described in paragraph (2), the ad-

1 vance payment of the premium tax credit allowed
2 under section 36B of the Internal Revenue Code of
3 1986 shall be made as follows:

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

9 “(B) The Secretary of the Treasury shall
10 make advance payment of 50 percent of such
11 premium tax credit into a health savings ac-
12 count (as defined in section 223(d) of the Inter-
13 nal Revenue Code of 1986) of such individual
14 (as designated by such individual) on the same
15 basis provided for under subparagraph (A), but
16 only to the extent that the aggregate amount of
17 such payments does not exceed the limitation
18 under section 223(b) of such Code (determined
19 without regard to this subsection) which is ap-
20 plicable to such individual for the taxable year
21 in which such payments are made.

22 “(2) ELIGIBLE ENROLLED INDIVIDUAL.—For
23 purposes of this subsection, the term ‘eligible en-
24 rolled individual’ means, with respect to a plan year
25 (starting with 2026), an individual—

1 “(A) with respect to whom an advance de-
2 termination has been made under section 1411
3 that such individual is eligible for a premium
4 tax credit under section 36B of the Internal
5 Revenue Code of 1986;

6 “(B) who is, for the first month of such
7 plan year, a qualified Exchange enrollee (as de-
8 fined in section 223(i) of the Internal Revenue
9 Code of 1986); and

10 “(C) who does not elect to make an ad-
11 vance premium payment under subsection
12 (c)(2)(C).”.

13 **SEC. 306. REPORT.**

14 Not later than one year after the date of the enact-
15 ment of this Act, the Secretary of the Treasury and the
16 Secretary of Health and Human Services shall jointly sub-
17 mit to Congress a report on the implementation of sections
18 306 and 307 and any recommendations on expanding ac-
19 cessibility of health savings accounts.

20 **SEC. 307. ADDRESSING WASTE, FRAUD, AND ABUSE IN THE**
21 **ACA EXCHANGES.**

22 (a) CHANGES TO ENROLLMENT PERIODS FOR EN-
23 ROLLING IN EXCHANGES.—Section 1311 of the Patient
24 Protection and Affordable Care Act (42 U.S.C. 18031) is
25 amended—

1 (1) in subsection (c)(6)—

2 (A) by striking subparagraph (A);

3 (B) by striking “The Secretary” and in-
4 serting the following:

5 “(A) IN GENERAL.—The Secretary”;

6 (C) by redesignating subparagraphs (B)
7 through (D) as clauses (i) through (iii), respec-
8 tively, and adjusting the margins accordingly;

9 (D) in clause (i), as so redesignated, by
10 striking “periods, as determined by the Sec-
11 retary for calendar years after the initial enroll-
12 ment period;” and inserting the following: “pe-
13 riods for plans offered in the individual mar-
14 ket—

15 “(I) for enrollment for plan years
16 beginning before January 1, 2026, as
17 determined by the Secretary;

18 “(II) for enrollment for plan year
19 2026, beginning not later than No-
20 vember 1, 2025, and ending on March
21 31, 2026; and

22 “(III) for enrollment for plan
23 years beginning on or after January
24 1, 2027—

1 “(aa) beginning not later
2 than November 1 and ending on
3 or before December 31 of the
4 preceding calendar year; and
5 “(bb) of a duration not to
6 exceed 9 weeks;”;

7 (E) in clause (ii), as so redesignated, by
8 inserting “subject to subparagraph (B),” before
9 “special enrollment periods specified”; and
10 (F) by adding at the end the following new
11 subparagraph:

12 “(B) PROHIBITED SPECIAL ENROLLMENT
13 PERIOD.—With respect to plan years beginning
14 on or after January 1, 2027, the Secretary may
15 not require an Exchange to provide for a spe-
16 cial enrollment period for an individual on the
17 basis of the relationship of the income of such
18 individual to the poverty line, other than a spe-
19 cial enrollment period based on a change in cir-
20 cumstances or the occurrence of a specific
21 event.”; and

22 (2) in subsection (d), by adding at the end the
23 following new paragraphs:

24 “(8) PROHIBITED ENROLLMENT PERIODS.—An
25 Exchange may not provide for, with respect to en-

1 rollment for plan years beginning on or after Janu-
2 ary 1, 2027—

3 “(A) an annual open enrollment period
4 other than the period described in subpara-
5 graph (A)(i) of subsection (c)(6); or

6 “(B) a special enrollment period described
7 in subparagraph (B) of such subsection.

8 “(9) VERIFICATION OF ELIGIBILITY FOR SPE-
9 CIAL ENROLLMENT PERIODS.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), with respect to enrollment for plan
12 years beginning on or after January 1, 2027,
13 an Exchange shall, with respect to not less than
14 75 percent of all individuals not enrolled in a
15 qualified health plan offered by the Exchange
16 who are seeking to enroll in such a plan during
17 a special enrollment period with respect to such
18 plan year, verify the eligibility of such individ-
19 uals to enroll during the relevant special enroll-
20 ment period prior to enrolling such individuals
21 in such plan.

22 “(B) FLEXIBILITY FOR STATE-BASED EX-
23 CHANGES.—Subparagraph (A) shall not apply
24 with respect to an Exchange established by a
25 State under section 1311 in the case that the

1 Secretary approves, and the Exchange imple-
2 ments, an alternative process for verifying that
3 individuals described in such subparagraph are
4 eligible to enroll during the relevant special en-
5 rollment period.”.

6 (b) VERIFYING INCOME FOR INDIVIDUALS ENROLL-
7 ING IN A QUALIFIED HEALTH PLAN THROUGH AN EX-
8 CHANGE.—

9 (1) IN GENERAL.—Section 1411(e)(4) of the
10 Patient Protection and Affordable Care Act (42
11 U.S.C. 18081(e)(4)) is amended—

12 (A) by redesignating subparagraph (C) as
13 subparagraph (E); and

14 (B) by inserting after subparagraph (B)
15 the following new subparagraphs:

16 “(C) REQUIRING VERIFICATION OF IN-
17 COME AND FAMILY SIZE WHEN TAX DATA IS
18 UNAVAILABLE.—For plan years beginning on or
19 after January 1, 2027, for purposes of subpara-
20 graph (A), in the case that the Exchange re-
21 quests data from the Secretary of the Treasury
22 regarding an individual’s household income and
23 the Secretary of the Treasury does not return
24 such data, such information may not be verified
25 solely on the basis of the attestation of such in-

1 dividual with respect to such household income,
2 and the Exchange shall take the actions de-
3 scribed in subparagraph (A).

4 “(D) REQUIRING VERIFICATION OF IN-
5 COME IN THE CASE OF CERTAIN INCOME DIS-
6 CREPANCIES.—

7 “(i) IN GENERAL.—For plan years be-
8 ginning on or after January 1, 2027, for
9 purposes of subparagraph (A), in the case
10 that a specified income discrepancy de-
11 scribed in clause (ii) of this subparagraph
12 exists with respect to the information pro-
13 vided by an applicant under subsection
14 (b)(3), the household income of such indi-
15 vidual shall be treated as inconsistent with
16 information in the records maintained by
17 persons under subsection (c), or as not
18 verified under subsection (d), and the Ex-
19 change shall take the actions described in
20 such subparagraph (A).

21 “(ii) SPECIFIED INCOME DISCREP-
22 ANCY.—For purposes of clause (i), a speci-
23 fied income discrepancy exists with respect
24 to the information provided by an appli-
25 cant under subsection (b)(3) if—

1 “(I) the applicant attests to a
2 projected annual household income
3 that would qualify such applicant to
4 be an applicable taxpayer under sec-
5 tion 36B(c)(1)(A) of the Internal Rev-
6 enue Code of 1986 with respect to the
7 taxable year involved;

8 “(II) the Exchange receives data
9 from the Secretary of the Treasury or
10 other reliable, third party data, that
11 indicates that the household income of
12 such applicant is less than the house-
13 hold income that would qualify such
14 applicant to be an applicable taxpayer
15 under such section 36B(c)(1)(A) with
16 respect to the taxable year involved;

17 “(III) such attested projected an-
18 nual household income exceeds the in-
19 come reflected in the data described in
20 subclause (II) by a reasonable thresh-
21 old established by the Exchange and
22 approved by the Secretary (which
23 shall be not less than 10 percent, and
24 may also be a dollar amount); and

1 “(IV) the Exchange has not as-
2 sessed or determined based on the
3 data described in subclause (II) that
4 the household income of the applicant
5 meets the applicable income-based eli-
6 gibility standard for the Medicaid pro-
7 gram under title XIX of the Social
8 Security Act or the State children’s
9 health insurance program under title
10 XXI of such Act.”.

11 (2) REQUIRING INDIVIDUALS ON WHOSE BE-
12 HALF ADVANCE PAYMENTS OF THE PREMIUM TAX
13 CREDITS ARE MADE TO FILE AND RECONCILE ON AN
14 ANNUAL BASIS.—Section 1412(b) of the Patient
15 Protection and Affordable Care Act (42 U.S.C.
16 18082(b)) is amended by adding at the end the fol-
17 lowing new paragraph:

18 “(3) ANNUAL REQUIREMENT TO FILE AND REC-
19 ONCILE.—

20 “(A) IN GENERAL.—For plan years begin-
21 ning on or after January 1, 2027, in the case
22 of an individual with respect to whom any ad-
23 vance payment of the premium tax credit allow-
24 able under section 36B of the Internal Revenue
25 Code of 1986 was made under this section to

1 the issuer of a qualified health plan for the rel-
2 evant prior tax year, an advance determination
3 of eligibility for such premium tax credit may
4 not be made under this subsection with respect
5 to such individual and such plan year if the Ex-
6 change determines, based on information pro-
7 vided by the Secretary of the Treasury, that
8 such individual—

9 “(i) has not filed an income tax re-
10 turn, as required under sections 6011 and
11 6012 of such Code (and implementing reg-
12 ulations), for the relevant prior tax year;
13 or

14 “(ii) as necessary, has not reconciled
15 (in accordance with subsection (f) of such
16 section 36B) the advance payment of the
17 premium tax credit made with respect to
18 such individual for such relevant prior tax
19 year.

20 “(B) RELEVANT PRIOR TAX YEAR.—For
21 purposes of subparagraph (A), the term ‘rel-
22 evant prior tax year’ means, with respect to the
23 advance determination of eligibility made under
24 this subsection with respect to an individual,
25 the taxable year for which tax return data

1 would be used for purposes of verifying the
2 household income and family size of such indi-
3 vidual (as described in section 1411(b)(3)(A)).

4 “(C) PRELIMINARY ATTESTATION.—If an
5 individual subject to subparagraph (A) attests
6 that such individual has fulfilled the require-
7 ments to file an income tax return for the rel-
8 evant prior tax year and, as necessary, to rec-
9 oncile the advance payment of the premium tax
10 credit made with respect to such individual for
11 such relevant prior tax year (as described in
12 clauses (i) and (ii) of such subparagraph), the
13 Secretary may make an initial advance deter-
14 mination of eligibility with respect to such indi-
15 vidual and may delay for a reasonable period
16 (as determined by the Secretary) any deter-
17 mination based on information provided by the
18 Secretary of the Treasury that such individual
19 has not fulfilled such requirements.

20 “(D) NOTICE.—If the Secretary deter-
21 mines that an individual did not meet the re-
22 quirements described in subparagraph (A) with
23 respect to the relevant prior tax year and noti-
24 fies the Exchange of such determination, the
25 Exchange shall comply with the notification re-

1 requirement described in section 155.305(f)(4)(i)
2 of title 45, Code of Federal Regulations (as in
3 effect with respect to plan year 2025).”.

4 (3) REMOVING AUTOMATIC EXTENSION OF PE-
5 RIOD TO RESOLVE INCOME INCONSISTENCIES.—Sec-
6 tion 1411(e)(4)(A)(ii) of the Patient Protection and
7 Affordable Care Act (42 U.S.C. 18081(e)(4)(A)(ii))
8 is amended in the flush-left text by inserting “, and
9 may not extend such period for enrollments occur-
10 ring during a year after 2014” before the period at
11 the end.

12 (c) REVISING RULES ON ALLOWABLE VARIATION IN
13 ACTUARIAL VALUE OF HEALTH PLANS.—The Secretary
14 of Health and Human Services shall—

15 (1) revise section 156.140(c) of title 45, Code
16 of Federal Regulations, to provide that, for plan
17 years beginning on or after January 1, 2027, the al-
18 lowable variation in the actuarial value of a health
19 plan applicable under such section shall be the allow-
20 able variation for such plan applicable under such
21 section for plan year 2022;

22 (2) revise section 156.200(b)(3) of title 45,
23 Code of Federal Regulations, to provide that, for
24 plan years beginning on or after January 1, 2027,
25 the requirement for a qualified health plan issuer de-

1 scribed in such section is that the issuer ensures
2 that each qualified health plan complies with benefit
3 design standards, as defined in section 156.20 of
4 such title; and

5 (3) revise section 156.400 of title 45, Code of
6 Federal Regulations, to provide that, for plan years
7 beginning on or after January 1, 2027, the term “de
8 minimis variation for a silver plan variation” means
9 a minus 1 percentage point and plus 1 percentage
10 point allowable actuarial value variation.

11 (d) UPDATING PREMIUM ADJUSTMENT PERCENTAGE
12 METHODOLOGY.—Section 1302(c)(4) of the Patient Pro-
13 tection and Affordable Care Act (42 U.S.C. 18022(c)(4))
14 is amended—

15 (1) by striking “For purposes” and inserting:

16 “(A) IN GENERAL.—For purposes”; and

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(B) UPDATE TO METHODOLOGY.—For
20 calendar years beginning with 2027, for pur-
21 poses of calculating the premium adjustment
22 percentage under this paragraph for such cal-
23 endar year, the average per capita premium for
24 health insurance coverage in the United States
25 for the preceding calendar year is equal to—

1 “(i) the total premiums paid in such
2 year for health insurance coverage in the
3 individual and group markets, minus the
4 total premiums paid in such year for medi-
5 care supplemental policies (as defined in
6 section 1882(g)(1) of the Social Security
7 Act) and property and casualty insurance
8 (as defined by the Secretary); divided by
9 “(ii) the number of unique private
10 health insurance enrollees with comprehen-
11 sive coverage in such year (as determined
12 by the Secretary).”.

13 (e) ELIMINATING THE FIXED-DOLLAR AND GROSS-
14 PERCENTAGE THRESHOLDS APPLICABLE TO EXCHANGE
15 ENROLLMENTS.—The Secretary of Health and Human
16 Services shall revise section 155.400(g) of title 45, Code
17 of Federal Regulations to eliminate, for plan years begin-
18 ning on or after January 1, 2027, the gross premium per-
19 centage-based premium payment threshold policy de-
20 scribed in paragraph (2) of such section and the fixed-
21 dollar premium payment threshold policy described in
22 paragraph (3) of such section.

23 (f) PROHIBITING AUTOMATIC REENROLLMENT FROM
24 BRONZE TO SILVER LEVEL QUALIFIED HEALTH PLANS
25 OFFERED BY EXCHANGES.—For plan years beginning on

1 or after January 1, 2027, an Exchange established under
2 subtitle D of title I of the Patient Protection and Afford-
3 able Care Act (42 U.S.C. 18021 et seq.) may not reenroll
4 an individual who was enrolled in a bronze level qualified
5 health plan in a silver level qualified health plan (as such
6 terms are defined in section 1301(a) and described in
7 1302(d) of such Act) unless otherwise permitted under
8 section 155.335(a) or section 155.335(j) of title 45, Code
9 of Federal Regulations, as in effect on the day before the
10 date of the enactment of this section.

11 (g) IMPLEMENTATION.—Notwithstanding any other
12 provision of law, the Secretary of Health and Human
13 Services may implement this section, and the amendments
14 made by this section, through the use of an interim final
15 rule, subregulatory guidance, or otherwise.

