I

119TH CONGRESS
1ST SESSION

H. R. 3947

To streamline enrollment in health insurance affordability programs and minimum essential coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 12, 2025

Mr. BERA introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To streamline enrollment in health insurance affordability programs and minimum essential coverage, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Easy Enrollment in Health Care Act''.

SEC. 2. DEFINITIONS.

In this Act:

(1) CHIP PROGRAM.—The term ''CHIP program'' means a State plan for child health assistance under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), including any waiver of such a plan.

(2) EXCHANGE.—The term ''Exchange'' means an American Health Benefit Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.).

(3) FAMILY SIZE.—The term ''family size'' has the meaning given such term in section 36B(d) of the Internal Revenue Code of 1986.

(4) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986.

(5) HOUSEHOLD INCOME.—The term ''household income'' has the meaning given such term in section 36B(d) of the Internal Revenue Code of 1986.

(6) HOUSEHOLD MEMBER.—The term ''household member'' means the taxpayer, the taxpayer's spouse, and any dependent of the taxpayer.

(7) INSURANCE AFFORDABILITY PROGRAM.—The term ''insurance affordability program'' means any of the following:

(A) A Medicaid program.

(B) A CHIP program.

(C) The program under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986, cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071), and the advance payment of such credits and reductions under section 1412(a)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(a)(3)).

(D) A State basic health program under section 1331 of the Patient Protection and Affordable Care Act (42 U.S.C. 18051).

(E) Any other Federal, State, or local program that provides assistance for some or all of the cost of minimum essential coverage and requires eligibility for such program to be based

in whole or in part on income, including such a program carried out through a waiver under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) or a State program supplementing the advanced payment of tax credits and cost-sharing reductions under section 1412(a)(3) of such Act (42 U.S.C. 18082(a)(3)).

(8) MEDICAID PROGRAM.—The term ''Medicaid program'' means a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), including any waiver of such a plan.

(9) MINIMUM ESSENTIAL COVERAGE.—The term ''minimum essential coverage'' has the meaning given such term in section 5000A(f) of the Internal Revenue Code of 1986.

(10) MODIFIED ADJUSTED GROSS INCOME.—The term ''modified adjusted gross income'' has the meaning given such term in section 36B(d)(2)(B) of the Internal Revenue Code of 1986.

(11) NET PREMIUM.—The term ''net premium'', with respect to a health plan or other form of minimum essential coverage—

(A) except as provided in subparagraph (B), means the payment from or on behalf of an individual required to enroll in such plan or coverage, after application of the premium tax credit under section 36B of the Internal Revenue Code of 1986, the advance payment of such credit under section 1412(a)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(a)(3)), and any other assistance provided by an insurance affordability program; and

(B) does not include any amounts described in section 36B(b)(3)(D) of the Internal Revenue Code of 1986 or section 1303(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18023(b)(2)).

(12) POVERTY LINE.—The term ''poverty line'' has the meaning given such term in section 36B(d)(3) of the Internal Revenue Code of 1986.

(13) QUALIFIED HEALTH PLAN.—The term ''qualified health plan'' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)).

(14) RELEVANT RETURN INFORMATION.—The term ''relevant return information'' means, with re-

spect to a taxpayer, any return information, as defined in section 6103(b)(2) of the Internal Revenue Code of 1986, which may be relevant, as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, with respect to—

(A) determining, or facilitating determination of, the eligibility of any household member of the taxpayer for any insurance affordability program, either directly or through enabling access to additional information potentially relevant to such eligibility; or

(B) enrolling, or facilitating the enrollment of, such individual in minimum essential coverage.

(15) SINGLE, STREAMLINED APPLICATION.—The term ''single, streamlined application'' means the form described in section 1413(b)(1)(A) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(b)(1)(A)).

(16) TAX RETURN PREPARER.—The term ''tax return preparer'' has the meaning given such term in section 7701(a)(36) of the Internal Revenue Code of 1986.

(17) ZERO NET PREMIUM.—The term ''zero net premium'', with respect to a health plan or other form of minimum essential coverage, means a net premium of $0.00 for such plan or coverage.

SEC. 3. FEDERAL INCOME TAX RETURNS USED TO FACILITATE ENROLLMENT INTO INSURANCE AFFORDABILITY PROGRAMS.

(a) IN GENERAL.—Not later than January 1, 2028, the Secretary shall establish a program which allows any taxpayer who is not covered under minimum essential coverage at the time their return of tax for the taxable year is filed, as well as any other household member who is not covered under such coverage, to, in conjunction with the filing of their return of tax for any taxable year which begins after December 31, 2026, elect to—

(1) have a determination made as to whether the household member who is not covered under such coverage is eligible for an insurance affordability program; and

(2) have such household member enrolled into minimum essential coverage, provided that—

(A) such coverage is provided through a zero-net-premium plan, and

(B) the taxpayer does not—

(i) opt out of coverage through the zero-net-premium plan, or

(ii) select a different plan.

(b) TAXPAYER REQUIREMENTS AND CONSENT.—

(1) IN GENERAL.—Pursuant to the program established under subsection (a), the taxpayer may, in conjunction with the filing of their return of tax for the taxable year—

(A) identify any household member who is not covered under minimum essential coverage at the time of such filing; and

(B) with respect to each household member identified under subparagraph (A), elect whether to—

(i) in accordance with section 6103(l)(23) of the Internal Revenue Code of 1986 (as added by subsection (f)), consent to the disclosure and transfer to the applicable Exchange of any relevant return information for purposes of determining whether such household member may be eligible for any insurance affordability program and facilitating enrollment into such program and minimum essential coverage, including any further disclosure and trans-

fer by the Exchange to any other entity as is deemed necessary to accomplish such purposes; and

(ii) in the case consent is provided under clause (i) with respect to such household member, enroll such household member in any minimum essential coverage that is available with a zero net premium, if—

(I) the member is eligible for such coverage through an insurance affordability program; and

(II) the member does not, by the end of the special enrollment period described in section 4(c)(1)(A)—

(aa) select a different plan offering minimum essential coverage; or

(bb) opt out of such coverage that is available with a zero net premium.

(2) ESTABLISHMENT OF OPTIONS FOR TAXPAYER CONSENT AND ELECTION.—For purposes of paragraph (1)(B), the Secretary, in consultation with the Secretary of Health and Human Services,

may provide the elections under such paragraph as a single election or as 2 elections.

(3) SUPPLEMENTAL FORM.—

(A) IN GENERAL.—In the case of a taxpayer who has consented to disclosure and transfer of relevant return information pursuant to paragraph (1)(B)(i), such taxpayer shall be enrolled in the insurance affordability program only if the taxpayer submits a supplemental form which is designed to collect additional information necessary (as determined by the Secretary of Health and Human Services) to establish eligibility for and enrollment in an insurance affordability program, which may include (except as provided in subparagraph (B)), with respect to each individual described in paragraph (1)(A), the following:

(i) State of residence.

(ii) Date of birth.

(iii) Employment and the availability of benefits under a group health plan at the time the return of tax is filed.

(iv) Any changed circumstances described in section 1412(b)(2) of the Pa-

tient Protection and Affordable Care Act; (42 U.S.C. 18082(b)(2)).

(v) Solely for the purpose of facilitating automatic renewal of coverage and eligibility redeterminations under section 1413(c)(3)(A) of such Act (42 U.S.C. 18083(c)(3)(A)), authorization for the Secretary to disclose relevant return information for subsequent taxable years to insurance affordability programs.

(vi) Any methods preferred by the taxpayer or household member for the purpose of being contacted by the applicable Exchange or insurance affordability program with respect to any eligibility determination for, or enrollment in, an insurance affordability program or minimum essential coverage, such as an email address or a phone number for calls or text messages.

(vii) Information about household composition that—

(I) may affect eligibility for an insurance affordability program, and

(II) is not otherwise included on the return of tax.

(viii) Such other information as the Secretary, in consultation with the Secretary of Health and Human Services, may require, including information requested on the single, streamlined application.

(B) LIMITATIONS.—The information obtained through the form described in subparagraph (A) may not include any request for information with respect to citizenship, immigration status, or health status of any household member.

(C) ADDITIONAL INFORMATION.—The form described in subparagraph (A) and the accompanying tax instructions may provide the taxpayer with additional information about insurance affordability programs, including information provided to applicants on the single, streamlined application.

(D) ACCESSIBILITY.—

(i) IN GENERAL.—The Secretary shall ensure that the form described in subparagraph (A) is made available to all taxpayers without discrimination based on

language, disability, literacy, or internet access.

(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as diminishing, reducing, or otherwise limiting any other legal obligation for the Secretary to avoid or to prevent discrimination.

(4) RETURN LANGUAGE.—The Secretary, in consultation with the Secretary of Health and Human Services, shall, with respect to any items described in this subsection which are to be included in a taxpayer's return of tax, develop language for such items which is as simple and clear as possible (such as referring to ''insurance affordability programs'' as ''free or low-cost health insurance'').

(c) TAX RETURN PREPARERS.—

(1) IN GENERAL.—With respect to any information submitted in conjunction with a tax return solely for purposes of the program described in subsection (a), any tax return preparer involved in preparing the return containing such information shall not be obligated to assess the accuracy of such information as provided by the taxpayer.

(2) SUBMISSION OF INFORMATION.—As part of the program described in subsection (a), the Sec-

retary shall establish methods to allow for the immediate transfer of any relevant return information to the applicable Exchange and insurance affordability programs in order to increase the potential for immediate determinations of eligibility for and enrollment in insurance affordability programs and minimum essential coverage.

(d) TRANSFER OF INFORMATION THROUGH SECURE INTERFACE.—

(1) IN GENERAL.—As part of the program established under subsection (a), the Secretary shall develop a secure, electronic interface allowing an exchange of relevant return information with the applicable Exchange in a manner similar to the interface described in section 1413(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(c)(1)). Upon receipt of such information, the applicable Exchange may convey such information to any other entity as needed to facilitate determination of eligibility for an insurance affordability program or enrollment into minimum essential coverage.

(2) TRANSFER BY TREASURY OR TAX PREPARERS.—

(A) IN GENERAL.—The interface described in paragraph (1) shall allow, for any taxpayer who has provided consent pursuant to subsection (b)(1)(B)(i), for relevant return information, along with confirmation that the Secretary has accepted the return filing as meeting applicable processing criteria, to be transferred to an applicable Exchange by—

(i) the Secretary; or

(ii) pursuant to such requirements and standards as are established by the Secretary (in consultation with the Secretary of Health and Human Services)—

(I) if the Secretary is not able to transfer such information to the applicable Exchange, the taxpayer; or

(II) the tax return preparer who prepared the return containing such information.

(B) TRANSFER REQUIREMENTS.—As soon as is practicable after the filing of a return described in subsection (a) in which the taxpayer has provided consent pursuant to subsection (b)(1)(B)(i), the Secretary shall provide for all

relevant return information to be transferred to the applicable Exchange.

(C) DATA SECURITY.—Any transfer of relevant return information described in this subsection shall be conducted—

(i) pursuant to interagency agreements that ensure data security and maintain privacy in a manner that satisfies the requirements under section 1942(b) of the Social Security Act (42 U.S.C. 1396w–2(b)); and

(ii) in the case of any taxpayer filing their tax return electronically, in a manner that maximizes the opportunity for such taxpayer, as part of the process of filing such return, to immediately—

(I) obtain a determination with respect to the eligibility of any household member for any insurance affordability program; and

(II) enroll in minimum essential coverage.

(e) ERRORS THAT AFFECT ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS.—The Secretary of Health and Human Services, in consultation with the Sec-

retary, shall establish procedures for addressing instances in which an error in relevant return information that was transferred to an Exchange under subsection (d) may have resulted in a determination that an individual is eligible for more or less assistance under an insurance affordability program than the assistance for which the individual would otherwise have been eligible without the error. Such procedures shall include procedures for—

(1) the reporting of such error to the individual, the Secretary of Health and Human Services, and the applicable Exchange and insurance affordability program, regardless of whether such error was included in an amendment to the tax return; and

(2) correcting, as soon as practicable, the individual's eligibility status for insurance affordability programs, subject to, in the case of reduced eligibility for assistance, any right of notice and appeal under laws governing the applicable insurance affordability program, including section 1411(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f)).

(f) DISCLOSURE OF RETURN INFORMATION FOR DETERMINING ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS AND ENROLLMENT INTO MINIMUM ESSENTIAL HEALTH COVERAGE.—

(1) IN GENERAL.—Section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(23) DISCLOSURE OF RETURN INFORMATION FOR DETERMINING ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS AND ENROLLMENT INTO MINIMUM ESSENTIAL HEALTH COVERAGE.—

''(A) IN GENERAL.—In the case of any taxpayer who has consented to the disclosure and transfer of any relevant return information with respect to any household member pursuant to section 3(b) of the Easy Enrollment in Health Care Act, the Secretary shall disclose such information to the applicable Exchange.

''(B) RESTRICTION ON DISCLOSURE.—Return information disclosed under subparagraph (A) may be—

''(i) used by an Exchange only for the purposes of, and to the extent necessary in—

''(I) determining eligibility for an insurance affordability program, or

''(II) facilitating enrollment into minimum essential coverage, and

''(ii) further disclosed by an Exchange to any other person only for the purposes of, and to the extent necessary, to carry out subclauses (I) and (II) of clause (i).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'relevant return information', 'Exchange', 'insurance affordability program', and 'minimum essential coverage' have the same meanings given such terms under section 2 of the Easy Enrollment in Health Care Act.''.

(2) SAFEGUARDS.—Section 6103(p)(4) of the Internal Revenue Code of 1986 is amended by inserting ''or any Exchange described in subsection (l)(23),'' after ''or any entity described in subsection (l)(21),'' each place it appears.

(g) APPLICATIONS FOR INSURANCE AFFORDABILITY PROGRAMS WITHOUT RELIANCE ON FEDERAL INCOME TAX RETURNS.—

(1) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed as requiring any individual, as a condition of applying for an insurance affordability program, to—

(A) file a return of tax for any taxable year for which filing a return of tax would not otherwise be required for such taxable year; or

(B) consent to disclosure of relevant return information under subsection (b)(1)(B)(i).

(2) METHODS AND PROCEDURES.—Any agency administering an insurance affordability program shall implement methods and procedures, as prescribed by the Secretary of Health and Human Services, in consultation with the Secretary, through which, in the case of an individual applying for an insurance affordability program without filing a return of tax or consenting to disclosure of relevant return information under subsection (b)(1)(B)(i), the program determines household income and family size for—

(A) a calendar year described in section 1902(e)(14)(D)(vii)(I) of the Social Security Act (42 U.S.C. 1396a), as added by section 5(a); and

(B) an applicable taxable year, as defined in section 36B(c)(5) of the Internal Revenue Code of 1986 (as added by section 5(b)).

(h) SECRETARY.—In this section, the term ''Secretary'' means the Secretary of the Treasury, or the Secretary's delegate.

SEC. 4. EXCHANGE USE OF RELEVANT RETURN INFORMATION.

(a) IN GENERAL.—An Exchange that receives relevant return information under section 3(d) with respect to a taxpayer who has provided consent under section 3(b)(1)(B) shall—

(1) minimize additional information (if any) that is required to be provided by such taxpayer for a household member to qualify for any insurance affordability program by, whenever feasible, qualifying such household member for such program based on—

(A) relevant information provided on the tax return filed by the taxpayer, including information on the supplemental form described in section 3(b)(3); and

(B) information from other reliable third-party data sources that is relevant to eligibility for such program but not available from the return, including information obtained through data matching based on social security num-

bers, other identifying information, and other items obtained from such return;

(2) determine the eligibility of any household member for the CHIP program and, where eligibility is determined based on modified adjusted gross income, the Medicaid program, as required under section 1413 of the Patient Protection and Affordable Care Act (42 U.S.C. 18083) and section 1943 of the Social Security Act (42 U.S.C. 1396w–3), subject to any right of notice and appeal under laws governing such programs, including section 1411(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f));

(3) to the extent that any additional information is necessary for determining the eligibility of any household member for an insurance affordability program, obtain such information in the manner that—

(A) imposes the lowest feasible procedural burden to the taxpayer, including—

(i) in the case of a taxpayer filing their tax return electronically, online collection of such information at or near the time of such filing; and

(ii) prior to a denial of eligibility or enrollment due to failure to provide such information, attempting to contact the taxpayer multiple times using the preferred contact methods described in section 3(b)(3)(A)(vi); and

(B) provides the individual with all procedural protections that would otherwise be available in applying for such program, including the reasonable opportunity period described in section 1137(d)(4)(A) of the Social Security Act (42 U.S.C. 1320b–7(d)(4)(A)); and

(4) when an individual is found eligible for an insurance affordability program other than the Medicaid program—

(A) enable such individual, through procedures prescribed by the Secretary of Health and Human Services, to seek coverage under the Medicaid program or CHIP program by providing additional information demonstrating potential eligibility for such program, with any resulting determination subject to rights of notice and appeal under laws governing insurance affordability programs, including section 1411(f)

of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f)); and

(B) provide such individual with notice of such procedures.

(b) MEDICAID AND CHIP.—

(1) STATE OPTIONS.—

(A) IN GENERAL.—In a State for which the Secretary of Health and Human Services is determining eligibility for individuals who apply for insurance affordability programs at the Exchange serving residents of the individual's State, the Secretary of Health and Human Services shall present the State with not less than 3 sets of options for verification procedures and business rules that the Exchange serving residents of such State shall use in determining eligibility for the State Medicaid program and CHIP program with respect to individuals who are household members described in section 3(b)(1)(B). Notwithstanding any other provision of law, the Secretary of Health and Human Services may present each State with the same 3 sets of options, provided that each set can be customized to reflect each State's decisions about optional eligibility cat-

egories and criteria for the Medicaid program and CHIP program.

(B) BUSINESS RULES.—The business rules described in subparagraph (A) shall specify detailed eligibility determination rules and procedures for processing initial applications and renewals, including—

(i) the Secretary's use of data from State agencies and other sources described in subsection (c)(3)(A)(ii) of section 1413 of the Patient Protection and Affordable Care Act (42 U.S.C. 18083); and

(ii) the circumstances for administrative renewal of eligibility for the Medicaid program and the CHIP program, based on data showing probable continued eligibility.

(C) DEFAULT.—In the case of a State described in subparagraph (A) that does not select an option from the set presented under such subparagraph within a timeframe specified by the Secretary of Health and Human Services, the Secretary of Health and Human Services shall determine the option that the Exchange shall use for such State for the purposes described in such subparagraph.

(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring a State to provide benefits under title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) to a category of individuals, or to set an income eligibility threshold for benefits under such titles at a certain level, if the State is not otherwise required to do so under such titles.

(2) ENROLLMENT.—

(A) IN GENERAL.—If the Exchange in a State determines that an individual described in paragraph (1)(A) is eligible for benefits under the State Medicaid program or CHIP program, the Exchange shall send the relevant information about the individual to the State and, if consent has been given under section 3(b)(1)(B) to enrollment in a health plan or other form of minimum essential coverage with a zero net premium, the State shall enroll such individual in the State Medicaid program or CHIP program (as applicable) as soon as practicable, except as provided in subparagraphs (B) and (D).

(B) EXCEPTION.—A State shall not enroll an individual in coverage under the State Medicaid program or CHIP program without the affirmative consent of the individual if the individual would be required to pay a premium for such coverage.

(C) MANAGED CARE.—If the State Medicaid program or CHIP program requires an individual enrolled under subparagraph (A) to receive coverage through a managed care organization or entity, the State shall use a procedure for assigning the individual to such an organization or entity (including auto-assignment procedures) that is commonly used in the State when an individual who is found eligible for such program does not affirmatively select a particular organization or entity.

(D) OPT-OUT PROCEDURES.—Notwithstanding subparagraph (A), an individual described in such subparagraph shall be given one or more opportunities to opt out of coverage under a State Medicaid program or CHIP program, using procedures prescribed by the Secretary of Health and Human Services.

(c) ADVANCE PREMIUM TAX CREDITS FOR QUALIFIED HEALTH PLANS.—

(1) IN GENERAL.—In the case where a taxpayer has filed their return of tax for a taxable year on or before the date specified under section 6072(a) of the Internal Revenue Code of 1986 with respect to such year and has provided consent described in section 3(b)(1)(B)(i), if the Exchange has determined that an applicable household member has not qualified for the Medicaid program or the CHIP program, such Exchange shall—

(A) in addition to any such period that may otherwise be available, provide a special enrollment period that begins on the date the taxpayer has provided such consent; and

(B) determine—

(i) whether the taxpayer would, pursuant to section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082), be eligible for advance payment of the premium assistance tax credit under section 36B of the Internal Revenue Code of 1986 if such household member of the taxpayer were enrolled in a qualified health plan; and

(ii) if the taxpayer has made the election described in section 3(b)(1)(B)(ii), whether such household member has one or more options to enroll in a qualified health plan with a zero net premium.

(2) ENROLLMENT IN A QUALIFIED HEALTH PLAN WITH A ZERO NET PREMIUM.—

(A) IN GENERAL.—In the case that a household member described in paragraph (1) has one or more options to enroll in a qualified health plan with a zero net premium, and consent has been given under section 3(b)(1)(B) for enrollment of such household member in a qualified health plan with a zero net premium—

(i) the Exchange shall identify a set of options (as described in subparagraph (B)) for qualified health plans offering a zero net premium; and

(ii) from such set, select a qualified health plan as the default enrollment choice for the household member in accordance with subparagraph (C).

(B) OPTION SETS.—

(i) IN GENERAL.—In the case that multiple qualified health plans with a zero

net premium are available with more than 1 actuarial value, the Exchange shall limit the set of options under subparagraph (A)(i) to such qualified health plans with the highest available actuarial value.

(ii) FURTHER RESTRICTIONS.—In the case described in clause (i), the Exchange may further limit the set of options under subparagraph (A)(i), among the qualified health plans that have the highest available actuarial value as described in clause (i), based on the generosity of such plans' coverage of services not subject to a deductible.

(iii) DEFINITION OF HIGHEST ACTUARIAL VALUE.—For purposes of this subparagraph, the term ''highest actuarial value'' means the highest actuarial value among—

(I) the levels of coverage described in paragraph (1) of section 1302(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(d)), without regard to allow-

able variance under paragraph (3) of such section; and

(II) as applicable, the levels of coverage that result from the application of cost-sharing reductions under section 1402 of such Act (42 U.S.C. 18071).

(C) SELECTING A DEFAULT OPTION.—The Secretary of Health and Human Services shall establish procedures that Exchanges may use in selecting, from the set of options described in subparagraph (B), the default enrollment choice under subparagraph (A)(ii). Such procedures shall include—

(i) State options for randomization among health insurance issuers; and

(ii) factors that may be used to weight such randomization.

(D) NOTIFICATION OF DEFAULT ENROLLMENT.—As soon as possible after an Exchange has identified a default enrollment choice for an individual under subparagraph (A)(ii), the Exchange shall provide the individual with notice of such selection. The notice shall include—

(i) a description of coverage provided by the selected qualified health plan;

(ii) encouragement to learn about all available qualified health plan options before the end of the special enrollment period under paragraph (1)(A) and to select a plan that best meets the needs of the individual and the individual's family;

(iii) an explanation that, if the individual does not select a qualified health plan by the end of such special enrollment period or opt out of default enrollment in accordance with the process described in clause (iv), the Exchange will enroll the individual in such selected qualified health plan in accordance with subparagraph (E);

(iv) an explanation of the opt-out process preceding implementation of default enrollment, which shall meet standards prescribed by the Secretary of Health and Human Services; and

(v) information on options for assistance with enrollment and plan choice, including publicly funded navigators and pri-

vate brokers and agents approved by the Exchange.

(E) DEFAULT ENROLLMENT.—

(i) IN GENERAL.—Subject to subparagraph (F), an Exchange shall enroll in a default enrollment choice any individual who—

(I) is sent a notice under subparagraph (D); and

(II) fails to select a different qualified health plan, or opt out of default enrollment under this paragraph, by the end of the special enrollment period described in paragraph (1)(A).

(ii) UPDATED NOTICE.—At the time of the default enrollment described in clause (i), the Exchange shall send a notice to the individual explaining that default enrollment has occurred, describing the plan into which the individual has been enrolled, and explaining the reconsideration procedures described in subparagraph (F).

(F) RECONSIDERATION.—

(i) IN GENERAL.—Not later than 30 days after receiving a notice under sub-

paragraph (E)(ii), the individual receiving such notice may use a method provided by the Exchange to indicate—

(I) the individual's decision to disenroll from the qualified health plan selected under subparagraph (A)(ii); or

(II) in the case of a household member for whom the selected qualified health plan under such subparagraph is a high cost-sharing qualified health plan, the individual's decision to enroll in a specified lower cost-sharing qualified health plan, identified by the Exchange, that is offered by the same health insurance issuer that sponsors the qualified health plan that was selected under such subparagraph.

(ii) DEFINITIONS.—For purposes of this subparagraph:

(I) HIGH COST-SHARING QUALIFIED HEALTH PLAN.—The term ''high cost-sharing qualified health plan'' means—

(aa) in the case of a household member with a household income at or below 200 percent of the poverty line, a qualified health plan that is not at the silver level; or

(bb) in the case of a household member with a household income above 200 percent of the poverty line, a qualified health plan that is not at the gold or platinum level.

(II) SPECIFIED LOWER COST-SHARING QUALIFIED HEALTH PLAN.—The term ''specified lower cost-sharing qualified health plan'' means—

(aa) in the case of a household member with a household income at or below 200 percent of the poverty line, the lowest-premium qualified health plan offered by the health insurance issuer that is at the silver level; or

(bb) in the case of a household member with a household income above 200 percent of the poverty line, the lowest-premium qualified health plan offered by the health insurance issuer that is at the gold level.

SEC. 5. MODERNIZING ELIGIBILITY CRITERIA FOR INSURANCE AFFORDABILITY PROGRAMS.

(a) INCOME ELIGIBILITY DETERMINATIONS FOR MEDICAID AND CHIP.—

(1) IN GENERAL.—Section 1902(e)(14)(D) of the Social Security Act (42 U.S.C. 1396a(e)(14)(D)) is amended by adding at the end the following new clauses:

''(vi) SNAP AND TANF ELIGIBILITY FINDINGS.—

''(I) IN GENERAL.—Subject to subclause (III), a State shall provide that an individual for whom a finding has been made as described in clause (II) shall meet applicable eligibility for assistance under the State plan or a waiver of the plan involving financial eligibility, citizenship or satisfactory

immigration status, and State residence. A State shall rely on such a finding both for the initial determination of eligibility for medical assistance under the plan or waiver and any subsequent redetermination of eligibility.

''(II) FINDINGS DESCRIBED.—A finding described in this subclause is a determination made within a reasonable period (as determined by the Secretary) by a State agency responsible for administering the Temporary Assistance for Needy Families program under part A of title IV or the Supplemental Nutrition Assistance Program established under the Food and Nutrition Act of 2008 that an individual is eligible for benefits under such program.

''(III) LIMITATION.—A State shall be required to rely on the findings of the State agency responsible for administering the supplemental nutrition assistance program estab-

lished under the Food and Nutrition Act of 2008 only in the case of—

"(aa) an individual who is under 19 years of age; or

"(bb) an individual who is described in subsection (a)(10)(A)(i)(VIII).

"(IV) STATE OPTION.—A State may rely on the findings of the State agency responsible for administering the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 in the case of an individual not described in subclause (III).

"(vii) RECENT ANNUAL INCOME ESTABLISHING ELIGIBILITY.—

"(I) IN GENERAL.—For purposes of determining the income eligibility for medical assistance of an individual whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall provide that an individual whose eligibility date oc-

curs in January, February, March, or April of a calendar year shall be financially eligible if the individual's modified adjusted gross income for the preceding calendar year satisfies the income eligibility requirement applicable to the individual.

''(II) DEFINITION.—For purposes of this clause, an 'eligibility date' means—

''(aa) in the case of an individual who is not receiving medical assistance when the individual applies for an insurance affordability program (as defined in section 2 of the Easy Enrollment in Health Care Act), whether such application takes place through section 3(b) of such Act or otherwise, the date on which such individual applies for such program; and

''(bb) in the case of an individual who is receiving medical assistance and whose continued

eligibility for such assistance is being redetermined, the date on which the individual is determined to satisfy all eligibility requirements applicable to the individual other than income eligibility.

"(III) RULES OF CONSTRUCTION.—

"(aa) ELIGIBILITY DETERMINATIONS DURING MAY THROUGH DECEMBER.—Nothing in subclause (I) shall be construed as diminishing, reducing, or otherwise limiting the State's obligation to grant eligibility, under circumstances other than those described in such subclause, based on data that include income shown on an individual's tax return, including the obligation under section 1413(c)(3)(A) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(c)(3)(A)).

"(bb) ALTERNATIVE GROUNDS FOR ELIGIBILITY.—Nothing in subclause (I) shall be construed as diminishing, reducing, or otherwise limiting grounds for eligibility other than those described in such subclause, including eligibility based on income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed.

"(cc) QUALIFYING FOR ADDITIONAL ASSISTANCE.—Notwithstanding subclause (I), a State shall use an individual's modified adjusted gross income as determined as of the point in time at which the individual's application for medical assistance is processed or, in the case of redetermination of eligibility, projected annual income, to determine the individual's eligibility

for medical assistance if using the individual's modified adjusted gross income, as so determined, would result in the individual being eligible for greater benefits under the State plan (or a waiver of such plan) or in the imposition of lower premiums or cost-sharing on the individual under the plan (or waiver) than if the individual's eligibility was determined using the modified adjusted gross income of the individual as shown on the individual's tax return for the preceding calendar year.''.

(2) CONFORMING AMENDMENT.—Section 1902(e)(14)(H)(i) of the Social Security Act (42 U.S.C. 1396a(e)(14)(H)(i)) is amended by inserting ''except as provided in subparagraph (D)(vii)(I),'' before ''the requirement''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2027.

(b) IMPROVING THE STABILITY AND PREDICTABILITY OF EXCHANGE COVERAGE.—

(1) INTERNAL REVENUE CODE OF 1986.—Section 36B of the Internal Revenue Code of 1986 is amended—

(A) in subsection (b)—

(i) in paragraph (2)(B)(ii), by striking ''taxable year'' and inserting ''applicable tax year'', and

(ii) in paragraph (3)—

(I) in subparagraph (A)—

(aa) in clause (i), by striking ''taxable year'' and inserting ''applicable taxable year'', and

(bb) in clause (ii)(I), by inserting ''(or, in the case of applicable taxable years beginning in any calendar year after 2027)'' after ''2014'', and

(II) in subparagraph (B)—

(aa) in clause (ii)(I)(aa), by striking ''the taxable year'' each place it appears and inserting ''the applicable taxable year'', and

(bb) in the flush matter at the end—

(AA) striking ''files a joint return and no credit is allowed'' and inserting ''filed a joint return during the applicable taxable year and no credit was allowed'', and

(BB) striking ''unless a deduction is allowed under section 151 for the taxable year'' and inserting ''unless a deduction was allowed under section 151 for the applicable taxable year'',

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in subparagraphs (A) and (C), by striking ''taxable year'' each place it appears and inserting ''applicable taxable year'', and

(II) in subparagraph (D), by striking ''is allowable'' and all that follows through the period and inserting ''was allowable to another taxpayer for the applicable taxable year.'',

(ii) in paragraph (2)(C), by adding at the end the following:

''(v) TIME PERIOD.—

''(I) IN GENERAL.—Except as provided under subclause (II), eligibility for minimum essential coverage under this subparagraph shall be based on the individual's eligibility for employer-sponsored minimum essential coverage during the open enrollment period (or during a special enrollment period for an individual who enrolls or who changes their qualified health plan during a special enrollment period), as determined by the applicable Exchange.

''(II) EXCEPTION.—An individual shall be considered eligible for minimum essential coverage under clause (iii) for a month for which such Exchange has determined, subject to rights of notice and appeal under laws governing the applicable insurance affordability program (including section 1411(f) of the Patient Protection and

Affordable Care Act (42 U.S.C. 18081(f))), that the individual is covered by an eligible employer-sponsored plan.'', and

(iii) by adding at the end the following:

''(5) APPLICABLE TAXABLE YEAR.—The term 'applicable taxable year' means—

''(A) with respect to a coverage month that is January, February, March, April, or May, the most recent taxable year that ended at least 12 months before January 1 of the plan year, and

''(B) with respect to any coverage month not described in subparagraph (A), the most recent taxable year that ended before January 1 of the plan year.

''(6) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.).

''(7) OPEN ENROLLMENT PERIOD.—The term 'open enrollment period' means an open enrollment period described in subsection (c)(6)(B) of section

1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031).'',

(C) in subsection (d)—

(i) in paragraph (1)—

(I) by striking ''is allowed'' and inserting ''was allowed'', and

(II) by inserting ''applicable'' before ''taxable year'', and

(ii) in paragraph (3)(B), by inserting ''applicable'' before ''taxable year'',

(D) in subsection (e)(1)—

(i) by striking ''is allowed'' and inserting ''was allowed'', and

(ii) by inserting ''applicable'' before ''taxable year'', and

(E) in subsection (f)(2)—

(i) in subparagraph (A), by striking ''If'' and inserting ''Except as provided in subparagraphs (B) and (C), if'', and

(ii) by inserting at the end the following:

''(C) SAFE HARBOR.—

''(i) INCOME AND FAMILY SIZE.—No increase under subparagraph (A) shall be imposed if the advance payments do not

exceed amounts that are consistent with income and family size, either—

"(I) as shown on the return of tax for the applicable plan year, provided such return was accepted by the Secretary as meeting applicable processing criteria, or

"(II) as determined by the applicable Exchange under subsection (b)(4) of section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082).

"(ii) EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—No increase under subparagraph (A) shall be imposed based on eligibility for minimum essential coverage under subsection (c)(2)(C) if the applicable Exchange—

"(I) determined, under clause (v)(I) of such subsection, that the individual was ineligible for employer-sponsored minimum essential coverage, and

"(II) did not determine, under clause (v)(II) of such subsection, that

the individual was covered through employer-sponsored minimum essential coverage.

''(iii) EXCEPTION.—Clauses (i) and (ii) shall not apply to the extent that any determination described in such clauses was based on a false statement by the taxpayer which—

''(I) was intentional or grossly negligent, and

''(II) was—

''(aa) made on a return of tax, or

''(bb) provided or caused to be provided to an Exchange by the taxpayer.''.

(2) PATIENT PROTECTION AND AFFORDABLE CARE ACT.—Section 1412(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(b)) is amended—

(A) in paragraph (1)(B), by striking ''the most recent'' and all that follows through the period at the end and inserting ''the applicable taxable year, as defined in section 36B(c)(5) of the Internal Revenue Code of 1986.'';

(B) in paragraph (2)(B), by striking ''second preceding taxable year'' and inserting ''applicable taxable year, as defined in such section 36B(c)(5)''; and

(C) by adding at the end the following:

''(3) CHANGE FORM.—If, after the submission of an individual's application form, the individual experiences changes in circumstances as described in paragraph (2), the individual may, by submitting a change form as prescribed by the Secretary, apply for an increased amount of advance payments of the premium tax credit under section 36B of the Internal Revenue Code of 1986, increased cost-sharing reductions under section 1402, increased assistance under the basic health program under section 1331, and coverage through a State Medicaid program or CHIP program.

''(4) ELIGIBILITY FOR ADDITIONAL ASSISTANCE.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a process through which—

''(i) an Exchange determines, through data sources and procedures described in sections 1411 and 1413 (42 U.S.C. 18081;

42 U.S.C. 18083), whether each individual who has submitted a change form under paragraph (3) has experienced substantial changes in circumstances that warrant additional assistance through an insurance affordability program, as defined in section 2 of the Easy Enrollment in Health Care Act;

''(ii) in the case the Exchange determines an individual has experienced substantial changes in circumstances as described in clause (i), the Exchange conveys such determination to the Secretary of the Treasury under section 36B(f) of the Internal Revenue Code of 1986 and to the administrator of an insurance affordability program for which the individual may qualify under that determination; and

''(iii) in the case the Exchange determines an individual has experienced substantial changes in circumstances described in clause (i), the individual may qualify without delay for additional advance premium tax credits under section 36B of the Internal Revenue Code of 1986, increased

cost-sharing reductions under section 1402, additional basic health program assistance under section 1331, or coverage through a State Medicaid program or CHIP program.

''(B) RIGHTS TO NOTICE AND APPEAL.—A determination made by an Exchange under this paragraph shall be subject to any applicable rights of notice and appeal, including such rights under section 1411(f).''.

(3) EFFECTIVE DATES.—The amendments made by this subsection shall take effect on January 1, 2028, and continue in effect through December 31, 2034.

SEC. 6. STRENGTHENING DATA INFRASTRUCTURE FOR ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS.

(a) INSURANCE AFFORDABILITY PROGRAM ACCESS TO NATIONAL DIRECTORY OF NEW HIRES.—Section 453(i) of the Social Security Act (42 U.S.C. 653(i)) is amended by adding at the end the following new paragraph:

''(5) ADMINISTRATION OF INSURANCE AFFORDABILITY PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall provide access to insurance affordability programs (as such term is defined in section 2 of the Easy Enrollment in Health Care Act) to information in the National Directory of New Hires that involves—

''(i) identity, employer, quarterly wages, and unemployment compensation, to the extent such information is potentially relevant to determining the eligibility or scope of coverage of an individual for benefits provided by such a program; and

''(ii) new hires, to the extent such information is potentially relevant to determining whether an individual is offered minimum essential coverage through a group health plan, as defined in section 5000(b)(1) of the Internal Revenue Code of 1986.

''(B) REIMBURSEMENT OF HHS COSTS.—Insurance affordability programs shall reimburse the Secretary, in accordance with subsection (k)(3), for the additional costs incurred by the Secretary in furnishing information under this paragraph.''.

(b) USE OF INFORMATION FROM THE NATIONAL DIRECTORY OF NEW HIRES.—Notwithstanding any other provision of law—

(1) in determining an individual's eligibility for advance payment of premium tax credits under section 1412(a)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(a)(3)), and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071), and a basic health program under section 1331 of the Patient Protection and Affordable Care Act (42 U.S.C. 18051), an Exchange may use information about identity, employer, quarterly wages, and unemployment compensation in the National Directory of New Hires, and information about new hires to determine whether an individual is offered minimum essential coverage through a group health plan, as defined in section 5000(b)(1) of the Internal Revenue Code of 1986, subject to notice and appeal rights for any resulting eligibility determination, including the rights described in section 1411(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f)); and

(2) Medicaid programs and CHIP programs may use information in the National Directory of

New Hires about identity, employer, quarterly wages, and unemployment compensation to determine eligibility and to implement third-party liability procedures or premium assistance programs otherwise permitted or mandated under Federal law, and use information about new hires to implement such procedures and policies, subject to notice and appeal rights for any resulting determination, including those available under title XIX or title XXI of the Social Security Act or under section 1411(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(f)).

(c) USE OF INFORMATION ABOUT ELIGIBILITY FOR OR RECEIPT OF GROUP HEALTH COVERAGE.—Notwithstanding any other provision of Federal or State law:

(1) IN GENERAL.—Subject to the requirements described in paragraph (2), for purposes of determining eligibility and, in the case of a Medicaid program, for purposes of determining the applicability of third-party liability procedures or premium assistance policies otherwise permitted or mandated under Federal law, an insurance affordability program shall have access to any source of information, maintained by or accessible to a public entity, about re-

ceipt or offers of coverage through a group health plan. Such sources shall include—

(A) information maintained by or accessible to the Secretary of Health and Human Services for purposes of implementing section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b));

(B) information maintained by or accessible to a State Medicaid program for purposes of implementing subsection (a)(25) or (a)(60) of section 1902 of the Social Security Act (42 U.S.C. 1396a); and

(C) information reported under sections 6055 and 6056 of the Internal Revenue Code of 1986.

(2) REQUIREMENTS.—An insurance affordability program shall obtain the information described in paragraph (1) pursuant to an interagency or other agreement, consistent with standards prescribed by the Secretary of Health and Human Services, in consultation with the Secretary, that prevents the unauthorized use, disclosure, or modification of such information and otherwise protects privacy and data security.

(d) AUTHORIZATION TO RECEIVE RELEVANT INFORMATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially relevant to eligibility for an insurance affordability program is authorized to convey such data or information to the insurance affordability program, and such program is authorized to receive the data or information and to use it in determining eligibility.

(2) APPLICATION OF REQUIREMENTS AND PENALTIES.—A conveyance of data to an insurance affordability program under this subsection shall be subject to the same requirements that apply to a conveyance of data to a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under section 1942 of such Act (42 U.S.C. 1396w–2), and the penalties that apply to a violation of such requirements, including penalties that apply to a private entity making a conveyance.

(e) ELECTRONIC TRANSMISSION OF INFORMATION.—In determining an individual's eligibility for an insurance affordability program, the program shall—

(1) with respect to verifying an element of eligibility that is based on information from an Express Lane Agency (as defined in section 1902(e)(13)(F) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F))), from another public agency, or from another reliable source of relevant data, waive any otherwise applicable requirement that the individual must verify such information, provide an attestation as to the subject of such information, or provide a signature for attestations that include that subject, before the individual is enrolled into minimum essential coverage; and

(2) satisfy any otherwise applicable signature requirement with respect to an individual's enrollment in an insurance affordability program through an electronic signature (as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note)).

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as diminishing, reducing, or otherwise limiting the legal authority for an insurance affordability program to grant eligibility, in whole or in part, based on an attestation alone, without requiring verification through data matches or other sources.

SEC. 7. FUNDING FOR INFORMATION TECHNOLOGY DEVELOPMENT AND OPERATIONS.

(a) IN GENERAL.—Out of amounts in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services such sums as may be necessary to establish information exchange and processing infrastructure and operate all information exchange and processing procedures described in this Act, including for the costs of staff and contractors.

(b) AGENCIES RECEIVING FUNDING.—The Secretary of Health and Human Services may, as necessary and in accordance with the procedures described in subsection (c), transfer amounts appropriated under subsection (a) to entities that include the following for the purposes described in such subsection:

(1) The Secretary of the Treasury, including the Internal Revenue Service.

(2) The Office of Child Support Enforcement of the Department of Health and Human Services.

(3) A State-administered insurance affordability program, including a Medicaid or CHIP program and a State basic health program under section 1331 of the Patient Protection and Affordable Care Act (42 U.S.C. 18051).

(4) An entity operating an Exchange.

(5) A third-party data source, which may be a public or private entity.

(c) PROCEDURES.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish procedures for the entities described in subsection (b) to request a transfer of funding from the amounts appropriated under subsection (a), including procedures for reviewing such requests, modifying and approving such requests, appealing decisions about transfers, and auditing such transfers.

SEC. 8. CONFORMING STATUTORY CHANGES.

(a) STATE INCOME AND ELIGIBILITY VERIFICATION SYSTEMS.—Section 1137 of the Social Security Act (42 U.S.C. 1320b–7) is amended—

(1) in subsection (a)(1), by inserting ''(in the case of an individual who has consented to the disclosure and transfer of relevant return information that includes the individual's social security account number pursuant to section 3(b)(1)(B) of the Easy Enrollment in Health Care Act, the State shall deem such individual to have satisfied the requirement to furnish such account number to the State under this paragraph)'' before the semicolon; and

(2) in subsection (d)—

(A) in paragraph (1)(A), by striking ''The State shall require'' and inserting ''Subject to paragraph (6), the State shall require''; and

(B) by adding at the end the following new paragraph:

''(6) SATISFACTION OF REQUIREMENT THROUGH RELIABLE DATA MATCHES.—In the case of an individual applying for the program described in subsection (b) or the Children's Health Insurance Program under title XXI of this Act, the program shall not require an individual to make the declaration described in paragraph (1)(A) if the procedures established pursuant to section 3(a)(1) of the Easy Enrollment in Health Care Act or section 1413(c)(2)(B)(ii)(II) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(c)(2)(B)(ii)(II)) were used to verify the individual's citizenship, based on the individual's social security number as well as other identifying information, which may include such facts as name and date of birth, that increases the accuracy of matches with applicable sources of citizenship data.''.

(b) ELIGIBILITY DETERMINATIONS UNDER PPACA.—Section 1411(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(b)) is amended—

(1) in paragraph (3), by striking subparagraph (A) and inserting the following:

''(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in paragraphs (21) and (23) of section 6103(l) of the Internal Revenue Code of 1986 for the applicable taxable year, as defined in section 36B(c)(5) of such Code.''; and

(2) by adding at the end the following:

''(6) RECEIPT OF INFORMATION.—The requirements for providing information under this subsection may be satisfied through data submitted to the Exchange through reliable data matches, rather than by the applicant providing information. In the case described in paragraph (2)(A), data matches shall not be used for this purpose unless they meet the requirements described in section 1137(d)(6) of the Social Security Act (42 U.S.C. 1320b–7(d)(6)).''.

SEC. 9. ADVISORY COMMITTEE.

(a) IN GENERAL.—The Secretary of the Treasury, in conjunction with the Secretary of Health and Human Services, shall establish an advisory committee to provide guidance to both Secretaries in carrying out this Act. The members of the committee shall include—

(1) national experts in behavioral economics, other behavioral science, insurance affordability programs, enrollment and retention in health programs and other benefit programs, public benefits for immigrants, public benefits for other historically marginalized or disadvantaged communities, and Federal income tax policy and operations; and

(2) representatives of all relevant stakeholders, including—

(A) consumers;

(B) health insurance issuers;

(C) health care providers; and

(D) tax return preparers.

(b) PURVIEW.—The advisory committee established under subsection (a) shall be solicited for advice on any topic chosen by the Secretary of the Treasury or the Secretary of Health and Human Services, including (at a minimum) all matters as to which a provision in this Act, other than subsection (a), requires a consultation between the Secretary of the Treasury and the Secretary of Health and Human Services.

SEC. 10. STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study analyzing the impact of this Act and making recommendations for—

(1) State pilot projects to test improvements to this Act, including an analysis of policies that automatically enroll eligible individuals into group health plans;

(2) modifying open enrollment periods for Exchanges and plan years so that open enrollment coincides with filing of Federal income tax returns; and

(3) other steps to improve outcomes achieved by this Act.

(b) REPORT.—Not later than July 1, 2030, the Secretary of Health and Human Services shall deliver a report on the study and recommendations under subsection (a) to the Committee on Ways and Means, the Committee on Education and the Workforce, and the Committee on Energy and Commerce of the House of Representatives and to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate.

SEC. 11. APPROPRIATIONS.

Out of amounts in the Treasury not otherwise appropriated, there are appropriated, in addition to the amounts described in section 7 and any amounts otherwise made available, to carry out the purposes of this Act, such sums as may be necessary to the Secretary of the Treasury, and

such sums as may be necessary to the Secretary of Health and Human Services, to remain available until expended.

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