AMENDMENT TO H.R. 6703

OFFERED BY MR. KILEY OF CALIFORNIA

Add at the end the following new title:

TITLE III—MISCELLANEOUS

SEC. 301. 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—

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

(2) by striking ''TEMPORARY PERCENTAGES FOR 2021 THROUGH 2025.—In the case of'' and inserting ''TEMPORARY RULES FOR CERTAIN YEARS.—

''(I) BEFORE 2026.—In the case of'', and

(3) by adding at the end the following:

''(II) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 150 PERCENT OF POVERTY LINE.—In the case of a tax-

able year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's household income does not exceed 150 percent of the poverty line for such taxable year, the premium assistance amount determined under subsection (b)(2), with respect to any coverage month, is the excess of the lesser of the amount described in paragraph (2)(A) or the amount described in paragraph (2)(B)(i), over $5.

''(III) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 200 PERCENT OF POVERTY LINE.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's 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 subsection (b)(2), with respect to any coverage

month, shall be such that the premium assistance amount for such a taxpayer shall decrease, on a sliding scale in a linear manner, from the amount that would result if determined in accordance with subclause (II) to the amount that would result under subsection (b)(2) by substituting '2 percent' for 'the applicable percentage' in subparagraph (B)(ii) thereof.

''(IV) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME EXCEEDS 200 PERCENT OF POVERTY LINE.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's household income exceeds 200 percent of the poverty line for such taxable year—

''(aa) clause (ii) shall not apply for purposes of adjusting premium percentages under this subparagraph, and

''(bb) the following table shall be applied in lieu of the 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%''.

(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—

(1) by striking ''TEMPORARY RULE FOR 2021 THROUGH 2025.—In the case of'' and inserting ''TEMPORARY RULE FOR CERTAIN YEARS.—

''(i) BEFORE 2026.—In the case of'', and

(2) by adding at the end the following:

''(ii) AFTER 2025.—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. 302. 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, including subparagraph (C), 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)'';

(B) in subparagraph (B)—

(i) by inserting ''including subparagraph (C),'' after ''law,'';

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

''(i) IN GENERAL.—Any person''; and

(iii) 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, including subparagraph (C), 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 Sec-

retary 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 in-

consistencies 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 uni-

laterally 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.—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 90 days after the date of the enactment of this paragraph, and on a quarterly basis thereafter, the Secretary shall conduct a check of the Death Master File (as such term is 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—

''(i) establish a process to verify that an individual identified pursuant to a check described in subparagraph (A) is deceased; and

''(ii) require an Exchange to terminate such individual's enrollment under a qualified health plan.''.

(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. 303. 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. 304. 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.—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 sav-

ings 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)).

''(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. 305. 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)(II) 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 ad-

vance 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. 306. 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 306 and 307 and any recommendations on expanding accessibility of health savings accounts.

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

(a) CHANGES TO ENROLLMENT PERIODS FOR ENROLLING IN EXCHANGES.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended—

(1) in subsection (c)(6)—

(A) by striking subparagraph (A);

(B) by striking ''The Secretary'' and inserting the following:

''(A) IN GENERAL.—The Secretary'';

(C) by redesignating subparagraphs (B) through (D) as clauses (i) through (iii), respectively, and adjusting the margins accordingly;

(D) in clause (i), as so redesignated, by striking ''periods, as determined by the Secretary for calendar years after the initial enrollment period;'' and inserting the following: ''periods for plans offered in the individual market—

''(I) for enrollment for plan years beginning before January 1, 2026, as determined by the Secretary;

''(II) for enrollment for plan year 2026, beginning not later than November 1, 2025, and ending on March 31, 2026; and

''(III) for enrollment for plan years beginning on or after January 1, 2027—

''(aa) beginning not later than November 1 and ending on or before December 31 of the preceding calendar year; and

''(bb) of a duration not to exceed 9 weeks;'';

(E) in clause (ii), as so redesignated, by inserting ''subject to subparagraph (B),'' before ''special enrollment periods specified''; and

(F) by adding at the end the following new subparagraph:

''(B) PROHIBITED SPECIAL ENROLLMENT PERIOD.—With respect to plan years beginning on or after January 1, 2027, the Secretary may not require an Exchange to provide for a special enrollment period for an individual on the basis of the relationship of the income of such individual to the poverty line, other than a special enrollment period based on a change in circumstances or the occurrence of a specific event.''; and

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

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

rollment for plan years beginning on or after January 1, 2027—

"(A) an annual open enrollment period other than the period described in subparagraph (A)(i) of subsection (c)(6); or

"(B) a special enrollment period described in subparagraph (B) of such subsection.

"(9) VERIFICATION OF ELIGIBILITY FOR SPECIAL ENROLLMENT PERIODS.—

"(A) IN GENERAL.—Subject to subparagraph (B), with respect to enrollment for plan years beginning on or after January 1, 2027, an Exchange shall, with respect to not less than 75 percent of all individuals not enrolled in a qualified health plan offered by the Exchange who are seeking to enroll in such a plan during a special enrollment period with respect to such plan year, verify the eligibility of such individuals to enroll during the relevant special enrollment period prior to enrolling such individuals in such plan.

"(B) FLEXIBILITY FOR STATE-BASED EXCHANGES.—Subparagraph (A) shall not apply with respect to an Exchange established by a State under section 1311 in the case that the

Secretary approves, and the Exchange implements, an alternative process for verifying that individuals described in such subparagraph are eligible to enroll during the relevant special enrollment period.''.

(b) VERIFYING INCOME FOR INDIVIDUALS ENROLLING IN A QUALIFIED HEALTH PLAN THROUGH AN EXCHANGE.—

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

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

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

''(C) REQUIRING VERIFICATION OF INCOME AND FAMILY SIZE WHEN TAX DATA IS UNAVAILABLE.—For plan years beginning on or after January 1, 2027, for purposes of subparagraph (A), in the case that the Exchange requests data from the Secretary of the Treasury regarding an individual's household income and the Secretary of the Treasury does not return such data, such information may not be verified solely on the basis of the attestation of such in-

dividual with respect to such household income, and the Exchange shall take the actions described in subparagraph (A).

"(D) REQUIRING VERIFICATION OF INCOME IN THE CASE OF CERTAIN INCOME DISCREPANCIES.—

"(i) IN GENERAL.—For plan years beginning on or after January 1, 2027, for purposes of subparagraph (A), in the case that a specified income discrepancy described in clause (ii) of this subparagraph exists with respect to the information provided by an applicant under subsection (b)(3), the household income of such individual shall be treated as inconsistent with information in the records maintained by persons under subsection (c), or as not verified under subsection (d), and the Exchange shall take the actions described in such subparagraph (A).

"(ii) SPECIFIED INCOME DISCREPANCY.—For purposes of clause (i), a specified income discrepancy exists with respect to the information provided by an applicant under subsection (b)(3) if—

''(I) the applicant attests to a projected annual household income that would qualify such applicant to be an applicable taxpayer under section 36B(c)(1)(A) of the Internal Revenue Code of 1986 with respect to the taxable year involved;

''(II) the Exchange receives data from the Secretary of the Treasury or other reliable, third party data, that indicates that the household income of such applicant is less than the household income that would qualify such applicant to be an applicable taxpayer under such section 36B(c)(1)(A) with respect to the taxable year involved;

''(III) such attested projected annual household income exceeds the income reflected in the data described in subclause (II) by a reasonable threshold established by the Exchange and approved by the Secretary (which shall be not less than 10 percent, and may also be a dollar amount); and

''(IV) the Exchange has not assessed or determined based on the data described in subclause (II) that the household income of the applicant meets the applicable income-based eligibility standard for the Medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act.''.

(2) REQUIRING INDIVIDUALS ON WHOSE BEHALF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDITS ARE MADE TO FILE AND RECONCILE ON AN ANNUAL BASIS.—Section 1412(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(b)) is amended by adding at the end the following new paragraph:

''(3) ANNUAL REQUIREMENT TO FILE AND RECONCILE.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2027, in the case of an individual with respect to whom any advance payment of the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 was made under this section to

the issuer of a qualified health plan for the relevant prior tax year, an advance determination of eligibility for such premium tax credit may not be made under this subsection with respect to such individual and such plan year if the Exchange determines, based on information provided by the Secretary of the Treasury, that such individual—

''(i) has not filed an income tax return, as required under sections 6011 and 6012 of such Code (and implementing regulations), for the relevant prior tax year; or

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

''(B) RELEVANT PRIOR TAX YEAR.—For purposes of subparagraph (A), the term 'relevant prior tax year' means, with respect to the advance determination of eligibility made under this subsection with respect to an individual, the taxable year for which tax return data

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

''(C) PRELIMINARY ATTESTATION.—If an individual subject to subparagraph (A) attests that such individual has fulfilled the requirements to file an income tax return for the relevant prior tax year and, as necessary, to reconcile the advance payment of the premium tax credit made with respect to such individual for such relevant prior tax year (as described in clauses (i) and (ii) of such subparagraph), the Secretary may make an initial advance determination of eligibility with respect to such individual and may delay for a reasonable period (as determined by the Secretary) any determination based on information provided by the Secretary of the Treasury that such individual has not fulfilled such requirements.

''(D) NOTICE.—If the Secretary determines that an individual did not meet the requirements described in subparagraph (A) with respect to the relevant prior tax year and notifies the Exchange of such determination, the Exchange shall comply with the notification re-

quirement described in section 155.305(f)(4)(i) of title 45, Code of Federal Regulations (as in effect with respect to plan year 2025).''.

(3) REMOVING AUTOMATIC EXTENSION OF PERIOD TO RESOLVE INCOME INCONSISTENCIES.—Section 1411(e)(4)(A)(ii) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(e)(4)(A)(ii)) is amended in the flush-left text by inserting '', and may not extend such period for enrollments occurring during a year after 2014'' before the period at the end.

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

(1) revise section 156.140(c) of title 45, Code of Federal Regulations, to provide that, for plan years beginning on or after January 1, 2027, the allowable variation in the actuarial value of a health plan applicable under such section shall be the allowable variation for such plan applicable under such section for plan year 2022;

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

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

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

(d) UPDATING PREMIUM ADJUSTMENT PERCENTAGE METHODOLOGY.—Section 1302(c)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(c)(4)) is amended—

(1) by striking ''For purposes'' and inserting:

''(A) IN GENERAL.—For purposes''; and

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

''(B) UPDATE TO METHODOLOGY.—For calendar years beginning with 2027, for purposes of calculating the premium adjustment percentage under this paragraph for such calendar year, the average per capita premium for health insurance coverage in the United States for the preceding calendar year is equal to—

''(i) the total premiums paid in such year for health insurance coverage in the individual and group markets, minus the total premiums paid in such year for medicare supplemental policies (as defined in section 1882(g)(1) of the Social Security Act) and property and casualty insurance (as defined by the Secretary); divided by

''(ii) the number of unique private health insurance enrollees with comprehensive coverage in such year (as determined by the Secretary).''.

(e) ELIMINATING THE FIXED-DOLLAR AND GROSS-PERCENTAGE THRESHOLDS APPLICABLE TO EXCHANGE ENROLLMENTS.—The Secretary of Health and Human Services shall revise section 155.400(g) of title 45, Code of Federal Regulations to eliminate, for plan years beginning on or after January 1, 2027, the gross premium percentage-based premium payment threshold policy described in paragraph (2) of such section and the fixed-dollar premium payment threshold policy described in paragraph (3) of such section.

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

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

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