Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

June 17, 2025

Senate Finance Committee Releases Its Version of Proposed Tax Provisions to be Included in the Budget Reconciliation Bill Being Considered by Congress

The Senate's Finance Committee has released both a 549-page legislative text version and a 48-page summary of its tax provisions to be included in the budget reconciliation bill being considered by Congress. The House of Representatives passed its version of the bill, H.R. 1, known as the One Big Beautiful Bill Act, in May.

Copies of the Senate items are available at:

https://www.finance.senate.gov/chairmans-news/chairman-crapo-releases-finance-committee-reconciliation-text, and https://www.finance.senate.gov/download/finance-committee-section-by-section-title-vii.

Comments

First, the text does not contain specific cost amounts. Second, the Senate material contains numerous and controversial items compared to the House Bill. Among these are the retention of the itemized tax deduction limit of $10,000 whereas the House increased the amount to $40,000 in order to secure several Republican lawmakers.

Third, the Senate proposal would increase the debt by $5 trillion. The House measure would add $4 trillion.

Senator Josh Hawley, R-Missouri, and Senator Jim Justice, R-West Virginia, have been critical of a provision in the bill that limits states from raising money to pay for their part of Medicaid spending through health-care-related taxes known as "provider taxes." But instead of rolling back the House's proposal, Senate lawmakers made deeper cuts to Medicaid through changes to the provider tax.

Currently, states charge taxes to health care providers that the providers then recoup through higher Medicaid payments. This system extracts more federal spending on state Medicaid programs because federal payments match state payments. The Senate bill would gradually reduce those taxes and thus the federal contribution.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

4712 Country Club Drive, Jefferson City, Mo. 65109
P.O. Box 60, Jefferson City, Mo. 65102
573/893-3700 | www.mhanet.com

MISSOURI HOSPITAL ASSOCIATION

Below are portions of the Senate Finance committee's proposals on health care from the 48-page summary document.

SENATE FINANCE COMMITTEE SECTION-BY-SECTION

SUBTITLE B - HEALTH CARE -- Health Care

Chapter 1 -- Medicaid

Subchapter A – Reducing Fraud and Improving Enrollment Processes

Sec. 71101. Prohibition on implementation of rules relating to eligibility and enrollment in Medicare savings programs.

The Medicare Savings Program (MSP) final rule, issued by the Centers for Medicare & Medicaid (CMS) on September 21, 2023, changes certain MSP enrollment processes and grants automatic MSP entitlement to qualifying Medicare beneficiaries without requiring a separate application. It also requires states to use Medicare Part D Low-Income Subsidy (LIS) information for the purpose of determining MSP eligibility.

This provision would prohibit the Secretary of Department of Health and Human Services (HHS) from implementing, administering, or enforcing this final rule.

Sec. 71102. Prohibition on implementation of rules relating to eligibility and enrollment for Medicaid and CHIP.

CMS finalized the "Medicaid Program, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" final rule on April 2, 2024.

This provision would prohibit the HHS Secretary from implementing, administering, or enforcing this final rule under Medicaid or CHIP.

Sec. 71103. Reducing duplicate enrollment under the Medicaid and CHIP programs.

This provision would require state Medicaid programs to regularly obtain an act upon updated address information from reliable data sources, including from managed care entities. The HHS Secretary would be required to establish a system to prevent simultaneous Medicaid enrollment in multiple states.

Sec. 71104. Ensuring deceased individuals do not remain enrolled.

This provision would require states to review the Social Security Administration's (SSA) Death Master File (or other electronic data sources) at least quarterly to determine if any enrollees are deceased. The provision would specify processes for disenrollment of deceased enrollees and for reinstatement of coverage in the event of an error.

Sec. 71105. Ensuring deceased providers do not remain enrolled.

This provision would codify the requirement for states to check the SSA's Death Master File during a provider or supplier's enrollment and reenrollment and would add a new requirement for states to check the file not less than quarterly. Ensuring deceased providers do not remain enrolled.

Sec. 71106. Payment reduction related to certain erroneous excess payments under Medicaid.

This provision would reduce the amount of erroneous excess payments that the Secretary may waive and would expand the definition of erroneous excess payments to include items and services furnished to individuals who are not eligible for federal reimbursement in Medicaid.

Sec. 71107. Eligibility redeterminations.

This provision would require states to conduct eligibility redeterminations once every 6 months for individuals enrolled through the ***Patient Protection and Affordable Care Act's*** (ACA) Medicaid expansion.

Sec. 71108. Revising home equity limit for determining eligibility for long-term care services under the Medicaid program.

This provision would cap the home equity limit maximum at $1,000,000 regardless of inflation indexing, except for certain homes on agricultural lots. The section also would prohibit states from excluding certain income or assets when determining an individual's eligibility for Medicaid-covered LTSS without applying home equity limits. Additionally, the section would require the application of home equity limits for the purpose of determining eligibility for Medicaid-covered LTSS for modified adjusted gross income (MAGI)-excepted enrollees.

Sec. 71109. Prohibiting federal financial participation under Medicaid and CHIP for individuals without verified citizenship, nationality or satisfactory immigration status.

The provision would allow states to elect to provide coverage to applicants during such period but would prohibit the use of federal funds for amounts spent on services unless U.S. citizenship or nationality or satisfactory immigration status is verified before the end of the period.

Sec. 71110. Alien Medicaid eligibility.

This provision would amend the definition of qualified alien to include: (1) LPRs; (2) certain Cuban immigrants; and (3) individuals living in the United States through a Compact of Free Association (CoFA).

Sec. 71111. Expansion FMAP for certain states providing payments for health care furnished to certain individuals.

This provision would reduce the federal share of Medicaid expansion expenditures for "specified states" from 90 percent to 80 percent. Specified states would include states that, during a quarter, provide state-based Medicaid coverage to aliens who are not qualified aliens.

Sec. 71112. Expansion FMAP for emergency Medicaid.

Unlawfully present aliens that would otherwise qualify for Medicaid expansion if not for their immigration status qualify for the enhanced ACA expansion FMAP of 90 percent. This provision would equalize the FMAP for otherwise ineligible aliens receiving emergency Medicaid, ensuring that they do not receive a higher FMAP than the traditional Medicaid population.

Subchapter B – Preventing Wasteful Spending

Sec. 71113. Prohibition on implementation of the final staffing rule for nursing facilities.

In May 2024, the HHS Secretary finalized a rule to set minimum staffing standards for Medicare and Medicaid long-term care facilities. These standards include requirements on nursing home personnel and the minimum threshold of staff-to-resident ratios. This provision would prohibit the HHS Secretary from implementing, administering or enforcing any part of the final rule.

Sec. 71114. Reducing state Medicaid costs.

States are required to cover Medicaid benefits retroactively for the three months prior to enrollment.

This provision would limit retroactive coverage to the month preceding enrollment for ACA Medicaid expansion beneficiaries, and two months preceding enrollment for the traditional Medicaid beneficiaries.

Sec. 71115. Ensuring accurate payments to pharmacies under Medicaid.

This provision would expand the National Average Drug Acquisition Cost (NADAC) survey to include certain non-retail pharmacies (e.g., specialty and mail-order pharmacies), and would require applicable pharmacies to respond to the survey. This section also would require pharmacies to report the net of all price concessions, such as discounts or rebates. Pharmacies that do not comply with the survey requirements may be subject to civil monetary penalties. The OIG of HHS would receive $5 million to conduct periodic studies of the survey, and the HHS Secretary would receive $8 million for each year from FY2026 through FY2033 to carry out the survey.

Sec. 71116. Spread pricing in Medicaid.

This provision would require pharmacy benefit managers (PBMs) to reimburse pharmacies or providers for the dispensing drugs using a "pass-through" structure. Under the pass-through pricing structure, the PBM would reimburse the pharmacy or provider for an amount that is the sum of the ingredient cost and a professional dispensing fee, passed through in its entirety from the PBM to the pharmacy or provider. For drugs purchased through the 340B program, the ingredient cost paid for dispensing the drug would be allowed to exceed the actual acquisition cost of the drug by the covered entity. Any form of spread pricing, whereby the PBM charges the state or MCO an amount for the dispensing of a drug that exceeds the amount paid to the pharmacies or providers, net of all pricing concessions, would not be allowable for purposes of claiming federal matching funds. Compensation to PBMs would be limited to an administrative fee that reflects fair market value for services performed.

Sec. 71117. Prohibiting federal Medicaid and CHIP funding for certain items and services.

This provision would prohibit federal Medicaid or CHIP funds for amounts spent on specified items and services for gender transition purposes. The provision includes certain exceptions, including cases of disease, injury or chromosomal anomaly.

Sec. 71118. Federal payments to prohibited entities.

This provision would prohibit federal Medicaid payments for items and services provided by "prohibited entities" for a period of 10 years beginning on the date of enactment. Prohibited entities include tax-exempt essential community providers that deliver family planning and abortion services, other than those allowable under the Hyde Amendment. Further, a prohibited entity is defined as one that received federal and state Medicaid reimbursements exceeding $800,000 in 2023.

Subchapter C – Stopping Abusive Finance Practices

Sec. 71119. Sunsetting increased FMAP incentive.

The American Rescue Plan Act provides qualifying states (defined as non-expansion states in March 2021) with a five percent increase to the traditional FMAP for eight quarters after a state expands Medicaid. This provision would eliminate the five percentage-point increase to the traditional FMAP rate for states implementing ACA Medicaid expansion.

Sec. 71120. Provider taxes.

Federal statute and regulations define a provider tax as a health care-related fee, assessment, or other mandatory payment for which at least 85 percent of the burden of the tax revenue falls on health care providers. Under the so-called hold harmless threshold, the federal government and states may make providers whole for net patient revenue up to 6 percent.

This provision would prohibit non-expansion states from increasing the rate of current provider taxes or increasing the base of the tax to a class or items of services that the tax did not previously apply. Beginning in 2027, the hold harmless threshold in expansion states for provider classes other than nursing or intermediate care facilities would be reduced by 0.5 percent annually until the maximum hold harmless threshold reaches 3.5 percent in 2031.

Sec. 71121. State directed payments.

This provision would direct the HHS Secretary to revise the payment limit for state directed payments. For states that have implemented ACA Medicaid expansion, the current payment limit would be reduced from the average commercial rate to 100 percent of the Medicare payment rate. In non-expansion states, the payment limit would be reduced to 110 percent of the Medicare payment rate. Further, existing state-directed payment limits would be reduced by 10 percent annually until the allowable Medicare-related payment limit is achieved. The section would provide the HHS Secretary with $7 million for each of FY2026 through FY2033 for implementation.

Sec. 71122. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

This provision would limit the definition of generally redistributive to qualify for a waiver of the uniform requirement. For instance, provider taxes would not be considered generally redistributive if (1) the tax rate is lower for providers with a lower volume or percentage of Medicaid taxable units or (2) the tax rate on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.

Sec. 71123. Requiring budget neutrality for Medicaid demonstration projects under Section 1115.

This section would codify and strengthen budget neutrality requirements for demonstration projects under section 1115 of the Social Security Act. CMS's Chief Actuary would be required to certify that the total federal expenditures do not exceed what would otherwise have been spent under Medicaid absent the demonstration project.

Subchapter D – Increasing Personal Accountability

Sec. 71124. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

This provision would require certain specified nonpregnant, nondisabled, childless adults, aged 19 through 64, to complete a minimum of 80 hours of qualifying community engagement activities prior to initial application as a condition of Medicaid eligibility.

Exempted Individuals:

The provision would exempt certain specified groups from meeting community engagement requirements, including:

- Veterans with a disability rated as total;
- Individuals who are medically frail or otherwise have special medical needs;
- Individuals who are blind, have a substance use disorder, a disabling mental disorder, a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living, or a serious or complex medical condition;
- Parents, guardians, and caretaker relatives of children aged 14 or under or a disabled individual;
- Foster care youth through the age of 26;
- Individuals who are Indians, Urban Indians, California Indians, and other Indians who are eligible for the Indian Health Service as determined by the HHS Secretary through regulations; or
- Individuals who are inmates in a public institution or who were inmates in a public institution at any point during the three-month period prior to the month where compliance with community engagement activities is being verified.

Good Cause Exemptions:

The provision would permit states to exempt "applicable individuals" from the community engagement requirement for short-term hardships during a month. Short-term hardships would be defined as for all or part of the month that the requesting individual:

- Receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services or other services of similar acuity (including outpatient care), as determined by the HHS Secretary;
- Resides in an area where there is declared an emergency or disaster by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act;
- Lives in areas with an unemployment rate that is at or above the lesser of 8 percent or 1.5 times the national unemployment rate; or
- Must travel outside of their community for an extended period of time to receive medical services not available within their community of residence.

Qualifying Activities:

The provision would require "qualifying individuals" to meet one or more of the four qualifying activities for a combined total of at least 80 hours per month. Qualifying activities include:

- Work;
- Participation in a work program;
- Participation in community service;
- Enrollment in an education program; or
- To have a monthly income "that is not less than the applicable minimum wage requirement under Section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours." Consequences for Not Meeting the Community Engagement Requirement: The provision would stipulate that failure to meet the community engagement requirement would result in denial of eligibility or disenrollment for noncompliance.

State Verification Requirements:

The provision would require states to verify compliance with the community engagement requirement at eligibility redeterminations or more frequently at the option of the state.

State Procedures for Noncompliance:

The provision would require states to establish processes and use reliable information available to the states (e.g., payroll data) without requiring, where possible, the applicable individual to submit additional information. The state would be required to provide notice of noncompliance. Within 30 days from the date the notice is received, the enrollee must demonstrate either compliance with the requirement or that the individual does not meet the definition of applicable individual. After 30 days, if the noncompliance has not been resolved, the state must provide timely and adequate written notice (as specified) and deny or terminate eligibility within 30 days.

Outreach and Enrollee Education Requirements:

The provision would require states to notify individuals subject to the Medicaid community engagement requirements at least three months before the requirement becomes effective and periodically thereafter by mail, electronic format, and one or more additional methods, including telephone, text message, website or other available electronic means. Enrollee education would include information on who is impacted, how to comply, how to report compliance and consequences for noncompliance.

Implementation Funding to States:

For FY2026, the provision would appropriate $100 million for the HHS Secretary to award grants to states to establish systems necessary to carry out the community engagement requirements. States would be awarded a share of these funds based on the ratio of the total number of applicable individuals residing in the state as compared to the total number of applicable individuals residing in all states.

Implementation Funding to Federal Agency:

For FY2026, the provision would appropriate $50 million (to remain available until expended) to the HHS Secretary to carry out the section.

Sec. 71125. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program

This provision would require Medicaid expansion enrollers earning more than 100 percent of FPL to pay cost-sharing amounts up to $35 per service. The requirements would not apply to primary, prenatal, pediatric or emergency room care (except for non-emergency services provided in an emergency room).

Chapter 2 – Medicare

Sec. 71201. Limiting Medicare coverage of certain individuals.

This provision would limit non-citizen eligibility for Medicare to the following groups: (1) lawful permanent residents (LPRs); (2) certain Cuban immigrants; and (3) Compact of Free Association (CoFA) migrants lawfully residing in the United States. Additionally, individuals would have to be otherwise eligible for Medicare to enroll in or receive benefits under the program. The Social Security Commissioner would be required to identify non-citizen Medicare beneficiaries who no longer qualify for the program within six months after the date of enactment. The Commissioner would then be required to notify such non-citizens as soon as practicable, and in a manner designed to ensure comprehension, that their Medicare entitlement or enrollment will be terminated effective one year after the date of enactment.

Chapter 3 – Health Tax

Subchapter A – Improving Eligibility Criteria

Sec. 71301. Permitting premium tax credits only for certain individuals.

This provision would limit eligibility for the premium tax credit (PTC) to the following defined eligible aliens: (1) lawful permanent residents (LPRs); (2) certain Cuban immigrants; and (3) CoFA migrants lawfully residing in the United States.

Sec. 71302. Disallowing premium tax credit during periods of Medicaid ineligibility due to alien status.

This provision would disallow lawfully present individuals who are ineligible for Medicaid with incomes below 100 percent of FPL from receiving the PTC.

Subchapter B – Preventing Waste, Fraud, and Abuse

Sec. 71303. Requiring verification of eligibility for the premium tax credit.

This provision would require verification of specific insurance application information in order for an enrollee to qualify for the PTC. Such information would include household income, any immigration status, any health coverage status or eligibility for coverage, place of residence, family size and other information that may be determined by the Secretary of the Treasury to be necessary to conduct verification. The Secretary would be allowed to waive the verification requirement for an individual who enrolls in an exchange plan during a special enrollment period (SEP) due to a change in family size. An exchange would be required to implement a pre-enrollment verification process to allow insurance applicants to verify their income for enrollment in exchange plans and the PTC.

Sec. 71304. Disallowing premium tax credit in case of certain coverage enrolled in during special enrollment period

This provision would disallow the PTC for individuals who enrolled in an exchange plan during an income-based SEP that is not connected to a change in other circumstances.

Sec. 71305. Eliminating limitation on recapture of advance payment of premium tax credit.

This provision would disallow partial repayments of excess advanced PTCs, requiring taxpayers to repay the full amount of any excess. Individuals with estimated annual income at or above 100

percent of FPL that received an advanced PTC, but whose actual income is less than 100 percent of FPL, would not be required to return excess payments unless the Secretary determines the individual provided incorrect information intentionally or with "reckless disregard for the facts."

SUBTITLE C - INCREASE IN DEBT LIMIT

Sec. 72001. Modification of limitation on the public debt.

This provision increases the statutory debt limit by $5 trillion.