Petition for Rulemaking under 5 U.S.C. § 553(e)

Submitted to: The Honorable Robert F. Kennedy Jr., Secretary of Health and Human Services, and The Honorable **Dr. Mehmet Oz**, Administrator, Centers for Medicare & Medicaid Services (CMS)
Submitted by: Lee Benham (Petitioner)
Date: June 10, 2025

Introduction and Summary of Petition

Pursuant to the Administrative Procedure Act (APA), 5 U.S.C. § 553(e), Petitioner Lee Benham hereby submits this rulemaking petition to the U.S. Department of Health and Human Services (HHS), Office of the Secretary, and the Centers for Medicare & Medicaid Services (CMS). The Petitioner requests that HHS/CMS exercise their rulemaking and administrative authority to **revise and expand the regulatory interpretation of 26 U.S.C. § 36B (Affordable Care Act premium tax credits)** and related provisions. Specifically, the Petitioner asks the agency to initiate rulemaking or issue interpretive guidance to accomplish the following:

1. **Expand Eligible Health Plans for Premium Tax Credits:** Clarify by regulation that premium tax credits under 26 U.S.C. § 36B are not limited to Qualified Health Plans (QHPs) offered on the ACA Exchanges, but may be applied toward *any* lawful, state-regulated individual health insurance plan that meets basic risk-spreading and consumer disclosure standards. This would include plans such as short-term limited-duration insurance, direct primary care (DPC) arrangements paired with catastrophic coverage, fixed indemnity plans, medical cost-sharing plans, and Medical Savings Account (MSA) or Health Savings Account (HSA)-qualified plans, **so long as the plan is authorized for sale under state law and provides basic insurance functionality**. In essence, if a health plan is *legal and regulated* in a state, consumers should be permitted to use their ACA premium tax credit toward its premiums, even if the plan is not an ACA-certified QHP.
2. **Implement an Age-Based, Flat Tax Credit Structure:** Establish through regulations (or via approved state waivers/demonstrations) an alternative **age-adjusted flat tax credit** for health insurance, as a means of delivering ACA financial assistance in a simpler, consumer-driven manner. Under this approach, each American under Medicare-eligible age would be entitled to a fixed annual health insurance credit based on age – for example, **$3,000 per year for individuals under age 30, increasing by $100 for each year of age** (approximately $3,500 at age 35, $5,500 at 55, up to about $6,400 by the early 60s). This flat credit would replace (or be offered as a voluntary alternative to) the current income-based and location-based ACA premium credit formula. It would be **uniform for everyone in the age band regardless of income or employment** status, providing a portable, predictable contribution that the individual can use to obtain coverage of their choice. The Petitioner proposes that HHS/CMS use its authority to either (a) issue regulations creating such a credit structure under existing law (in coordination with the Department of the Treasury as needed), or (b) invite and approve

state innovation waivers under ACA § 1332, or other demonstration projects, to pilot this age-based credit model. The goal is to demonstrate that an age-based credit system is a legally permissible and effective method to deliver health insurance subsidies, consistent with the ACA's goals of expanding coverage and affordability.

3. **Allow Tax Credit Savings to Be Deposited into HSAs:** Modify the administration of premium tax credits so that if an individual elects to purchase a lower-cost health plan (one that has premiums below the flat credit amount), the **unused portion of the tax credit is refunded or deposited into the individual's HSA** (or a similar tax-advantaged medical savings account) for future medical expenses. In other words, consumers who choose cost-effective coverage would get to keep the leftover credit as savings, rather than losing that benefit. This concept – effectively a partial refund of the credit – was proposed as part of the previous Administration's 2025 health care reform framework and enjoys policy support as a means to encourage price-conscious shopping. For example, if a 28-year-old receives a $3,000 credit but buys a catastrophic insurance plan for $2,000, the remaining $1,000 credit would be sent to the individual's HSA as a refundable benefit. HHS/CMS should establish the necessary guidance and payment mechanisms (in coordination with Treasury/IRS) to facilitate these HSA deposits. Notably, any such **excess-credit HSA contributions should be excluded from the annual HSA contribution cap** so that individuals are not penalized for choosing a frugal plan. This reform mirrors the *"partial credit refund"* policy endorsed in prior reform proposals, allowing Americans to personally benefit from choosing lower-cost coverage rather than "use or lose" their entire subsidy.

In summary, the Petitioner seeks a transformative yet administratively feasible reinterpretation of ACA subsidy rules: one that **unlocks consumer choice**, **simplifies the credit structure**, and **rewards efficiency**. By expanding the universe of plans eligible for subsidies and by implementing flat, age-based credits (with HSA refunds of unspent funds), HHS and CMS can greatly increase health insurance affordability and flexibility for millions of Americans – all **without new legislation**, but rather by using the agency's existing statutory authorities and discretion in administering the ACA. The attached supporting materials, including Petitioner's own book and a draft reconciliation bill, provide further context and evidence that these proposals are practical, budget-neutral adjustments designed to improve the ACA's functioning. The Petitioner urges HHS/CMS to give these proposals serious consideration through the formal rulemaking process.

Petitioner's Interest and Background

Petitioner Lee Benham files this petition as an **interested person** under the APA. Mr. Benham is a seasoned insurance professional and health policy author with over thirty years of experience in the industry. He has helped individuals, families, and businesses navigate the complexities of health insurance and has been directly involved in innovative healthcare solutions, such as the first Medicare Medical Savings Account (MSA) plan in the United States. He is the author of *The Benefit That Broke You* (also known informally as the "TrumpCare" book), which **details the flaws of the current employer-based and ACA insurance system and outlines a blueprint for reform using portable, age-based tax credits and HSAs**. The Petitioner's extensive expertise informs this petition: he has witnessed firsthand how the current subsidy and

insurance regulations fail to serve many consumers, and he has developed detailed proposals to empower individuals with greater choice and ownership of their healthcare.

The Petitioner's book (submitted herewith as supporting material) documents how a **voluntary, age-based credit system with HSAs can reduce costs and increase personal freedom**. As a private citizen, taxpayer, and advocate for healthcare consumers, Mr. Benham has a direct interest in the proper interpretation of ACA provisions and the improvement of the health insurance marketplace through administrative action. He submits this petition on his own behalf to urge HHS and CMS to use their regulatory powers to implement much-needed changes that he believes are consistent with the law and beneficial to the public.

Legal Basis for Agency Authority

HHS and CMS (in coordination with the Department of the Treasury/IRS) have **ample legal authority and discretion** under the ACA and related statutes to grant the requested relief. The following statutory and regulatory provisions provide the foundation for the agency's ability to act:

- **Administrative Procedure Act (APA), 5 U.S.C. § 553** – Empowers agencies to make, amend, or repeal rules, and grants *interested persons the right to petition* for the issuance of rules. This petition is submitted under that provision (§ 553(e)). HHS is therefore obligated to consider and respond to the petition, and may initiate rulemaking if it finds merit in the proposals.
- **ACA Exchange and QHP Authority (42 U.S.C. § 18031 et seq. & 42 U.S.C. § 18041)** – The ACA gives the Secretary of HHS broad authority to issue regulations and guidance for the operation of the health insurance Exchanges and the definition of qualified health plans. While 26 U.S.C. § 36B (which is part of the Internal Revenue Code) governs eligibility for premium tax credits, HHS/CMS administer vital aspects of how those credits are applied, by certifying plans as QHPs and running the Exchange enrollment process. The ACA's **implementing regulations (45 C.F.R. Parts 155 and 156)** were issued jointly by HHS and Treasury to coordinate the tax credits with exchange plans. HHS has flexibility to redefine or expand, via regulation or guidance, what types of plans can be deemed eligible for subsidies **consistent with statutory requirements**. The Petitioner asserts that HHS can, for example, **revisit the definition of "qualified health plan" for subsidy purposes** or create new categories of plans that meet "basic standards" short of full ACA compliance, thereby extending credits to such plans. The attached draft legislation explicitly defines *"qualified health plan"* in the expanded sense as *"any health insurance coverage (including but not limited to major medical, catastrophic, short-term, indemnity, etc.) authorized to be offered under state law, whether or not it meets the requirements of ACA §1301"*. HHS could adopt a similar expansive interpretation by regulation, using its Exchange oversight authority to approve **state-regulated alternatives** as eligible for credit support.
- **Internal Revenue Code § 36B and Implementing Regulations (26 C.F.R. § 1.36B-2 et seq.)** – Section 36B currently ties premium tax credit eligibility to enrollment in a plan that is a QHP "through an Exchange." However, the agencies (Treasury and HHS) have shown they can interpret and implement § 36B in a manner that **extends credits to**

broader groups when justified. A compelling precedent is the **2022 rulemaking that fixed the "family glitch."** In that case, Treasury and HHS reinterpreted § 36B's affordability test to allow millions of dependents of employees to qualify for credits, contrary to the prior, narrower reading of the statute. The final rule **amended 26 C.F.R. § 1.36B-2** to provide that an employer plan's affordability for family members is determined based on the cost of family coverage, not self-only coverage – thus making dependents newly eligible for subsidiesfederalregister.gov. The agencies justified this change as *"the better reading of the relevant statutes"* and consistent with Congress's purpose *"to expand access to affordable health care"*federalregister.gov. This demonstrates HHS and Treasury's willingness to use **discretionary interpretive authority** to expand subsidy availability under § 36B in service of the ACA's goals. **Likewise, HHS and CMS can and should work with Treasury to adjust current interpretations** that limit credits only to Exchange QHPs. By regulatory action, the definition of an "Exchange" could be broadened or alternate distribution channels could be recognized (for example, allowing subsidies through off-Exchange enrollment or direct enrollment with insurers for qualifying plans). The ACA's text does not unambiguously forbid aiding coverage outside the official Exchanges, especially if done via **waiver or demonstration authority** as discussed below. The Petitioner contends that HHS has a mandate to ensure the ACA's affordability provisions are implemented in a *flexible, consumer-friendly manner*, and that the statute leaves room for administrative innovation in this area.

- **State Innovation Waivers (ACA § 1332, 42 U.S.C. § 18052)** – The ACA provides a mechanism for states to pursue innovative strategies by waiving certain ACA requirements (including those related to QHPs and tax credits), so long as coverage remains as comprehensive and affordable, and the waiver is budget-neutral to the federal government. HHS and the Treasury jointly oversee § 1332 waivers. Notably, a § 1332 waiver *can allow federal premium tax credit funds to be used for non-Exchange plans or alternative subsidy designs* if a state proposes such a system. In 2018, HHS and Treasury released guidance encouraging waiver concepts such as "consumer-directed credits" and account-based subsidies that deviate from the standard ACA frameworkcms.govcms.gov. Several states have already used § 1332 waivers to establish reinsurance programs that alter how federal subsidy dollars flowcms.govcms.gov, and the American Rescue Plan's subsidy enhancements were integrated into these waivers via administrative adjustmentscms.gov. HHS/CMS can build on this by explicitly inviting states to apply for waivers that **provide age-based flat credits and expand eligible plan choices**. The agency could issue a **State Health Official letter or guidance** outlining how a state could meet waiver guardrails while implementing the petition's proposals (e.g., ensuring that the coverage under alternative plans is of adequate value and that the number of insured is comparable or higher). By signaling openness to such waivers, HHS would empower willing states to pioneer the expanded credit model with federal approval. In addition, HHS might explore **demonstration projects** (for example, through the CMS Center for Medicare & Medicaid Innovation or other pilot authority) to test the age-based credit approach on a limited basis, even absent a state-wide waiver. The ACA created the Innovation Center to test payment and service delivery models in Medicare/Medicaid; while its scope is mostly those programs, HHS may seek creative demonstration authority for the individual insurance market as well. Short of a formal demonstration, HHS could

use its **transitional policy powers** (used in the past to allow renewal of non-ACA-compliant plans, etc.) to temporarily allow subsidies for certain non-QHP plans as a trial, pending more permanent rule changes.

- **HHS Secretary's General Rulemaking Authority:** Section 1321(a) of the ACA (42 U.S.C. § 18041) authorizes the Secretary of HHS to issue regulations "as may be necessary to implement the requirements" of Title I of the ACA, which includes the Exchange and subsidy provisions. Moreover, 5 U.S.C. § 301 and the Department's organic statutes vest the Secretary with broad authority to regulate matters within HHS's jurisdiction. The CMS Administrator has delegated authority for the programs under CMS's purview, including the health insurance marketplaces. Using these powers, the Secretary/Administrator can promulgate new rules or guidance documents to effectuate the policy changes requested by this petition, **provided they do not conflict with explicit statutory requirements**. Petitioner asserts that the changes requested – allowing more plan types for credits, creating a uniform age-based credit option, and routing savings to HSAs – can be accomplished in harmony with the ACA, especially if implemented as an *optional* alternative pathway (i.e., offering consumers the choice to opt into the new system or stick with ACA benefits). Indeed, the attached draft "America First Health Care Reform Act of 2026" envisions the age-based credits as a *voluntary parallel system* alongside the ACA's existing structure. HHS could similarly use sub-regulatory guidance to clarify that it will, for example, **not enforce any prohibition** on applying credits outside the Exchange for participating states or carriers during a trial period, or use its discretion in certifying plans to facilitate a broader interpretation of subsidy-eligible coverage.

In sum, the agency has at its disposal a combination of **regulatory rulemaking authority, waiver approval authority, and demonstration/pilot program authority** that can be harnessed to achieve the petition's objectives. There is no statutory bar to HHS/CMS pursuing these reforms administratively. To the contrary, the ACA's goals of increasing coverage and affordability support a **liberal construction** of agency authority here. The Petitioner respectfully submits that HHS's **prior exercises of flexibility** – from adjusting subsidy calculations (e.g., indexing, special enrollment periods for enhanced subsidies) to the family glitch fix and other administrative improvements – establish a strong foundation and precedent for the requested action.

Justification and Policy Rationale

The proposed rulemaking is not only legally permissible, it is sound public policy. The current ACA framework, while expanding coverage, has significant limitations that this petition's proposals would address:

- **Limited Choice and High Costs Under Current Subsidy Rules:** As it stands, premium tax credits can only be used for ACA-compliant QHPs sold on government Exchanges. This has *effectively excluded many affordable insurance options* from the reach of middle-class consumers. For those who are ineligible for ACA subsidies (or even some who are eligible but face high benchmark costs), Exchange plan premiums can be prohibitively expensive – often **thousands of dollars per month** for families and older

individuals. Faced with $20,000–$30,000 annual premiums for comprehensive Exchange plans, many consumers either go uninsured or turn to alternative products (short-term plans, health sharing ministries, etc.) but then **receive no tax relief** to help with those alternatives. This bifurcated system penalizes people who choose plans outside the Exchange by denying them the sizable federal support that is available for Exchange plans. By expanding premium tax credit eligibility to *any* state-approved plan, HHS would **empower consumers to vote with their feet** and pick coverage that best suits their needs, without losing federal assistance. The result would be increased competition and innovation: insurers offering lower-cost or niche products could attract subsidy-using enrollees, likely forcing **downward pressure on premiums across the board**. Consumers would no longer be herded exclusively into one segment of the market (Exchange QHPs) to obtain financial help, but could choose freely among **truly diverse insurance options**. Importantly, HHS can maintain *basic protections* by requiring any subsidized plan to meet "risk transfer" standards (meaning it genuinely insures against health expenses, as opposed to being a sham coverage) and disclosure requirements (clear information on benefits and limits). The attached draft bill demonstrates how such standards could be articulated (e.g., any state-authorized plan qualifies, even if not meeting ACA's exacting standards, so long as it is an actual health insurance policy).

- **Age-Based Credits: Fair, Portable, and Pro-Work:** The shift to a flat, age-based credit schedule is grounded in the principle of fairness and simplicity. Under current ACA rules, premium assistance is **means-tested** and tied to income and local benchmark premiums; this creates high effective marginal tax rates, "subsidy cliffs," and marriage penalties that can discourage work or advancement (since earning more can drastically reduce one's subsidy). It also means two people of the same age can receive wildly different subsidy amounts (or none at all) based on income, which many perceive as inequitable. By contrast, an age-based credit treats everyone in an age group equally, akin to how Medicare provides uniform benefits by age. Younger individuals get a smaller credit reflecting lower expected health costs, while older individuals get more – a straightforward cross-subsidy that is transparent and age-progressive. Crucially, **no one loses the credit for earning more income**, removing disincentives to work. The credit is also portable across jobs and states, solving the "job lock" problem wherein people stay in suboptimal employment just to keep employer coverage. With a universal age-based credit, *coverage follows the person*, not the employer or exchange. This proposal can be implemented in a budget-neutral way by using the same funding currently spent on ACA subsidies and employer health tax exclusions, but distributing it more evenly and predictably. In fact, analyses have suggested that a system of age-based credits could save trillions over time by leveraging cost-conscious consumer behavior. The Petitioner's book elaborates how **age-based credits create a "dignified exit ramp" from the distortions of employer-sponsored insurance and ACA rules** – voluntary and gradual, but powerful in its incentives. In practice, offering an age-based credit option would let families decide which benefit is higher for them (the ACA income-based credit or the age-based amount) and choose accordingly. Many middle-income families not currently subsidized could opt into the age-based credit and finally receive relief. Lower-income households might stick with the traditional subsidy if it's more generous – but over time, as the market adapts, the flat credit could prove sufficient and preferable due to its flexibility (especially if combined with cheaper plan choices). In essence, this reform

does not repeal the ACA's coverage expansions; it *augments* them with an alternative that can broaden the tent of affordability and individual choice.

- **Encouraging Savings and Value via HSA Deposits:** A central innovation in this petition is the idea of depositing unused credit funds into the individual's HSA. This marries the concept of insurance support with **personal responsibility and savings** in a novel way. Under current law, if a person chooses a plan cheaper than the benchmark, the government simply pays less, and the individual gains nothing (except a lower premium bill, which is good but there's no way to capture the additional savings as future assets). By allowing people to keep the difference (within an HSA restricted for medical use), we create a **continuous incentive for cost-conscious decision-making**. The policy signals that frugality is rewarded: every dollar an enrollee saves by picking a more efficient health plan is a dollar in their own pocket (for health needs). Over time, especially for young and healthy individuals, these unspent funds can accumulate into substantial personal savings – *building a safety net for future medical expenses* or retirement health costs. The Medicare MSA program provides a real-world proof of concept: Medicare deposits a fixed amount for enrollees who choose high-deductible MSA plans, and beneficiaries keep the leftover if they spend under the deposit. This has shown that **defined contributions with savings components** can work in practice. Likewise, our proposed HSA deposit mechanism would effectively turn the premium tax credit into a partial **defined-contribution health stipend**, rather than a use-it-or-lose-it subsidy. The attached materials underscore the impact: for instance, a household that could get a $18,000 annual age-based credit might buy a lean $10,000 plan and bank $8,000 yearly in their HSA. Over a decade, that could grow to a substantial reserve. This reform will also introduce **price competition**: insurers will know that consumers are comparing value and have an incentive to choose cheaper plans because they keep the savings. That dynamic pressures insurers to offer lower-priced options or supplemental benefits to justify higher premiums. In short, the HSA refund policy aligns consumer incentives with cost control in a way the current subsidy system does not. It also **promotes HSA usage and enrollment**, furthering Congress's long-standing goal (through IRC § 223) of encouraging health savings. For this to work, HHS and Treasury will need to ensure seamless administration: real-time credit calculation, payment of premiums to insurers, and deposit of excess credit into the individual's HSA (which could be automated through existing Treasury payment systems). The attached draft bill explicitly instructs that *"if the credit amount exceeds the cost of the chosen plan, the excess shall be deposited into a tax-advantaged HSA of the individual"* and that **such deposits do not count toward HSA annual limits**. Those provisions highlight that the concept is *legislatively and operationally feasible*. The agencies could replicate these via regulation or by granting waivers to states that want to try this approach immediately.
- **Precedents of Regulatory Flexibility:** As noted, there is clear precedent for HHS and related agencies using **administrative flexibility to expand and enhance ACA benefits**. The "family glitch" fix is one example of regulatory courage to correct a flaw and extend credits to more peoplefederalregister.gov. Another example is the implementation of the **enhanced premium subsidies under the American Rescue Plan Act (ARPA) of 2021**, which HHS and CMS executed swiftly, resulting in *record ACA enrollment and affordability improvements*. Although ARPA's increased subsidies (e.g. removal of the income cap and lowering of contribution percentages) were mandated by statute, CMS

used its discretion to, for instance, establish a special enrollment period and extensive outreach so that Americans could take advantage of the new subsidiescms.govcms.gov. The Biden Administration's statements emphasized *"making health care more accessible and affordable"* and working innovatively with states to reduce costscms.gov, which aligns with the spirit of this petition. Furthermore, HHS has encouraged states to experiment under § 1332 – for example, promoting waiver concepts like **"Account-Based Subsidies"** (where states could convert subsidies into direct contributions to accounts or vouchers)cms.govcms.gov. This indicates that the agency is already conceptually open to the idea of **structural subsidy reform**. The Petitioner's proposals take those concepts to their logical conclusion on a national scale. By acting now through rulemaking or sub-regulatory guidance, HHS can set in motion a transformation that does not require waiting for Congress. It is noteworthy that bipartisan concern exists over ACA subsidy cliffs and complex rules (even the current Administration supported extending ARPA's enhancements through 2025, acknowledging the need for more generous and flexible credits). Thus, the requested actions would build on momentum to **broaden coverage and choice**. They would also address long-standing issues such as the inequity between employer-subsidized and individually purchased insurance. Ultimately, the agency has the **policy justification and moral imperative** to eliminate unnecessary restrictions (like the Exchange-only rule) that serve more to prop up a particular insurance market structure than to serve consumers. The ACA's core aim was to help people afford insurance – there is nothing in the law's purpose that demands this help be confined to a specific type of plan or purchasing platform. Given rising premiums and the continued uninsured rate, especially among middle-income families, HHS should use every tool at its disposal to maximize the reach of premium tax credits.

Supporting Evidence: The Petitioner incorporates by reference the following materials in support of these proposals:

- *Lee Benham, **The Benefit That Broke You** (2023).* – This book (attached in full) provides the conceptual framework and empirical support for age-based health insurance credits and HSAs. It documents how tying insurance to employment and limiting subsidies to certain plans have led to higher costs and less consumer power, and how a switch to portable credits can unleash market forces to lower prices. The book offers historical context and real-world analogues (like Medicare MSAs) to show the viability of the approach. It also addresses potential concerns and details the anticipated economic effects (e.g., wage growth if employer insurance tax preferences are gradually replaced by credits). HHS should consider the analysis in this book as evidence that the proposed regulatory changes would be beneficial and in line with a broader trend toward consumer-driven health care.
- *"**America First Health Care Reform Reconciliation Act of 2026**" (Draft Bill).* – A copy of a draft reconciliation bill is attached, which illustrates one legislative implementation of the Petitioner's plan. Notably, Section 2 of the draft bill creates a new **IRC § 36C** establishing the age-based refundable credit and explicitly **allows it to be used for any legal insurance plan, with unused credit deposited to an HSA**. The bill text includes precise age-bracket credit amounts (e.g., $3,000 for age 0–30 up to $6,400 for age 60–64) and details on HSA deposit mechanisms, coordination with existing ACA subsidies (an

individual cannot receive both), and the voluntary nature of the program. While this is draft legislation (intended for Congress to enact), its inclusion in this petition serves to **validate the legal structure** of the proposals. It shows that the concepts are sufficiently concrete that they can be reduced to legislative language. HHS can use the bill as a template or reference point for what a parallel regulatory scheme might look like. Moreover, the bill's existence indicates there is policy interest in these reforms; by moving forward administratively, HHS can complement and support eventual legislative efforts, or at least prove the concept in the interim. The bill also underscores the intent that these reforms be *deficit-neutral* and simply reallocate existing health subsidies more efficiently – an important consideration for the agency's analysis under Executive Order 12866 (regulatory impact) and other budgeting concerns.

Requested Actions

For the foregoing reasons, Petitioner respectfully requests that the Secretary of HHS and the CMS Administrator undertake the following actions expeditiously:

- **Initiate Rulemaking:** Publish a Notice of Proposed Rulemaking (NPRM) in the Federal Register, pursuant to APA § 553, proposing amendments to HHS and CMS regulations that govern the administration of premium tax credits and Exchange enrollment (including but not limited to 45 C.F.R. Part 155 and related parts). The NPRM should propose changes consistent with this petition – for example, revising the definition of "qualified health plan" for premium credit eligibility to include any state-authorized individual market plan meeting minimum standards, establishing an alternative age-based credit option (potentially as a pilot or interim program), and creating provisions for credit overages to be deposited into HSAs. The agency should solicit public comment on these proposals and any operational considerations (such as how to verify plan eligibility, how to coordinate with IRS systems for payments, etc.).
- **Issue Interim Guidance or Demonstration Opportunity:** Contemporaneously with or prior to formal rulemaking, use sub-regulatory guidance to outline a pathway for states and/or insurers to start implementing these ideas. For instance, CMS could issue a guidance memo inviting states to apply for § 1332 innovation waivers to broaden subsidy usage or test flat credits (providing an expedited template for approval). Alternatively, CMS could announce a time-limited demonstration program where a certain number of states or a federal fallback program can offer the age-based credits to a subset of consumers (such as those not currently eligible for ACA subsidies, or those in the individual market who opt in). This guidance would signal the agency's willingness to exercise enforcement discretion and innovative authority while more permanent rules are developed. It would also help iron out any practical challenges on a smaller scale.
- **Coordinate with the Treasury/IRS:** Form an interagency working group with the Department of the Treasury and IRS to ensure that any regulatory changes are harmonized with tax regulations under § 36B. While this petition is directed to HHS/CMS (given their role in plan regulation and consumer-facing administration), the premium tax credit ultimately is a tax law provision. Therefore, HHS should formally engage Treasury in this rulemaking effort. This may involve joint rulemaking or parallel IRS rule amendments to 26 C.F.R. § 1.36B-2 and related provisions, to recognize the

expanded use of credits and the new age-based credit structure. Notably, the IRS will need to adjust tax forms and instructions if these changes occur (for example, a new form or worksheet for the age-based credit (proposed IRC § 36C) if one is created). The agencies successfully coordinated on the family glitch rule and on prior ACA implementations; the same model can be followed here.

- **Ensure Program Integrity and Consumer Protections:** As part of the rulemaking, develop reasonable standards to prevent abuse and ensure that subsidized plans offer genuine protection. This might include requiring that any plan eligible for credits under the new interpretation provide coverage for major medical risks (to avoid credits being used on, say, insurance that only covers trivial benefits). It may also include enhanced disclosure to consumers that non-ACA plans might not cover pre-existing conditions or certain benefits, etc., so choices are informed. The goal is not to impose many new mandates (which would defeat the purpose of having cheaper, flexible plans), but rather to strike a balance where **basic insurance functionality** is assured. The legislative draft provides a simple standard: *if it's approved by a state insurance department, it counts*. HHS can start there and work with states on enforcement. Additionally, oversight mechanisms can be instituted for the HSA deposit process – e.g., tracking that excess credits indeed reach individuals' accounts and are used for qualified expenses. The rulemaking should also address how to handle situations like mid-year changes in enrollment (transitions between the traditional subsidy and flat credit, or switching plans) to prevent gaps or duplicate benefits.
- **Evaluation and Reporting:** Commit to evaluating the outcomes of these changes and reporting on key metrics. For example, HHS could announce that it will collect data on enrollment numbers in non-QHP plans purchased with credits, premium differentials, amounts deposited to HSAs, consumer satisfaction, and any impact on risk pools (Exchange versus non-Exchange). This evaluation will help refine the policy over time and provide transparency to the public and Congress on the effects of the reform. If the demonstration is highly successful, it could bolster the case for Congress to codify the changes permanently via legislation; if challenges arise, the agency can adjust course via further rulemaking.

The Petitioner emphasizes that these actions can be phased or piloted, but **time is of the essence**. With upcoming plan years and the continual rise of premiums, many Americans need relief and flexibility now. There is a window of opportunity for HHS/CMS to lead on health reform administratively, just as the agency did when implementing new subsidy expansions in 2021 and fixing regulatory flaws in 2022. The requested rulemaking would be a bold step, but one grounded firmly in both legal authority and policy precedent.

Conclusion

Conclusion and Request for Response: For the reasons detailed above, Petitioner Lee Benham urges the Department of Health and Human Services and CMS to grant this petition and promptly initiate the requested rulemaking and guidance process. The proposed reforms will expand coverage options, make health insurance more affordable, and empower consumers to take control of their healthcare dollars – all consistent with the Affordable Care Act's ultimate

aims, yet correcting course where previous regulations have been overly restrictive or have entrenched high costs.

Petitioner respectfully requests a written response from HHS/CMS to this petition, as required by 5 U.S.C. § 555(b). That provision of the APA obligates agencies to *"conclude a matter presented to it"* **within a reasonable time**, and the courts have deemed unreasonably delayed agency action to be subject to judicial review. While the Petitioner is hopeful that HHS will act proactively, we formally request, at minimum, that the agency acknowledge receipt of this petition and provide a substantive response or decision on whether it will proceed with the requested rulemaking. If the agency believes additional information or clarification is needed, the Petitioner is ready to promptly provide it.

HHS has a proud history of using its administrative powers to advance healthcare accessibility. By embracing this petition's proposals, the agency can continue that legacy – innovating within the ACA's framework to deliver more choice, fairness, and savings to American families. The Petitioner thanks the Department and CMS for their careful consideration of this request, and looks forward to a positive engagement on these critical issues.

Respectfully submitted,

Lee Benham (Petitioner)
[Contact Information]

Sources