I

119TH CONGRESS
1ST SESSION

H. R. 6512

To Empower American Families with Direct Control Over Healthcare Dollars, Codify President Trump's Proven Reforms for Flexibility and Choice, Prohibit Taxpayer Funding for Abortion and Gender Transition Procedures, Eliminate Waste and Fraud in the Affordable Care Act, and Reject Extensions of Enhanced Subsidies to Insurance Companies.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 9, 2025

Mr. BIGGS of Arizona (for himself, Mr. OGLES, and Mr. CLYDE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Workforce, and the Judiciary, 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 Empower American Families with Direct Control Over Healthcare Dollars, Codify President Trump's Proven Reforms for Flexibility and Choice, Prohibit Taxpayer Funding for Abortion and Gender Transition Procedures, Eliminate Waste and Fraud in the Affordable Care Act, and Reject Extensions of Enhanced Subsidies to Insurance Companies.

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 ''Putting Patients First Healthcare Freedom Act''

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—PUTTING PATIENTS OVER HEALTH INSURANCE COMPANIES

Subtitle A—More Affordable Care Act

SEC. 1001. SHORT TITLE.

This Act may be cited as the ''More Affordable Care Act''.

SEC. 1002. HEALTH FREEDOM WAIVER PROGRAM.

Part 4 of subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18051 et seq.) is amended by adding the following:

''SEC. 1335. HEALTH FREEDOM WAIVER PROGRAM.

''(a) IN GENERAL.—

''(1) WAIVER PROGRAM.—The Secretary shall waive all or any requirements described in paragraph (4), as determined by the applicable State, for plan years beginning on or after January 1, 2026, with respect to health insurance coverage within any State that submits a notification under paragraph (2), provided that the State maintains an invisible high-risk insurance pool or another program designed to mitigate risk to insurance premium costs.

''(2) NOTIFICATION.—A State entity described in paragraph (3) desiring a waiver under this section for any plan year beginning on or after January 1, 2026, shall notify the Secretary of its intent to participate in the waiver program with respect to all or any requirements described in paragraph (4). Such notification shall be filed at such time, not later than 90 days before the State intends to begin participation in the waiver program, and in such manner as the Secretary may require, and contain such information as the Secretary may require, including the requirements under paragraph (4) that the State intends to waiver and evidence that the State maintains a high-risk insurance pool.

''(3) STATE SUBMISSION.—A notification with respect to a State may be submitted by—

''(A) the governor of the State; or

''(B) the legislature of the State, upon a majority vote by the State legislature.

''(4) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State are as follows:

''(A) Part 1 of subtitle D.

''(B) Part 2 of subtitle D.

''(C) Section 1402.

"(D) Sections 36B and 5000A of the Internal Revenue Code of 1986.

"(5) MONEY FOLLOWS THE PERSON.—

"(A) IN GENERAL.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sec. 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid into the Trump Health Freedom Accounts established under section 223(i) of the Internal Revenue Code of 1986 of eligible residents of the State.

"(B) PAYMENTS TO TRUMP HEALTH FREEDOM ACCOUNTS.—The Secretary shall pay into the Trump Health Freedom Accounts of each eligible resident of a State for which a waiver

is in effect for a play year the amount equal to the total amount for which the resident would have been eligible in premium tax credit amounts under section 36B of the Internal Revenue Code of 1986 and cost-sharing reduction amounts under section 1402 for the year, had the State not had such waiver in effect. In determining the appropriate payment amount under this subparagraph, the Secretary shall calculate premium tax credit amounts and cost-sharing reduction amounts based on the national average annual premium amount for a silver tier benchmark plan among States that do not have such waivers in effect for the applicable year. The Secretary shall make payments into the Trump Health Freedom Accounts of eligible residents on a monthly basis, quarterly basis, or in one lump sum at the beginning of the year, at the option of each eligible resident.

''(6) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under section 1332, and titles XVIII, XIX, and XXI of the Social

Security Act, and any other Federal law relating to the provision of health care items or services. Such processes shall permit a State to submit a single application for a waiver under any or all of such provisions.

''(7) EXCHANGES.—

''(A) IN GENERAL.—In the case of a State in which a waiver is in effect under this section for a plan year—

''(i) the State may—

''(I) operate an Exchange established as described in section 1311(b); or

''(II) allow one or more private entities to run commercial platforms that sell health plans approved by the State insurance commissioner; or

''(ii) if the State does not operate an Exchange as described in clause (i)(I) or allow for one or more commercial platforms described in clause (i)(II), the Secretary shall operate a Federal Exchange, as described in section 1321(c), provided that any State laws regarding the availability of health plans on, and the oper-

ation of, such Exchange shall apply in lieu of any provision under part 1 or part 2 that such State has waived.

''(B) APPLICATION PROGRAM INTERFACE.—The Secretary shall make available to any State that allows for commercial platforms described in subparagraph (A)(i)(II), the application program interface used for operating Federal and State Exchanges, for use by any private entity running such a platform under State authority.

''(8) DEFINITIONS.—In this section:

''(A) ELIGIBLE RESIDENT.—The term 'eligible resident' means, with respect to a State for which a waiver is in effect under this section, a resident who—

''(i) in the absence of such a waiver in the State, would be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 or a cost-sharing reduction under section 1402, if the resident enrolled in a qualified health plan offered on the Exchange of such State; and

''(ii) enrolls in a plan offered on the Exchange described in paragraph (7) for the applicable plan year.

''(B) SECRETARY.—The term 'Secretary' means—

''(i) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (4); and

''(ii) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (4)(D).

''(b) WAIVER PERIOD.—Each waiver under this section shall be in effect beginning on January 1 of the plan year for which a timely notice is submitted by the State under subsection (a)(2), and continuing until the entity of the State described in subparagraph (A) or (B) of subsection (a)(3) that submitted the notification under subsection (a)(2) submits to the Secretary a notification of intent to discontinue participation in the waiver program under this section.

''(c) LIMITATION.—The Secretary may not permit a waiver under this section of any Federal law or requirement that is not within the authority of the Secretary.

''(d) AVAILABILITY OF PLANS.—

''(1) IN GENERAL.—Any health insurance coverage offered in a State for which a waiver under this section is in effect, and authorized by the insurance commissioner of the State, shall be made available on, as applicable, the Federal or State Exchange or commercial platforms described in subsection (a)(7), of all States for which such a waiver is in effect, subject to the laws of each such State.

''(2) CHILD-ONLY PLANS.—In any State for which a waiver under this section is in effect, a health insurance issuer may offer a plan in which the only individuals eligible to enroll are individuals who, as of the beginning of a plan year, have not attained the age of 21.

''(e) REGULATIONS.—Not later than 1 year after the date of enactment of the More Affordable Care Act, the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, shall promulgate regulations to carry out this section.

''(f) RULE OF CONSTRUCTION REGARDING CONSUMER PROTECTIONS, INCLUDING THE PRE-EXISTING CONDITION PROTECTION.—Nothing in this section shall be construed to allow a State to waive the requirements of title XXVII of the Public Health Service Act, including

sections 2701, 2702, 2703, 2704, 2705, 2706, 2711, 2712, and 2718 of such Act.''.

SEC. 1003. TRUMP HEALTH FREEDOM 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) TRUMP HEALTH FREEDOM ACCOUNTS.—For purposes of this section—

''(1) IN GENERAL.—In the case of a Trump Health Freedom Account, this section shall be applied as provided in paragraphs (3) through (8).

''(2) TRUMP HEALTH FREEDOM ACCOUNT.—The term 'Trump Health Freedom Account' means a health savings account (determined as provided in this subsection) established by or on behalf of an individual residing in a State for which a waiver under section 1335 of the Patient Protection and Affordable Care Act is in effect which receives deposits of amounts transferred to the individual pursuant to section 1335(a)(5) of such Act.

''(3) ELIGIBLE INDIVIDUAL.—Any individual covered under a health plan authorized to be made available on an Exchange by section 1335(d) of such Act shall be treated as an eligible individual.

''(4) TREATMENT OF TRANSFERRED CONTRIBUTIONS.—Amounts transferred to a Trump Health Freedom Account pursuant to section 1335(a)(5) of such Act shall not be taken into account in determining the deduction allowed by subsection (a).

''(5) ACCOUNT MUST BE ONLY HSA OF INDIVIDUAL.—

''(A) IN GENERAL.—An individual who has a Trump Health Freedom Account shall not be treated as an eligible individual with respect to any health savings account other than such Trump Health Freedom Account.

''(B) ROLLOVER OF EXISTING ACCOUNT PERMITTED.—An individual on whose behalf a Trump Health Freedom Account is established may roll over the balance of any other health savings account of the individual to such Trump Health Freedom Account according to the rule of subsection (f)(5).

''(6) NO ROLLOVERS PERMITTED.—Except as provided in paragraph (6)(B), subsection (f)(5) shall not apply and no amount shall be contributed from a Trump Health Freedom Account to any health saving account other than a Trump Health Freedom Account.

''(7) RESTRICTION ON USE OF AMOUNTS.—No amounts in a Trump Health Freedom Account may be used—

''(A) to pay premiums for a health plan that covers—

''(i) gender transition procedures; or

''(ii) abortion; or

''(B) pay for any service described in clause (i) or (ii) or subparagraph (A).

''(8) DEFINITIONS.—For purposes of paragraph (8)—

''(A) GENDER TRANSITION PROCEDURE.—

''(i) IN GENERAL.—The term 'gender transition procedure' means any hormonal or surgical intervention for the purpose of gender transition, including—

''(I) gonadotropin-releasing hormone (GNRH) agonists or other puberty-blocking or suppressing drugs to stop or delay normal puberty;

''(II) testosterone, estrogen, progesterone, or other androgens to an individual at doses that are supraphysiologic to what would normally be

produced endogenously in a healthy individual of the same age and sex;

‘‘(III) castration;

‘‘(IV) orchiectomy;

‘‘(V) scrotoplasty;

‘‘(VI) implantation of erection or testicular prostheses;

‘‘(VII) vasectomy;

‘‘(VIII) hysterectomy;

‘‘(IX) oophorectomy;

‘‘(X) ovariectomy;

‘‘(XI) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

‘‘(XII) metoidioplasty;

‘‘(XIII) penectomy;

‘‘(XIV) phalloplasty;

‘‘(XV) vaginoplasty;

‘‘(XVI) clitoroplasty;

‘‘(XVII) vaginectomy;

‘‘(XVIII) vulvoplasty;

‘‘(XIX) reduction thyrochondroplasty;

‘‘(XX) chondrolaryngoplasty;

‘‘(XXI) mastectomy;

"(XXII) tubal ligation;

"(XXIII) sterilization;

"(XXIV) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other physiological features of an individual;

"(XXV) any placement of chest implants to create feminine breasts;

"(XXVI) any placement of fat or artificial implants in the gluteal region;

"(XXVII) augmentation mammoplasty;

"(XXVIII) liposuction;

"(XXIX) lipofilling;

"(XXX) voice surgery;

"(XXXI) hair reconstruction;

"(XXXII) pectoral implants; and

"(XXXIII) the removal of any otherwise healthy or non-diseased body part or tissue.

"(ii) EXCLUSIONS.—The term 'gender transition procedure' does not include the following when furnished to an individual by a health care provider with the consent

of such individual or, if applicable, such individual's parents or legal guardian:

"(I) Services to individuals born with a medically verifiable disorder of sex development, including an individual with external sex characteristics that are irresolvably ambiguous such as an individual born with 46 XX chromosomes with virilization, and individual born with 46 XY chromosomes with undervirilization, or an individual born having both ovarian and testicular tissue.

"(II) Service provided when a physician has otherwise diagnosed a disorder of sexual development in which the physician has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a healthy individual of the same sex and age.

"(III) The treatment of any infection, injury, disease, or disorder

that has been caused by or exacerbated by the performance of gender transition procedures, whether or not the gender transition procedure was performed in accordance with State and Federal law or whether or not funding for the gender transition procedure is permissible under this section.

''(IV) Any procedure undertaken because the individual suffers from a physical disorder, physical injury, or physical illness (but not mental, behavioral, or emotional distress or a mental, behavioral, or emotional disorder) that would, as certified by a physician, place the individual in imminent danger of death or impairment of major bodily function, unless the procedure is performed.

''(V) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for a minor experiencing precocious puberty.

''(VI) Male circumcision.

''(B) GENDER TRANSITION.—The term 'gender transition' means the process in which an individual goes from identifying with or presenting as his or her sex to identifying with or presenting a self-proclaimed identity that does not correspond with or is different from his or her sex and may be accompanied with social, legal, or physical changes.

''(C) SEX.—The term 'sex', when referring to an individual's sex, means to refer to either male or female, as biologically determined.

''(D) FEMALE.—The term 'female', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historic accident, or intentional or unintentional disruption, the reproductive system that at some point produces, transports, and utilizes eggs for fertilization.

''(E) MALE.—The term 'male', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historical accident, or intentional or unintentional

disruption, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.

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

Subtitle B—Improving HSA Access, Utility, and Flexibility

SEC. 1011. INDIVIDUALS ENTITLED TO PART A OF MEDICARE BY REASON OF AGE ALLOWED TO CONTRIBUTE TO HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(c)(1)(B) is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of section 226(a) of such Act.''.

(b) TREATMENT OF HEALTH INSURANCE PURCHASED FROM ACCOUNT.—Section 223(d)(2)(C)(iv) is amended by inserting ''and who is not an eligible individual'' after ''who has attained the age specified in section 1811 of the Social Security Act''.

(c) COORDINATION WITH PENALTY ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 223(f)(4)(C) is amended by striking ''Subparagraph (A)'' and inserting ''Except in the case of an eligible individual, subparagraph (A)''.

(d) CONFORMING AMENDMENT.—Section 223(b)(7) is amended by inserting ''(other than an entitlement to benefits described in subsection (c)(1)(B)(iv))'' after ''Social Security Act''.

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

SEC. 1012. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

''(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

''(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

''(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution

amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.''.

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

SEC. 1013. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAS.

(a) IN GENERAL.—Section 106(e)(2) is amended to read as follows:

''(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified HSA distribution' means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee contributed directly to a health savings account of such employee if—

''(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) if during the 4-year period preceding the

date the employee so establishes coverage the employee was not covered under such a high deductible health plan, and

''(ii) such arrangement is described in section 223(c)(1)(B)(v) with respect to any portion of the plan year remaining after such distribution is made, if such employee remains enrolled in such arrangement.

''(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).''.

(b) PARTIAL REDUCTION OF LIMITATION ON DEDUCTIBLE HSA CONTRIBUTIONS.—Section 223(b)(4) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).''.

(c) CONVERSION TO HSA-COMPATIBLE ARRANGEMENT FOR REMAINDER OF PLAN YEAR.—Section 223(c)(1)(B), as amended by this preceding provisions of this Act, is amended by striking ''and'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', and'', and by adding at the end the following new clause:

''(v) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan

year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year.''.

(d) INCLUSION OF QUALIFIED HSA DISTRIBUTIONS ON W–2.—

(1) IN GENERAL.—Section 6051(a), as amended by the preceding provisions of this Act, is amended by striking ''and'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting '', and'', and by inserting after paragraph (20) the following new paragraph:

''(21) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.''.

(2) CONFORMING AMENDMENT.—Section 6051(a)(12) is amended by inserting ''(other than any qualified HSA distribution, as defined in section 106(e)(2))'' before the comma at the end.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2025.

SEC. 1014. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2), as amended by the preceding provisions of this Act, is amended by adding at the end the following new subparagraph:

''(F) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.''.

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

SEC. 1015. CONTRIBUTIONS PERMITTED IF SPOUSE HAS HEALTH FLEXIBLE SPENDING ARRANGEMENT.

(a) CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ARRANGEMENT.—Section 223(c)(1)(B), as amended by this preceding provisions of

this Act, is amended by striking ''and'' at the end of clause (iv), by striking the period at the end of clause (v) and inserting '', and'', and by adding at the end the following new clause:

''(vi) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.''.

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

SEC. 1016. INCREASE IN HEALTH SAVINGS ACCOUNT CONTRIBUTION LIMITATION FOR CERTAIN INDIVIDUALS.

(a) INCREASE.—

(1) IN GENERAL.—Section 223(b) is amended by adding at the end the following new paragraph:

"(9) INCREASE IN LIMITATION FOR CERTAIN TAXPAYERS.—

"(A) IN GENERAL.—The applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by $4,300 and $8,550, respectively.

"(B) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The amount of the increase under subparagraph (A) (determined without regard to this subparagraph) shall be reduced (but not below zero) by the amount which bears the same ratio to the amount of such increase (as so determined) as—

"(i) the excess (if any) of—

"(I) the taxpayer's adjusted gross income for such taxable year, over

"(II) $75,000 ($150,000 in the case of a joint return, if the eligible individual has family coverage), bears to

"(ii) $25,000 ($50,000 in the case of a joint return, if the eligible individual has family coverage).

For purposes of the preceding sentence, adjusted gross income shall be determined in the same manner as under section 219(g)(3)(A), except determined without regard to any deduction allowed under this section.''.

(2) ONLY TO APPLY TO EMPLOYEE CONTRIBUTIONS.—Section 106(d)(1) is amended by inserting ''and section 223(b)(9)'' after ''determined without regard to this subsection''.

(b) INFLATION ADJUSTMENT.—Section 223(g), as amended by the preceding provisions of this Act, is amended—

(1) by inserting '', (b)(9)(A), (b)(9)(B)(i)(II),'' before ''and (c)(2)(A)'' each place it appears,

(2) by striking ''clauses (ii) and (ii)'' in paragraph (1)(B)(i) and inserting ''clauses (ii), (iii), and (iv)'',

(3) by striking ''and'' at the end of paragraph (1)(B)(ii),

(4) by striking the period at the end of paragraph (1)(B)(iii) and inserting '', and'', and

(5) by inserting after paragraph (1)(B)(iii) the following new clause:

"(iv) in the case of the dollar amounts in subsections (b)(9)(A) and (b)(9)(B)(i)(II), calendar year 2025".

(c) EFFECTIVE DATE.—

(1) SUBSECTION (A).—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2025.

(2) SUBSECTION (B).—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2026.

SEC. 1017. HEALTH SAVINGS ACCOUNTS USED TO PURCHASE INSURANCE.

(a) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended—

(1) by striking subparagraphs (B) and (C), and

(2) by redesignating subparagraph (D) as subparagraph (C).

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

Subtitle C—Health Care Sharing Ministries

SEC. 1018. TREATMENT OF HEALTH CARE SHARING MINISTRIES.

(a) INCLUSION AS MEDICAL EXPENSES.—Paragraph (2) of section 223(c) of the Internal Revenue Code of 1986, as redesignated and amended by the preceding provisions of this Act, is further amended by adding at the end the following new subparagraph:

"(D) INCLUSION OF HEALTH CARE SHARING MINISTRIES.—The term 'qualified medical expenses' shall include amounts paid by a member of a health care sharing ministry (as defined in section 5000A(d)(2)(B)(ii) without regard to subclause (IV) thereof) for—

"(i) the sharing of medical expenses among members, and

"(ii) administrative fees of the ministry.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of enactment of this Act.

SEC. 1019. HEALTH CARE SHARING MINISTRY FEES TREATED AS MEDICAL CARE.

(a) IN GENERAL.—Section 213(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(12) HEALTH CARE SHARING MINISTRIES.—For purposes of this section, the term 'medical care' shall include amounts paid by a member of a health care sharing ministry (as defined in section 5000A(d)(2)(B)(ii) without regard to subclause (IV) thereof) for—

''(A) the sharing of medical expenses among members, and

''(B) administrative fees of the ministry.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 1020. HEALTH CARE SHARING MINISTRIES NOT TREATED AS HEALTH INSURANCE.

(a) IN GENERAL.—Section 223(c) of the Internal Revenue Code of 1986, as redesignated and amended by the preceding provisions of this Act, is amended by adding at the end the following new paragraph:

''(5) HEALTH CARE SHARING MINISTRIES NOT TREATED AS HEALTH INSURANCE.—A health care sharing ministry (as defined in section

5000A(d)(2)(B)(ii) without regard to subclause (IV) thereof) shall not be treated as health plan or insurance for purposes of this title.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of enactment of this Act.

TITLE II—CODIFYING TRUMP HEALTHCARE FREEDOM AGENDA

Subtitle A—Association Health Plan Act

SEC. 2001. SHORT TITLE.

This Act may be cited the ''Association Health Plan Act''.

SEC. 2002. TREATMENT OF GROUP OR ASSOCIATION OF EMPLOYERS.

(a) IN GENERAL.—Section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)) is amended—

(1) by striking ''The term'' and inserting ''(A) The term''; and

(2) by adding at the end the following:

''(B) For purposes of subparagraph (A), a group or association of employers shall be treated as an 'employer', regardless of whether the

employers composing such group or association are in the same industry, trade, or profession, if such group or association—

"(i)(I) has established and maintains an employee welfare benefit plan that is a group health plan (as defined in section 733(a)(1));

"(II) provides coverage under such plan to at least 51 employees after all of the employees employed by all of the employer members of such group or association have been aggregated and counted together as described in subparagraph (D);

"(III) has been actively in existence for at least 2 years;

"(IV) has been formed and maintained in good faith for purposes other than providing medical care (as defined in section 733(a)(2)) through the purchase of insurance or otherwise;

"(V) does not condition membership in the group or association on any health status-related factor (as

described in section 702(a)(1)) relating to any individual;

''(VI) makes coverage under such plan available to all employer members of such group or association regardless of any health status-related factor (as described in section 702(a)(1)) relating to such employer members;

''(VII) does not provide coverage under such plan to any individual other than an employee of an employer member of such group or association;

''(VIII) has established a governing board with by-laws or other similar indications of formality to manage and operate such plan in both form and substance, of which at least 75 percent of the board members shall be made up of employer members of such group or association participating in the plan that are duly elected by each participating employer

member casting 1 vote during a scheduled election;

"(IX) is not a health insurance issuer (as defined in section 733(b)(2)), and is not owned or controlled by such a health insurance issuer or by a subsidiary or affiliate of such a health insurance issuer, other than to the extent such a health insurance issuer may participate in the group or association as a member;

"(ii) is structured in good faith with any set of criteria to qualify for such treatment in any advisory opinion issued prior to the date of enactment of the Association Health Plans Act; or

"(iii) meets any other set of criteria to qualify for such treatment that the Secretary by regulation may provide.

"(C)(i) For purposes of subparagraph (B), a self-employed individual shall be treated as—

"(I) an employer who may become a member of a group or association of employers;

''(II) an employee who may participate in an employee welfare benefit plan established and maintained by such group or association; and

''(III) a participant of such plan subject to the eligibility determination and monitoring requirements set forth in clause (iii).

''(ii) For purposes of this subparagraph, the term 'self-employed individual' means an individual who—

''(I) does not have any common law employees;

''(II) has a bona fide ownership right in a trade or business, regardless of whether such trade or business is incorporated or unincorporated;

''(III) earns wages (as defined in section 3121(a) of the Internal Revenue Code of 1986) or self-employment income (as defined in section 1402(b) of such Code) from such trade or business; and

''(IV) works at least 10 hours a week or 40 hours per month providing

personal services to such trade or business.

''(iii) The board of a group or association of employers shall—

''(I) initially determine whether an individual meets the requirements under clause (ii) to be considered to a self-employed individual for the purposes of being treated as an—

''(aa) employer member of such group or association (in accordance with clause (i)(I)); and

''(bb) employee who may participate in the employee welfare benefit plan established and maintained by such group or association (in accordance with clause (i)(II));

''(II) through reasonable monitoring procedures, periodically determine whether the individual continues to meet such requirements; and

''(III) if the board determines that an individual no longer meets such requirements, not make such

plan coverage available to such individual (or dependents thereof) for any plan year following the plan year during which the board makes such determination. If, subsequent to a determination that an individual no longer meets such requirements, such individual furnishes evidence of satisfying such requirements, such individual (and dependents thereof) shall be eligible to receive plan coverage.

''(D) For purposes of subparagraph (B), all of the employees (including self-employed individuals) employed by all of the employer members (including self-employed individuals) of a group or association of employers shall be—

''(i) treated as participants in a single plan multiple employer welfare arrangement; and

''(ii) aggregated and counted together for purposes of any regulation of an employee welfare benefit plan established and maintained by such group or association.''.

(b) DETERMINATION OF EMPLOYER OR JOINT EMPLOYER STATUS.—The provision of employee welfare benefit plan coverage by a group or association of employers shall not be construed as evidence for establishing an employer or joint employer relationship under any Federal or State law.

SEC. 2003. RULES APPLICABLE TO EMPLOYEE WELFARE BENEFIT PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181, et seq.) is amended by adding at the end the following:

"SEC. 736. RULES APPLICABLE TO EMPLOYEE WELFARE BENEFIT PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

''(a) PREMIUM RATES FOR A GROUP OR ASSOCIATION OF EMPLOYERS.—

''(1)(A) In the case of an employee welfare benefit plan established and maintained by a group or association of employers described in section 3(5)(B), such plan may, to the extent not prohibited under State law—

''(i) establish base premium rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all plan participant claims; and

''(ii) utilize the specific risk profile of each employer member of such group or association to determine contribution rates for each such employer member's share of a premium by actuarially adjusting above or below the established base premium rates.

''(B) For purposes of paragraph (1), the term 'employer member' means—

''(i) an employer who is a member of such group or association of employers and employs at least 1 common law employee; or

''(ii) a group made up solely of self-employed individuals, within which all of the self-employed individual members of such group or association are aggregated together as a single employer member group, provided the group includes at least 20 self-employed individual members.

''(2) In the event a group or association is made up solely of self-employed individuals (and no employers with at least 1 common law employee are members of such group or association), the employee welfare benefit plan established by such group or association shall—

''(A) treat all self-employed individuals who are members of such group or association as a single risk pool;

''(B) pool all plan participant claims; and

''(C) charge each plan participant the same premium rate.

''(b) DISCRIMINATION AND PRE-EXISTING CONDITION PROTECTIONS.—An employee welfare benefit plan established and maintained by a group or association of employers described in section 3(5)(B) shall be prohibited from—

''(1) establishing any rule for eligibility (including continued eligibility) of any individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual) to enroll for benefits under the terms of the plan that discriminates based on any health status-related factor that relates to

such individual (consistent with the rules under section 702(a)(1));

''(2) requiring an individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual), as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor that relates to such individual (consistent with the rules under section 702(b)(1)); and

''(3) denying coverage under such plan on the basis of a pre-existing condition (consistent with the rules under section 2704 of the Public Health Service Act).''.

SEC. 2004. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to exempt a group health plan which is an employee welfare benefit plan offered through a group or association of employers from the requirements of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.), including the provisions of part

A of title XXVII of the Public Health Service Act as incorporated by reference into this Act through section 715.

Subtitle B—CHOICE Arrangement Act

SEC. 2011. SHORT TITLE.

This Act may be cited as the ''CHOICE Arrangement Act''.

SEC. 2012. TREATMENT OF HEALTH REIMBURSEMENT ARRANGEMENTS INTEGRATED WITH INDIVIDUAL MARKET COVERAGE.

(a) IN GENERAL.—Section 9815(b) is amended—

(1) By striking ''exception Notwithstanding subsection (a)'' and inserting the following: ''Exceptions.—

''(1) SELF-INSURED GROUP HEALTH PLANS.—Notwithstanding subsection (a)''

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

''(2) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS.—

''(A) IN GENERAL.—For purposes of this subchapter, a custom health option and individual care expense arrangement shall be treated as meeting the requirements of section 9802

and sections 2705, 2711, 2713, and 2715 of title XXVII of the Public Health Service Act.

''(B) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS DEFINED.—For purposes of this section, the term 'custom health option and individual care expense arrangement' means a health reimbursement arrangement—

''(i) which is an employer-provided group health plan funded solely by employer contributions to provide payments or reimbursements for medical care subject to a maximum fixed dollar amount for a period,

''(ii) under which such payments or reimbursements may only be made for medical care provided during periods during which the individual is covered—

''(I) under individual health insurance coverage (other than coverage that consists solely of excepted benefits), or

''(II) under part A and B of title XVIII of the Social Security Act or part C of such title,

''(iii) which meets the nondiscrimination requirements of subparagraph (C),

''(iv) which meets the substantiation requirements of subparagraph (D), and

''(v) which meets the notice requirements of subparagraph (E).

''(C) NONDISCRIMINATION.—

''(i) IN GENERAL.—An arrangement meets the requirements of this subparagraph if an employer offering such arrangement to an employee within a specified class of employee—

''(I) offers such arrangement to all employees within such specified class on the same terms, and

''(II) does not offer any other group health plan (other than an account-based group health plan or a group health plan that consists solely of excepted benefits) to any employees within such specified class.

In the case of an employer who offers a group health plan provided through health insurance coverage in the small group market (that is subject to section 2701 of the

Public Health Service Act) to all employees within such specified class, subclause (II) shall not apply to such group health plan.

''(ii) SPECIFIED CLASS OF EMPLOYEE.—For purposes of this subparagraph, any of the following may be designated as a specified class of employee:

''(I) Full-time employees.

''(II) Part-time employees.

''(III) Salaried employees.

''(IV) Non-salaried employees.

''(V) Employees whose primary site of employment is in the same rating area.

''(VI) Employees who are included in a unit of employees covered under a collective bargaining agreement to which the employer is subject (determined under rules similar to the rules of section 105(h)).

''(VII) Employees who have not met a group health plan, or health insurance issuer offering group health insurance coverage, waiting period re-

quirement that satisfies section 2708 of the Public Health Service Act.

''(VIII) Seasonal employees.

''(IX) Employees who are non-resident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

''(X) Such other classes of employees as the Secretary may designate.

An employer may designate (in such manner as is prescribed by the Secretary) two or more of the classes described in the preceding subclauses as the specified class of employees to which the arrangement is offered for purposes of applying this subparagraph.

''(iii) SPECIAL RULE FOR NEW HIRES.—An employer may designate prospectively so much of a specified class of employees as are hired after a date set by the employer. Such subclass of employees

shall be treated as the specified class for purposes of applying clause (i).

''(iv) RULES FOR DETERMINING TYPE OF EMPLOYEE.—For purposes for clause (ii), any determination of full-time, part-time, or seasonal employment status shall be made under rules similar to the rules of section 105(h) or 4980H, whichever the employer elects for the plan year. Such election shall apply with respect to all employees of the employer for the plan year.

''(v) PERMITTED VARIATION.—For purposes of clause (i)(I), an arrangement shall not fail to be treated as provided on the same terms within a specified class merely because the maximum dollar amount of payments and reimbursements which may be made under the terms of the arrangement for the year with respect to each employee within such class—

''(I) increases as additional dependents of the employee are covered under the arrangement, and

''(II) increases with respect to a participant as the age of the partici-

pant increases, but not in excess of an amount equal to 300 percent of the lowest maximum dollar amount with respect to such a participant determined without regard to age.

''(D) SUBSTANTIATION REQUIREMENTS.—An arrangement meets the requirements of this subparagraph if the arrangement has reasonable procedures to substantiate—

''(i) that the participant and any dependents are, or will be, enrolled in coverage described in subparagraph (B)(ii) as of the beginning of the plan year of the arrangement (or as of the beginning of coverage under the arrangement in the case of an employee who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under subparagraph (E) (determined without regard to clause (iii) thereof)), and

''(ii) any requests made for payment or reimbursement of medical care under the arrangement and that the participant and any dependents remain so enrolled.

''(E) NOTICE.—

''(i) IN GENERAL.—Except as provided in clause (iii), an arrangement meets the requirements of this subparagraph if, under the arrangement, each employee eligible to participate is, not later than 60 days before the beginning of the plan year, given written notice of the employee's rights and obligations under the arrangement which—

''(I) is sufficiently accurate and comprehensive to apprise the employee of such rights and obligations, and

''(II) is written in a manner calculated to be understood by the average employee eligible to participate.

''(ii) NOTICE REQUIREMENTS.—Such notice shall include such information as the Secretary may by regulation prescribe.

''(iii) NOTICE DEADLINE FOR CERTAIN EMPLOYEES.—In the case of an employee—

''(I) who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under clause (i) (deter-

mined without regard to this clause), or

''(II) whose employer is first established fewer than 120 days before the beginning of the first plan year of the arrangement,

the requirements of this subparagraph shall be treated as met if the notice required under clause (i) is provided not later than the date the arrangement may take effect with respect to such employee.''.

(b) INCLUSION OF CHOICE ARRANGEMENT PERMITTED BENEFITS ON W–2.—

(1) IN GENERAL.—Section 6051(a), as amended by the preceding provisions of this Act, is amended by striking ''and'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting '', and'', and by inserting after paragraph (19) the following new paragraph:

''(20) the total amount of permitted benefits for enrolled individuals under a custom health option and individual care expense arrangement (as defined in section 9815(b)(2)) with respect to such employee.''.

(c) TREATMENT OF CURRENT RULES RELATING TO CERTAIN ARRANGEMENTS.—

(1) NO INFERENCE.—To the extent not inconsistent with the amendments made by this section—

(A) no inference shall be made from such amendments with respect to the rules prescribed in the Federal Register on June 20, 2019 (84 Fed. Reg. 28888), relating to health reimbursement arrangements and other account-based group health plans, and

(B) any reference to custom health option and individual care expense arrangements shall for purposes of such rules be treated as including a reference to individual coverage health reimbursement arrangements.

(2) OTHER CONFORMING OF RULES.—The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall modify such rules as may be necessary to conform to the amendments made by this section.

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

SEC. 2013. PARTICIPANTS IN CHOICE ARRANGEMENT ELIGIBLE FOR PURCHASE OF EXCHANGE INSURANCE FOR PURCHASE OF CAFETERIA PLAN.

(a) IN GENERAL.—Section 125(f)(3) is amended by adding at the end the following new subparagraph:

"(C) EXCEPTION FOR PARTICIPANTS IN CHOICE ARRANGEMENT.—Subparagraph (A) shall not apply in the case of an employee participating in a custom health option and individual care expense arrangement (within the meaning of section 9815(b)(2)) offered by the employee's employer.".

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

SEC. 2014. EMPLOYER CREDIT FOR CHOICE ARRANGEMENT.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 is amended by adding at the end the following new section:

"SEC. 45BB. EMPLOYER CREDIT FOR CHOICE ARRANGEMENT.

"(a) IN GENERAL.—For purposes of section 38, in the case of an eligible employer, the CHOICE arrangement credit determined under this section for any taxable year is an amount, with respect to each employee enrolled

during the credit period in a CHOICE arrangement maintained by the employer, equal to—

"(1) $100 multiplied by the number of months for which the employee is so enrolled during the first year in the credit period, and

"(2) one-half of the dollar amount in effect under paragraph (1) for the taxable year, multiplied by the number of months for which the employee is so enrolled during the second year of the credit period.

"(b) ARRANGEMENT MUST CONSTITUTE MINIMUM ESSENTIAL COVERAGE.—An employee shall not be taken into account under subsection (a) unless such employee's eligibility for the CHOICE arrangement (determined without regard to the employee being enrolled) would cause the employee to be treated under section 36B(c)(2) as being eligible for minimum essential coverage consisting of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)).

"(c) DEFINITIONS.—For purposes of this section—

"(1) CHOICE ARRANGEMENT.—The term 'CHOICE arrangement' means a custom health option and individual care expense arrangement (as defined in section 9815(b)(2)(B)).

''(2) CREDIT PERIOD.—The credit period with respect to an eligible employer is the first 2 one-year periods beginning with the month during which the employer first establishes a CHOICE arrangement on behalf of employees of the employer.

''(3) ELIGIBLE EMPLOYER.—The term 'eligible employer' means, with respect to any taxable year beginning in a calendar year, an employer who is not an applicable large employer for the calendar year under section 4980H.

''(d) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2026, the dollar amount in subsection (a) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2025' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

''(2) ROUNDING.—If any amount after adjustment under paragraph (1) is not a multiple of $10, such amount shall be rounded to the next lower multiple of $10.''.

(b) CREDIT MADE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) is amended by striking ''plus'' at the end of paragraph (40), by striking the period at the end of paragraph (41) and inserting '', plus'', and by adding at the end the following new paragraph:

''(42) the CHOICE arrangement credit determined under section 45BB(a).''.

(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) is amended—

(1) by redesignating clauses (x), (xi), and (xii) as clauses (xi), (xii), and (xiii), respectively, and

(2) by inserting after clause (ix) the following new clause:

''(x) the credit determined under section 45BB,''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 is amended by adding at the end the following new item:

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

Subtitle C—Self-Insurance Protection Act

SEC. 2021. SHORT TITLE.

This Act may be cited as the ''Self-Insurance Protection Act''.

SEC. 2022. FINDINGS.

Congress finds the following:

(1) Small and large employers offer health benefit plan coverage to employees in self-funded arrangements using company assets or a fund, or by paying premiums to purchase fully-insured coverage from a health insurance company.

(2) Employers that self-fund health benefit plans will often purchase stop-loss insurance as a financial risk management tool to protect against excess or unexpected catastrophic health plan claims losses that arise above projected costs paid out of company assets.

(3) Stop-loss coverage insures the employer sponsoring the health benefit plan against unforeseen health plan claims, does not insure the employee health benefit plan itself, and does not pay health care providers for medical services provided to the employees.

(4) Employer-sponsored health benefit plans are regulated under the Employee Retirement Income Security Act of 1974, however, States regulate the availability and the coverage terms of stop-loss insurance coverage that employers purchase to protect company assets and to protect a fund against excess or unexpected claims losses.

(5) Both large and small employers that choose to self-fund must also be able to protect company assets or a fund against excess or unexpected claims losses and States must reasonably regulate stop-loss insurance to assure its availability to both large and small employers.

SEC. 2023. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following sentence: ''Such term shall not include a stop-loss policy obtained by a self-insured group health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for

losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.''.

SEC. 2024. EFFECT ON OTHER LAWS.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following:

''(10) The provisions of this title (including part 7 relating to group health plans) shall preempt State laws insofar as they may now or hereafter prevent an employee benefit plan that is a group health plan from insuring against the risk of excess or unexpected health plan claims losses.''.

Subtitle D—Small Business Flexibility Act

SEC. 2031. SHORT TITLE.

This Act may be cited as the ''Small Business Flexibility Act''.

SEC. 2032. NOTIFICATION OF FLEXIBLE HEALTH INSURANCE BENEFITS.

(a) IN GENERAL.—Subchapter C of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9835. NOTIFICATION OF FLEXIBLE HEALTH INSURANCE BENEFITS.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary shall notify employers of the availability of tax-advantaged flexible health insurance benefits, with an initial focus on small businesses, particularly in rural areas (as defined in section 1393(a)(2)).

"(b) DEFINITIONS.—In this section:

"(1) EMPLOYER.—The term 'employer' has the meaning given such term in section 3(5) of the Employee Retirement Income Security Act (29 U.S.C. 1002(5)).

"(2) FLEXIBLE HEALTH INSURANCE BENEFITS.—The term 'flexible health insurance benefits' means—

"(A) an individual contribution health reimbursement arrangement (as described in the rule entitled 'Health Reimbursement Arrangements and Other Account-Based Group Health Plans' (84 Fed. Reg. 28888 (June 20, 2019)));

"(B) a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)); and

"(C) the small employer health insurance credit determined under section 45R.".

(b) CLERICAL AMENDMENT.—The table of sections for subchapter C of chapter 100 of such Code is amended by adding at the end the following new item:

''Sec. 9835. Notification of flexible health insurance benefits''.

Subtitle E—Health Coverage Choice Act

SEC. 2041. SHORT TITLE.

This Act may be cited as the ''Health Coverage Choice Act''.

SEC. 2042. DEFINITION OF SHORT-TERM LIMITED DURATION INSURANCE.

Section 2791(b) of the Public Health Service Act (42 U.S.C. 300gg–91(b)) is amended by adding at the end the following new paragraph:

''(6) SHORT-TERM LIMITED DURATION INSURANCE.—The term 'short-term limited duration insurance' means health insurance coverage provided under a contract with a health insurance issuer that—

''(A) has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract; and

''(B) has a duration of not more than 10 years (taking into account renewals or extensions) after the original effective date of the contract.''.

Subtitle F—IMPACT Act of 2025

SEC. 2051. SHORT TITLE.

This Act may be cited as the ''Improved Medical Patients Affordable Care Today Act of 2025'' or the ''IMPACT Act of 2025.''

SEC. 2052. EXPANDING ELIGIBILITY FOR CATASTROPHIC PLANS.

(a) IN GENERAL.—Section 1302(e)(2) of the Patient Protection and Affordable Care Act (42. U.S.C. 18022(e)(2) is amended—

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

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

''(C) with respect to the plan year involved, is determined to be ineligible (or reasonably expects to be ineligible) for the premium tax credit under section 36B of the Internal Revenue Code of 1986 or for reduced cost-sharing under section 1402 on the basis of the individual's household income for such year.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2026.

Subtitle G—New Health Options Act

SEC. 2061. SHORT TITLE.

This Act may be cited as the ''New Health Options Act''.

SEC. 2062. CREATION OF A REINSURANCE PROGRAM FOR A NEW HEALTH INSURANCE RISK POOL.

(a) IN GENERAL.—Part V of subtitle B of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18061 et seq.) is amended by adding at the end the following new section:

''SEC. 1344. REINSURANCE PROGRAM FOR CERTAIN OFF-EXCHANGE PLANS.

''(a) IN GENERAL.—There is established a Reinsurance Program, to be administered by the Secretary of Health and Human Services, to provide payments to health insurance issuers with respect to claims for eligible individuals for the purpose of lowering premiums for such individuals.

''(b) FUNDING.—

''(1) APPROPRIATION.—For the purpose of providing funding for the Reinsurance Program, for each year during the period beginning on January 1, 2026, and ending on December 31, 2030, there is appropriated out of any monies in the Treasury not

otherwise obligated an amount equal to the product of $50 and the aggregate number of member months for all eligible individuals enrolled in a covered plan during such year.

''(2) LIMITATION ON APPROPRIATION.—In no year shall the appropriation for the Reinsurance Program authorized in paragraph (1) exceed $6,000,000,000.

''(3) USE OF UNEXPENDED FUNDS.—Appropriated amounts remaining unexpended at the end of any year may be used to make payments under the Reinsurance Program in any future year.

''(4) LIMITATION ON USE OF FUNDS.—No funds received under the Reinsurance Program may be used to pay for services described in section 1303(b)(1)(B)(i) (as in effect on the date of the enactment of this section).

''(c) OPERATION OF PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish parameters for the operation of the Reinsurance Program consistent with this section.

''(2) DEADLINE FOR INITIAL OPERATION.—Not later than 120 days after the date of the enactment, the Secretary shall establish sufficient parameters to specify how the Program will operate for 2026.

''(3) DEFINITIONS.—In this section:

''(A) COVERED PLAN.—The term 'covered plan' means individual health insurance coverage (as such term is defined in section 2791 of the Public Health Service Act)—

''(i) with respect to which the issuer of such coverage has made the election described in section 1312(c)(1)(A); and

''(ii) that does not provide coverage for services described in section 1303(b)(1)(B)(i) (as in effect on the date of the enactment of this section).

''(B) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual enrolled in a covered plan.

''(d) ATTACHMENT DOLLAR AMOUNT AND PAYMENT PROPORTION.—

''(1) IN GENERAL.—The Secretary shall annually establish an attachment point, payment proportion, and reinsurance cap with respect to claims for eligible individuals for payments under the Reinsurance Program, consistent with the following:

''(A) The attachment point for the period beginning January 1, 2026, and ending December 31, 2026, shall be $110,000.

''(B) The payment proportion for the period beginning January 1, 2026, and ending December 31, 2026, shall be 90 percent.

''(C) The reinsurance cap for the period beginning January 1, 2026 and ending December 31, 2026, shall be $300,000.

''(2) ADJUSTMENT AUTHORITY.—The Secretary may adjust any amounts described in paragraph (1) as necessary to ensure the Reinsurance Program does not make payment for a year in excess of the amount available for such year under subsection (b).''.

(b) ELECTION TO OPT OUT OF SINGLE RISK POOL.—

(1) IN GENERAL.—Section 1312(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)(1)) is amended—

(A) by striking ''A health insurance issuer'' and inserting the following:

''(A) IN GENERAL.—A health insurance issuer'';

(B) in subparagraph (A), as inserted by paragraph (1), by inserting ''and other than any health plan with respect to which such

issuer has elected for this subparagraph not to apply'' after ''grandfathered health plans''; and

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

''(B) TREATMENT OF PLANS OPTING OUT OF SINGLE RISK POOL.—A health insurance issuer shall consider all enrollees in all health plans offered by such issuer in the individual market with respect to which such issuer has made the election described in subparagraph (A) to be members of a single risk pool.''.

(2) PROHIBITING SINGLE RISK POOL OPT OUT FOR QUALIFIED HEALTH PLANS.—Section 1301(a)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(1)) is amended—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(v) has not made the election described in section 1312(c)(1)(A) with respect to such plan.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after January 1, 2026.

(c) REMOVING AGE PREMIUM VARIATION LIMITATION FOR CERTAIN PLANS.—

(1) IN GENERAL.—

(A) REMOVAL OF LIMITATION FOR CERTAIN PLANS.—Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C 300gg(a)(1)(A)(iii)) is amended by inserting ''or, in the case of such coverage with respect to which the issuer of such coverage has made the election described in section 1312(c)(1)(A) of the Patient Protection and Affordable Care Act, by more than an actuarially justified amount for adults'' before ''; and''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply with respect to plan years beginning on or after January 1, 2026.

(2) MAINTAINING AGE PREMIUM VARIATION LIMITATION FOR QUALIFIED HEALTH PLANS.—Section 1301(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(1)), as amended by subsection (b), is further amended—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C)(v), by striking the period and inserting ''; and''; and

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

''(D) with respect to the premium rate charged by such plan, if such plan varies such rate by age, does not vary such rate by more than 3 to 1 for adults (consistent with section 2707(c) of the Public Health Service Act).''.

(d) TREATMENT OF OPT OUT PLANS IN RELATION TO INDIVIDUAL HEALTH COVERAGE REIMBURSEMENT ARRANGEMENTS.—The Secretaries of Health and Human Services, Labor, and the Treasury shall not fail to treat any individual health insurance coverage (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) as eligible for integration with an individual health care reimbursement arrangement on the basis that the health insurance issuer (as so defined) of such coverage has made the election described in section 1312(c)(1)(A) of the Patient Protection and Affordable Care Act (as inserted by subsection (b)).

SEC. 2062. PROMOTION OF HIGH-VALUE CARE.

(a) IN GENERAL.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following new section:

"SEC. 2730. APPLICATION OF CERTAIN OUT-OF-NETWORK COSTS TO DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS.

"(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, in the case that an individual enrolled under such plan or coverage is furnished items or services by a health care provider or health care facility that does not have in effect a contractual relationship with such plan or issuer for the furnishing of such items or services and such individual incurs any out-of-pockets costs with respect to such items and services, at the option of such individual, apply such costs to any deductible or out-of-pocket maximum applicable to items and services furnished by health care providers or health care facilities with contracts in effect with such plan or issuer for the furnishing of such items or services, but only if the following requirements are met:

"(1) The item or service furnished by such provider or facility without a contract in effect with

such plan or issuer is an item or service for which benefits are available under such plan or coverage.

''(2) The amount charged by such provider or facility for such item or service is equal to or less than—

''(A) the lowest amount recognized by the plan or coverage as payment for such item or service out of all health care providers and health care facilities with a contract in effect with such plan or issuer to furnish such item or service in the same rating area (as defined for purposes of section 2701) in which the item or service described in paragraph (1) was furnished; or

''(B) the 25th percentile of charges for such item or service furnished in the same State in which the item or service described in paragraph (1) was furnished.

''(b) DISCLOSURE OF INFORMATION.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, with respect to each item or service for which benefits are available under such plan or coverage, make available the lowest amount described in subsection (a)(2)(A) and the 25th

percentile described in subsection (a)(2)(B) to all individuals enrolled under such plan or coverage.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2026.

SEC. 2064. DISCLOSURE OF LOWER PRICES.

Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–131) is amended by adding at the end the following new section:

''SEC. 2799B–10. DISCLOSURE OF LOWER PRICES.

''(a) IN GENERAL.—Beginning January 1, 2026, each health care provider and health care facility shall disclose to patients and prospective patients enrolled in a group health plan, group or individual health insurance coverage, or a Federal health care program (as defined in section 1128B but including the program established under chapter 89 of title 5, United States Code) being furnished or seeking to be furnished an item or service by such provider or facility for which benefits are available under such plan, coverage, or program, as applicable, whether the amount of cost sharing (including deductibles, copayments, and coinsurance) that would be incurred by such individual for such item or service under such plan, coverage, or program, as applicable, exceeds the charge that would apply for such item or service for an individual

without benefits under any such plan, coverage, or program for such item or service.

''(b) ADDITIONAL ENFORCEMENT.—In addition to any other penalty applicable with respect to a violation of subsection (a), an individual who is harmed by a violation of this section by a health care provider or health care facility may bring an action against such provider or facility in an appropriate district court of the United States for—

''(1) appropriate injunctive relief; and

''(2) damages in an amount that is equal to the amount provided for such harm in a civil action under the law of the State in which the provider or facility is located.''.

Subtitle H—Fighting Waste Fraud and Abuse in the Unaffordable Care Act

SEC. 2071. SHORT TITLE.

This Act may be cited as the ''Fighting Waste Fraud and Abuse in the Unaffordable Care Exchanges Act of 2025''.

SEC. 2072. 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, 2027, as determined by the Secretary; and

''(II) for enrollment for plan years beginning on or after January 1, 2027, beginning on November 1, and ending on December 15 of the preceding calendar year;''.

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

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

''(B) PROHIBITED SPECIAL ENROLLMENT PERIOD.—With respect to plans 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.'';

(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 enrollment 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.—With respect to enrollment for plan years beginning on or after January 1, 2027, an Exchange shall verify that each individual seeking to enroll in a qualified health plan offered by the Exchange during a special enrollment period selected under paragraph (B) is eligible to enroll during such special enrollment period prior to enrolling such individual in such plan.

''(B) SELECTED SPECIAL ENROLLMENT PERIODS.—For purposes of subparagraph (A), an Exchange shall select one or more special enrollment periods for a plan year with respect to which such Exchange shall conduct the verification required under subparagraph (A) such that the Exchange conducts such verification for not less than 75 percent of all individuals enrolling in a qualified health plan offered by the Exchange during any special enrollment period with respect to such plan year.''.

(b) VERIFYING INCOME FOR INDIVIDUALS ENROLLED 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 individual 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.—Subject to clause (iii), 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.

''(iii) EXCLUSION OF CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID.—The subparagraph shall not apply in the case of an applicant who is an alien lawfully present in the United States, who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status.''.

(2) REQUIRING INDIVIDUALS ON WHOSE BEHALF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT 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 issuers 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 section 6011 and 6012 of such code (and implementing regulations), for the relevant prior tax year; or

"(ii) as necessarily, has not been 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 requirement 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.—The Secretary of Health and Human Services shall revise section 155.315(f) of title 45, Code of Federal Regulations, to remove paragraph (7) of such section, such that, with respect to enrollment for plan years beginning on or after January 1, 2027, in the case that an Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.) provides an individual applying for enrollment in a qualified health plan with a 90-day period to resolve an inconsistency in the application of such individual pursuant to section 1411(e)(4)(A)(ii)(II) of such Act, the Exchange may not provide for an automatic extension to such 90-day period on the basis that such individual is re-

quired to present satisfactory documentary evidence to verify household income.

(c) REVISING RULES OF 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 sections 156.29(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 described 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 plans years beginning on or after January 1, 2027, the term ''de minimum 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, the premium adjustment percentage under this paragraph for such calendar year shall be determined consistent with the methodology published in the Federal Register on April 25, 2019 (84 Fed. Reg. 17537 through 17541).''.

(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-base premium payment threshold policy described in paragraph (2) of such section and the fixed-dollar pre-

mium 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.—The Secretary of Health and Human Services shall revise section 155.335(j) of title 45, Code of Federal Regulations, to remove paragraph (4) of such section that, with respect to reenrollments 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(j) of title 45, Code of Federal Regulations, as in effect on the day before the date of the enactment of this section.

(g) REDUCING ADVANCE PAYMENTS OF PREMIUM TAX CREDITS FOR CERTAIN INDIVIDUALS REENROLLED IN EXCHANGES.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended—

(1) in subsection (a)(3), by inserting ", subject to subsection (c)(2)(C)," after "qualified health plans"; and

(2) in subsection (c)(2)—

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

(B) by adding at the end the following subparagraph:

''(C) REDUCTION IN ADVANCE PAYMENT FOR SPECIFIED REENROLLED INDIVIDUALS.—

''(i) IN GENERAL.—The amount of an advance payment made under subparagraph (A) to reduce the premium payable for a qualified health plan that provides coverage to a specific reenrolled individual for an applicable month shall be an amount equal to the amount that would otherwise be made under such subparagraph reduced by $5 (or such higher amount as the Secretary determines appropriate).

''(ii) DEFINITIONS.—In this subparagraph:

''(I) APPLICABLE MONTH.—The term 'applicable month' means, with respect to a specified reenrolled individual, any month during a plan year

beginning on or after January 1, 2027 (or, in the case of an individual reenrolled in a qualified health plan by an Exchange established pursuant to section 1321(c), January 1, 2027) if, prior to the first day of such month, such individual has failed to confirm or update such information as is necessary to redetermine the eligibility of such individual for such plan year pursuant to section 1411(f).

''(II) SPECIFIED REENROLLED INDIVIDUAL.—The term 'specified reenrolled individual' means an individual who is reenrolled in a qualified health plan and with respect to whom the advance payment made under subparagraph (A) would, without application of any reduction under this subparagraph, reduce the premium payable for a qualified health plan that provides coverage to such an individual to $0.''.

(h) PROHIBITING COVERAGE OF GENDER TRANSITION PROCEDURES AS AN ESSENTIAL HEALTH BENEFIT UNDER PLANS OFFERED BY EXCHANGES.—

(1) IN GENERAL.—Section 1302(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)(2)) is amended by adding at the end the following new subparagraph:

"(C) GENDER TRANSITION PROCEDURES.—For plan years beginning on or after January 1, 2027, the essential health benefits defined pursuant to paragraph (1) may not include items and services furnished for a gender transition procedure.".

(2) GENDER TRANSITION PROCEDURE DEFINED.—Section 1304 of the Patient Protection and Affordable Care Act (42 U.S.C. 18024) is amended by adding at the end the following new subsection:

"(f) GENDER TRANSITION PROCEDURE.—

"(1) IN GENERAL.—In this title, except as provided in paragraph (2), the term 'gender transition procedure' means, with respect to an individual, any of the following when performed for this purpose of intentionally changing the body of such individual (including by disrupting the body's development, inhibiting its natural functions, or modifying its ap-

pearance) to no longer correspond to the individuals sex:

"(A) Performing any surgery, including—

"(i) castration;

"(ii) sterilization;

"(iii) orchiectomy;

"(iv) scrotoplasty;

"(v) vasectomy;

"(vi) tubal ligation;

"(vii) hysterectomy;

"(viii) oophorectomy;

"(ix) ovariectomy;

"(x) metoidioplasty;

"(xi) clitoroplasty;

"(xii) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

"(xiii) penectomy;

"(xiv) phalloplasty;

"(xv) vaginoplasty;

"(xvi) vaginectomy;

"(xvii) vulvoplasty;

"(xviii) reduction thyrochondroplasty;

"(xix) chrondrolaryngoplasty;

"(xx) mastectomy; and

"(xxi) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other body features of an individual.

"(B) Any placement of chest implants to create feminine breasts or any placement of erection or testicular prostheses.

"(C) Any placement of fat or artificial implants in the gluteal region.

"(D) Administering, prescribing, or dispensing to an individual medications, including—

"(i) gonadotropin-releasing hormone (GnRH) analogues or other puberty-blocking drugs to stop or delay normal puberty; and

"(ii) testosterone, estrogen, or other androgens to an individual at doses that are superphysiologic than would normally be produced endogenously in a health individual of the same age and sex.

"(2) EXCEPTION.—Paragraph (1) shall not apply to the following:

"(A) Puberty suppression or blocking prescription drugs for the purpose of normalizing

puberty for an individual experiencing precocious puberty.

''(B) Medically necessary procedures or treatments to correct for—

''(i) a medically verifiable disorder of sex development, including—

''(I) 46, XX chromosomes with virilization;

''(II) 46, XY chromosomes with undervirilization; and

''(III) both ovarian and testicular tissue;

''(ii) sex chromosome structure, sex steroid hormone production, or sex hormone action, if determined to be abnormal by a physician through genetic or biochemical testing;

''(iii) infection, disease, injury, or disorder caused or exacerbated by a previous procedure described in paragraph (1), or a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function unless the procedure is per-

formed, not including procedures performed for the alleviation of mental distress; or

"(iv) procedures to restore or reconstruct the body of the individual in order to correspond to the individual's sex after one or more previous procedures described in paragraph (1), which may include the removal of a pseudo phallus or breast augmentation.

"(3) SEX.—For purposes of this subsection, the term 'sex' means either male or female, as biologically determined and defined by subparagraph (A) and subparagraph (B).

"(A) FEMALE.—The term 'female' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive systems that at some point produces, transports, and utilizes eggs for fertilization.

"(B) MALE.—The term 'male' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive

system that at some point produces, transports, and utilizes sperm for fertilization.''.

(i) ENSURING APPROPRIATE APPLICATION OF GUARANTEED ISSUE REQUIREMENTS IN CASE OF NON-PAYMENT OF PAST PREMIUMS.—

(1) IN GENERAL.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following new subsection:

''(e) NONPAYMENT OF PAST PREMIUMS.—

''(1) IN GENERAL.—A health insurance issuer offering individual health coverage may, to the extent allowed under State law, deny such coverage in the case of an individual who owes any amount for premiums for individual health insurance coverage offered by such issuer (or by a health insurance issuer in the same controlled group (as defined in paragraph (3)) as such issuer) in which such individual was previously enrolled.

''(2) ATTRIBUTION OF INITIAL PREMIUM PAYMENT OWED AMOUNT.—A health insurance issued offering individual health insurance coverage may, in the case of an individual described in paragraph (1) and to the extent allowed under State law, attribute the initial premium payment for such coverage applicable to such individual to the amount owed by such

individual for premiums for individual health insurance coverage offered by such issuer (or by a health insurance issuer in the same controlled group as the issuer) in which such individual was previously enrolled.

''(3) CONTROLLED GROUP DEFINED.—For purposes of this subsection, the term 'controlled group' means a group of two or more persons that is treated as a single employed under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to plan years beginning on or after January 1, 2027.

SEC. 2073. FUNDING COST-SHARING REDUCTION PAYMENTS.

Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

''(h) FUNDING.—

''(1) IN GENERAL.—There are appropriated out of any monies in the Treasury not otherwise appropriated such sums as may be necessary for purposes of making payments under this section for plan years beginning on or after January 1, 2027.

''(2) LIMITATION.—

''(A) IN GENERAL.—The amounts appropriated under paragraph (1) may not be used for purposes of making payments under this section for a qualified health plan that provides health benefit coverage that includes coverage of abortion.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to payments for a qualified health plan that provides coverage of abortion only if necessary to save the life of the mother or if the pregnancy is a result of an act of rape or incest.''.

TITLE III—ENDING TAXPAYER FUNDING FOR ABORTION AND GENDER TRANSITION PROCEDURES

Subtitle A—No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2025

SEC. 3000. APPLICABILITY TO ENTIRE ACT.

(a) Notwithstanding any other provision of law, the prohibitions and limitations set forth in this title, including the amendments made by this title, shall apply to all

funds authorized or appropriated under this Act, including under title I, title II, and every subtitle thereof, and to any trust fund to which such funds are contributed.

(b) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act.

SEC. 3001. SHORT TITLE.

This Act may be cited as the ''No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2025''.

SEC. 3002. PROHIBITING TAXPAYER FUNDED ABORTIONS.

Title 1, United States Code, is amended by adding at the end the following new chapter:

''CHAPTER 4—PROHIBITING TAXPAYER FUNDED ABORTIONS

''§ 301. Prohibition on funding for abortions

''No funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal law, shall be expended for any abortion.

''§ 302. Prohibition on funding for health benefits plans that cover abortion

''None of the funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal

law, shall be expended for health benefits coverage that includes coverage of abortion.

"§ 303. Limitation on federal facilities and employees

''No health care service furnished—

''(1) by or in a health care facility owned or operated by the Federal Government; or

''(2) by any physician or other individual employed by the Federal Government to provide health care services within the scope of the physician's or individual's employment, may include abortion.

"§ 304. Construction relating to separate coverage

''Nothing in this chapter shall be construed as prohibiting any individual, entity, or State or locality from purchasing separate abortion coverage or health benefits coverage that includes abortion so long as such coverage is paid for entirely using only funds not authorized or appropriated by Federal law and such coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"§ 305. Construction relating to the use of non-federal funds for health coverage

''Nothing in this chapter shall be construed as restricting the ability of any non-Federal health benefits coverage provider from offering abortion coverage, or the abil-

ity of a State or locality to contract separately with such a provider for such coverage, so long as only funds not authorized or appropriated by Federal law are used and such coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"§ 306. Non-preemption of other federal laws

''Nothing in this chapter shall repeal, amend, or have any effect on any other Federal law to the extent such law imposes any limitation on the use of funds for abortion or for health benefits coverage that includes coverage of abortion, beyond the limitations set forth in this chapter.

"§ 307. Construction relating to complications arising from abortion

''Nothing in this chapter shall be construed to apply to the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion. This rule of construction shall be applicable without regard to whether the abortion was performed in accord with Federal or State law, and without regard to whether funding for the abortion is permissible under section 308.

"§ 308. Treatment of abortions related to rape, incest, or preserving the life of the mother

''The limitations established in sections 301, 302, and 303 shall not apply to an abortion—

''(1) if the pregnancy is the result of an act of rape or incest; or

''(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

"§ 309. Application to district of columbia

''In this chapter:

''(1) Any reference to funds appropriated by Federal law shall be treated as including any amounts within the budget of the District of Columbia that have been approved by an Act of Congress pursuant to section 446 of the District of Columbia Home Rule Act (or any applicable successor Federal law).

''(2) The term 'Federal Government' includes the Government of the District of Columbia.''.

SEC. 3003. AMENDMENT TO TABLE OF CHAPTERS.

The table of chapters for title 1, United States Code, is amended by adding at the end the following new item:

"4 Prohibiting taxpayer funded abortions ..... 301".

SEC. 3004. CLARIFYING APPLICATION OF PROHIBITION TO PREMIUM CREDITS AND COST-SHARING REDUCTIONS UNDER ACA.

(a) IN GENERAL.—

(1) DISALLOWANCE OF REFUNDABLE CREDIT AND COST-SHARING REDUCTIONS FOR COVERAGE UNDER QUALIFIED HEALTH PLAN WHICH PROVIDES COVERAGE FOR ABORTION.—

(A) IN GENERAL.—Subparagraph (A) of section 36B(c)(3) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: "or any health plan that includes coverage for abortions (other than any abortion or treatment described in section 307 or 308 of title 1, United States Code)".

(B) OPTION TO PURCHASE OR OFFER SEPARATE COVERAGE OR PLAN.—Paragraph (3) of section 36B(c) of such Code is amended by adding at the end the following new subparagraph:

"(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

"(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

"(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).".

(2) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(A) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term''; and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—

''(A) IN GENERAL.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion or treatment described in section 307 or 308 of title 1, United States Code).

''(B) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

''(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any employer from purchasing for its employees separate coverage for abortions described in such subparagraph, or a health

plan that includes such abortions, so long as no credit is allowed under this section with respect to the employer contributions for such coverage or plan.

''(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as such separate coverage or plan is not paid for with any employer contribution eligible for the credit allowed under this section.''.

(3) CONFORMING ACA AMENDMENTS.—Section 1303(b) of Public Law 111–148 (42 U.S.C. 18023(b)) is amended—

(A) by striking paragraph (2);

(B) by striking paragraph (3), as amended by section 202(a); and

(C) by redesignating paragraph (4) as paragraph (2).

(b) APPLICATION TO MULTI-STATE PLANS.—Paragraph (6) of section 1334(a) of Public Law 111–148 (42 U.S.C. 18054(a)) is amended to read as follows:

''(6) COVERAGE CONSISTENT WITH FEDERAL ABORTION POLICY.—In entering into contracts under this subsection, the Director shall ensure that no multi-State qualified health plan offered in an Exchange provides health benefits coverage for which the expenditure of Federal funds is prohibited under chapter 4 of title 1, United States Code.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxable years ending after December 31, 2025, but only with respect to plan years beginning after such date, and the amendment made by subsection (b) shall apply to plan years beginning after such date.

SEC. 3005. REVISION TO NOTICE REQUIREMENTS REGARDING DISCLOSURE OF EXTENT OF HEALTH PLAN COVERAGE OF ABORTION AND ABORTION PREMIUM SURCHARGES.

(a) IN GENERAL.—Paragraph (3) of section 1303(b) of Public Law 111–148 (42 U.S.C. 18023(b)) is amended to read as follows:

''(3) RULES RELATING TO NOTICE.—

''(A) IN GENERAL.—The extent of coverage (if any) of services described in paragraph (1)(B)(i) or (1)(B)(ii) by a qualified health plan shall be disclosed to enrollees at the

time of enrollment in the plan and shall be prominently displayed in any marketing or advertising materials, comparison tools, or summary of benefits and coverage explanation made available with respect to such plan by the issuer of the plan, by an Exchange, or by the Secretary, including information made available through an internet portal or Exchange under sections 1311(c)(5) and 1311(d)(4)(C).

''(B) SEPARATE DISCLOSURE OF ABORTION SURCHARGES.—In the case of a qualified health plan that includes the services described in paragraph (1)(B)(i) and where the premium for the plan is disclosed, including in any marketing or advertising materials or any other information referred to in subparagraph (A), the surcharge described in paragraph (2)(B)(i)(II) that is attributable to such services shall also be disclosed and identified separately.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to materials, tools, or other information made available more than 30 days after the date of the enactment of this Act.

Subtitle B—Prohibiting Federal Funding for Gender Transition Procedures

SEC. 3006. SHORT TITLE.

This Act may be cited as the ''End Taxpayer Funding of Gender Experimentation Act of 2025''

SEC. 3007. PROHIBITING FEDERAL FUNDING FOR GENDER TRANSITION PROCEDURES.

(a) DEFINITION.—In this section, the term ''Specified sex-trait modification procedure'' means any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by:

(1) Intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or

(2) Intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

(3) This term does not include procedures undertaken:

(A) To treat a person with a medically verifiable disorder of sexual development; or

(B) For purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

(b) GENERAL PROHIBITION.—Notwithstanding any other provision of law, no Federal funds (including funds provided through grants, contracts, insurance, or any other means) may be used to pay for, reimburse, or otherwise support any specified sex-trait modification procedure.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to payments, reimbursements, and services provided on or after such date.

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