Submitted via Regulations.gov

September 14, 2026
Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: RIN 0938-AV93; CMS-2452-P
Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes

Dear Administrator Oz:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to comment on the Department of Health and Human Services' ("HHS" or "the Department") proposed rule, *Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes* ("Proposed Rule").[1]

The Proposed Rule attempts to leverage Medicaid provider tax cuts under § 71115 of the "One Big, Beautiful Bill Act" (OBBBA) to implement changes that go far beyond legal requirements. While its inadequate Regulatory Impact Analysis (RIA) fails to provide an accurate or comprehensive accounting of its true repercussions, the Department still estimates that the Proposed Rule would reduce federal Medicaid spending by $198.7 billion by 2035, representing a 27% cut to state provider tax revenue over the next decade.[2] When combined with state funding reductions, the agency estimates that the Proposed Rule would slash overall Medicaid funding by a staggering $384 billion.[3] Cuts at this level would worsen existing systemic barriers to accessing

high-quality care in Medicaid, with foreseeable and harmful consequences for beneficiaries.[4]

The Department's proposals ignore the larger context of unprecedented cuts to health care, including those initiated by OBBBA and accelerated by Administration actions, that are already worsening coverage, affordability, and access to care across the country.[5] Overall, CBO estimates that OBBBA will increase the number of uninsured people by 10 million in 2034. The deepest coverage losses will begin only after the Proposed Rule is finalized, as states implement Medicaid work requirements and other eligibility cuts across Medicaid, Medicare, and Marketplace programs starting in 2027.[6] If finalized, the Proposed Rule would exacerbate cuts baked into OBBBA by reducing states' ability to raise revenue that states could use to counterbalance increases in uncompensated care and worsening health care affordability.

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[1] HHS, *Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes*, 91 Fed. Reg. 46562 (July 21, 2026) (hereinafter "Proposed Rule").
[2] Proposed Rule at 46590.
[3] *Id*. at 46591, 46577-46581.
[4] *See, e.g.,* Jane Zhu, et al., *"Ghost" Physicians: More Than One-Quarter Of Physicians Enrolled In Medicaid Delivered No Care To Beneficiaries In 2021,"* HEALTH AFF., Vol. 45, No. 2 (Feb. 2, 2026), https://doi.org/10.1377/hlthaff.2025.00703; Allen M. Chen, *Re-Evaluating Access in Healthcare: Focus on Quality of Care,* PUBLIC HEALTH CHALLENGE (Nov. 11, 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12604675; Howard H. Goldman, *How Phantom Networks And Other Barriers Impede Progress On Mental Health Insurance Reform*, HEALTH AFF., Vol. 41, No. 7 (July 5, 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00541; Jane Zhu, et al., *Phantom networks: discrepancies between reported and realized mental health access in Medicaid*, HEALTH AFF., Vol. 41, No. 7 (July 5, 2022), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052.
[5] *See* State Marketplace Network, Summer 2026 Enrollment Update (Aug. 31, 2026), https://statemarketplacenetwork.org/state-marketplace-network-summer-2026-enrollment-update ("Overall, SBM enrollment…has now dropped 8.5 percent from 2025…In total, disenrollments are up 33.6 percent over last year, an acceleration in the rate of disenrollments reported in April. SBMs also report that new enrollments gained via SEPs are down 18.4 percent compared to last year" (citation omitted)); Matt McGough, et al., Peterson-KFF Health Tracker, *How much and why ACA Marketplace premiums are going up in 2027* (Updated Aug. 2, 2026) ("For 2027, across 276 insurers participating in the ACA Marketplaces from all 50 states and the District of Columbia with publicly available filings, this analysis shows a median proposed premium increase of 15%. This is the second consecutive year of double-digit premium hikes…the second-highest requested rate change since 2018…"); KFF, *Medicaid/CHIP Monthly Enrollment Tracker* (Updated Aug. 26, 2026), https://www.kff.org/medicaid/medicaid-enrollment-tracker ("Total Medicaid/CHIP enrollment has decreased in all states since April 2025. Enrollment changes since April 2025 vary from a less than 1% decrease in Iowa to a 20% decrease in Indiana. Child enrollment in Medicaid/CHIP decreased in all states and DC but Hawaii from April 2025 through April 2026."); Joan Alker, G'town Ctr. on Children & Families, *Drop in Child Medicaid and CHIP Enrollment Even Before HR 1 Policies Take Full Effect is Troubling Sign* (May 28, 2026), https://ccf.georgetown.edu/2026/05/08/drop-in-child-medicaid-and-chip-enrollment-even-before-hr-1-policies-take-full-effect-is-troubling-sign; Nat'l Health Law Program, *Budget Reconciliation Act Implementation Dates for Select Medicaid & Health Provisions* (Aug. 13, 2025).
[6] Congressional Budget Office (CBO), *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline* (July 21, 2025), https://www.cbo.gov/publication/61570; CBO, *CBO's Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, Public Law 119-21* (Aug. 11, 2025), https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx; *see also,* Matthew Buettgens, et al., Urban Institute and Robert Wood Johnson Fdn., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations* (March 2026), https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html.

For these reasons and others articulated in these comments, we urge HHS to withdraw the Proposed Rule. To the extent that OBBBA requires the Secretary to amend provider tax regulations, the Department should release a new notice of proposed rulemaking that is narrowly tailored to implement the statutory requirements only; and includes a thorough analysis of the effects of any changes on all relevant stakeholders, including Medicaid beneficiaries and consumers with other forms of coverage.

I. The Department's Regulatory Impact Analysis is Fundamentally Flawed

The Proposed Rule's RIA offers selective analysis of limited provisions of the rule based on unverifiable assumptions, ignores existing estimates of the impact of provider tax cuts under OBBBA, and omits any meaningful analysis of likely effects on Medicaid beneficiaries or individuals with other forms of coverage. As a result, the Department deprives the public of the opportunity to fully understand the impact of the rule and comment accordingly.

First, the RIA fails to provide transparent evidence to support its analysis. The Department largely bases its estimates on internal analysis of "reports submitted by the States at the request of [the Centers for Medicare & Medicaid Services (CMS)] in an effort to gather more information about existing taxes in 2025 and 2026."[7] While the Department dismisses CMS-64 data as inferior to these reports, the scope and nature of the CMS-requested data are unknown and unverifiable.[8] Moreover, the Department relies on a number of unfounded assumptions throughout the RIA. For example, the Department assumes that 90% of provider tax revenues are used to fund the state share of Medicaid payments to providers, citing a similarly unfounded statement in a single report that states "generally use provider taxes to either increase payment to providers or offset potential cuts to provider payment."[9] The RIA goes on to assume that states would "offset 30 percent of these cuts with other revenue sources," but provides no support for this estimate, which does not appear to acknowledge widely-reported and accelerating state budget constraints, driven by years of tax cuts and more recently by federal actions to shift cost burdens to states.[10]

Second, the RIA fails to address key provisions of the Proposed Rule; namely, its radical proposal to leverage Medicaid provider tax rules to expand federal oversight over state

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[7] Proposed Rule at 46589.
[8] *Id*.
[9] *Id.* at 46591, citing Medicaid and CHIP Payment and Access Commission (MACPAC), *The Effect of State Approaches to Medicaid Financing on Federal Medicaid Spending*," (November 2021), https://www.macpac.gov/wp-content/uploads/2021/11/The-Effect-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf. As MACPAC noted with respect to the assumption cited in the Proposed Rule, "[W]e do not have a data source that identified how funds from each source are used at the state level."
[10] *See supra* n. 5*; see also*, Nat'l Conference of State Legislatures, *State Budget Shortfall Database*, https://www.ncsl.org/fiscal/state-budget-shortfall-database; Ctr. on Budget and Pol'y Priorities, *Tracking the Fallout of State Budget Cuts* (updated July 16, 2026), https://www.cbpp.org/research/state-budget-and-tax/tracking-the-fallout-from-state-tax-cuts; Pew, *5 State Fiscal Debates to Watch* (Jan. 29, 2026), https://www.pew.org/en/research-and-analysis/articles/2024/02/02/5-state-fiscal-debates-to-watch; Matthew Wiederrecht, *State Budget Squeeze: Why States Are Running Out of Breathing Room,* https://capstonedc.com/insights/state-budget-squeeze-why-states-are-running-out-of-breathing-room.

taxes on entities including health insurers, regardless of whether the taxed entities or revenue associated with the tax have any discernible connection to state Medicaid expenditures.[11] The Department does not fully articulate the intended scope of this proposal, but implies the potential for a sweeping reinterpretation of longstanding federal statutory and regulatory requirements that could recategorize state taxes with no relationship to the Medicaid program as Medicaid provider taxes for purposes of reporting, oversight, and enforcement. If finalized as proposed, the prohibition on new and increased provider taxes in all states and the required phase-down of certain existing taxes in expansion states established under § 71115 of OBBBA, as well as proposals that go beyond OBBBA including onerous new reporting and enforcement mechanisms, would now apply to a far greater number of state taxes. These policies would undoubtedly have far-reaching, negative consequences for state budgets. Yet, the RIA provides no distinct analysis of the economic effects of this proposal on state budgets, health care providers, or consumers. The extent to which the RIA's general analysis of the Proposed Rule's impact on tax revenues or Medicaid spending incorporates the effects of this proposal is unclear because of the opacity of state data requested by CMS. However, states would have had little reason to provide historical data regarding taxes on private insurers and other entities that are not currently considered Medicaid provider taxes, suggesting that these data are not fully incorporated into the RIA's analysis. The RIA therefore provides states and other stakeholders with insufficient insight into the impact of the Proposed Rule on Medicaid funding, state budgets, and individual access to care.

Finally, HHS ignores the impact of the Proposed Rule on Medicaid beneficiaries. The Department asserts that the Proposed Rule "would have no effect on [Medicaid] enrollment." Instead, the Department claims without evidence that states will absorb reductions in federal funding by slashing health care provider payments and curtailing covered benefits within Medicaid.[12] These assertions are unsupported by evidence in the RIA. Even if they were shown to be accurate, the Department fails to present any analysis of the effects of reduced provider payments and benefit cuts on Medicaid beneficiaries.

First, the Department's claims related to enrollment conflict with credible estimates of major coverage losses directly related to the provider tax provisions of OBBBA and ignore data demonstrating the relationship between provider taxes and enrollment. Following OBBBA's enactment, the Congressional Budget Office (CBO) estimated that § 71115 of OBBBA would cause1.1 million to become uninsured.[13] Because OBBBA imposes a harsher hold harmless limit on states that expanded Medicaid, CBO noted "an increased likelihood that some states will discontinue that expanded coverage and that none will expand coverage in the future."[14] In June 2026, researchers estimated that the provider tax provisions of the law would cause 1.5 million fewer people to be covered by Medicaid by 2034, "because of reductions in federal funding that could lead states to reduce enrollment as a way of

[11] Proposed Rule at 46566-46570.
[12] Proposed Rule at 46590.
[13] CBO, Supplemental Cost Estimate (Oct. 28, 2025) at 4, https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.
[14] *Id*.

addressing budgetary shortfalls."[15] These estimates are rooted in extensive evidence that states rely on provider taxes to support enrollment and coverage. For example, at least 11 states reported using increases in existing provider taxes or new provider taxes to cover the state share of Medicaid expansion as of state fiscal year 2020 and at least 3 states that have expanded Medicaid since that date appear to use provider taxes to support expansion.[16] But HHS does not acknowledge these data, claiming only that "provider tax revenues…mostly have been associated with increased payments to providers and not expansions of enrollment."[17]

Second, while the Department admits that provider tax cuts are likely to result in reduced provider reimbursement, it fails to assess the impact on beneficiaries. Regarding provider payments, as HHS acknowledged in 2024:

> [P]rovider payment influences access [to care], with low rates of payment limiting the network of providers willing to accept Medicaid patients, capacity of those providers who do participate in Medicaid, and investments in emerging technology among providers that serve large numbers of Medicaid beneficiaries.[18]

The research on the relationship between provider payments and beneficiary access to care is settled: higher provider reimbursement improves access to and quality of care.[19]

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[15] Preethi Rao, et al., RAND, *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act* (June 18, 2026) at 8, https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html.

[16] *See* Congressional Research Service, *Medicaid Provider Taxes* (Updated Dec. 30, 2024), https://www.congress.gov/crs-product/RS22843; Robin Rudowitz, et al., KFF, *Medicaid Enrollment and Spending Growth: FY 2019 and 2020* (Oct. 2019), https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2019-2020; N.C. Gen. Stat. § 108A-54.3B (2026), *available at* https://www.ncleg.gov/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-54.3B.html and Jada Raphael, et al., KFF, *A Closer Look at North Carolina's Implementation of the 2025 Reconciliation Law Medicaid Provisions and Other Changes Amid Medicaid Budget Shortfalls*; Rudi Keller, Mo. Indep., *Senate battle over taxes that fund Missouri Medicaid leaves state budget in limbo* (Apr. 22, 2024), https://spectrumlocalnews.com/mo/st-louis/news/2024/04/22/missouri-senate-taxes-medicaid-budget (noting that a provider tax bill that was ultimately enacted would "supply $50 million toward the cost of Medicaid expansion" in 2025); Emma Morris, OK Pol'y Inst., *The 2021 session proved a mixed bag for health issues* (June 10, 2021), https://okpolicy.org/the-2021-session-proved-a-mixed-bag-for-health-issues (identifying an increase in the state's hospital provider tax as one of several funding sources for Oklahoma's Medicaid expansion).

[17] Proposed Rule at 46590.

[18] HHS, *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality,* 88 Fed. Reg. 28092, 28014 (May 3, 2023).

[19] Edward Alan Miller, et al., *The Effects of Medicaid Payment and Payment-to-Cost Ratio on Nursing Home Five-Star Quality Ratings*, J. OF THE POST-ACUTE AND LONG-TERM CARE MEDICAL ASS'N, Vol. 27, Issue 2 (Feb. 2026), https://www.jamda.com/article/S1525-8610(25)00559-6/abstract; Diane Alexander and Molly Schnell, NBER Working Paper No. 26095, *The Impacts of Physician Payments on Patient Access, Use, and Health* (July 2019), https://www.nber.org/system/files/working_papers/w26095/w26095.pdf and summarized at National Bureau of Economic Research, *Increased Medicaid Reimbursement Rates Expand Access to Care* (October 2019), https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care; Kayla Holgash and Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't*, HEALTH AFF. FOREFRONT (April 10, 2019),https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t; Michael Barnett, et al., *State policies and enrollees' experiences in Medicaid: Evidence from a new national survey,* HEALTH AFF., Vol. 27, No. 10 (Oct. 1, 2018), https://doi.org/10.1377/hlthaff.2018.0505; Joanna Bisgaier, et al., *Factors associated with increased specialty care access in an urban area: the roles of*

Cuts of the magnitude proposed by the Department would restrict access to covered services for Medicaid beneficiaries, because providers that are unable or unwilling to accept permanent, deep rate reductions will limit the number of Medicaid patients they serve or simply drop out of Medicaid entirely. Providers that rely more heavily on Medicaid payments, such as safety net hospitals, are likely to face severe financial distress. Many will reduce services or even close their doors.[20]

Finally, while HHS couches the impacts of its cuts in vague, impersonal language (passively referencing anticipated "reductions in…benefits provided") the Proposed Rule fails to clearly identify how these "reductions" would affect states, health care providers, or Medicaid beneficiaries.[21] Yet these effects are highly predictable based on recent precedent. For example, when they are faced with budgetary constraints, states have historically cut funding for home and community based services (HCBS) that allow people with disabilities to remain in the community rather than requiring care in an institution.[22] While HCBS may not be specifically targeted in the Proposed Rule, rate cuts for HCBS are a predictable outcome when federal funding for Medicaid is reduced and states are left with difficult choices.

The Department's analysis of the effects of its own proposals is fundamentally flawed. The RIA is based on unverifiable data, omits analysis of key proposals, fails to address valid estimates of enrollment losses, and ignores impacts to Medicaid beneficiaries and individuals with other forms of coverage who are likely to experience harm as a result of dramatic federal funding cuts that will drive reduced access to care. Ignoring the effects of such significant changes on those the Medicaid program is designed to serve is an unacceptable omission. As a result, the Department deprives the public of the opportunity to understand the impact of the Proposed Rule and comment accordingly.

II. § 433.56 — Classes of Health Care Services and Providers Defined

The Department proposes to add taxes on "services of health insurers" other than managed care organizations (MCOs) as a permissible class of "health care-related taxes,"

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local workforce capacity and practice location, J. OF HEALTH POLITICS, POL'Y AND L., Vol. 39, No. 6 (Sep. 23, 2014), https://pubmed.ncbi.nlm.nih.gov/25248959.

[20] Dawn Joyce and Lena Marceno, Commonwealth Fund, *How New Limits on State Provider Taxes Will Affect Medicaid Funding* (Dec. 19, 2025), https://www.commonwealthfund.org/publications/explainer/2025/dec/how-new-limits-state-provider-taxes-will-affect-medicaid-funding; Jesse Pines, *Trump's Beautiful Bill Puts 400 Hospitals At Risk of Closing. Here's the Full List*, FORBES (April 30, 2026), https://www.forbes.com/sites/jessepines/2026/04/30/trumps-beautiful-bill-puts-400-hospitals-at-risk-of-closing-heres-the-full-list; Anne O'Hagen Karl, et al., Manatt, *How States Can Ensure Safety Net Hospitals Benefit from the New Medicaid Access Rule* (July 24, 2024), https://www.manatt.com/insights/newsletters/health-highlights/how-states-can-ensure-safety-net-hospitals-benefit.

[21] *See also,* Nat'l Health Law Program, *Comments on CMS-2449-P: Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments* (July 21, 2026), https://healthlaw.org/resource/nhelp-comments-on-medicaid-managed-care-state-directed-payments-and-fee-for-service-targeted-payments-proposed-rule.

[22] Jessica Schubel et al., *History Repeats? Faced with Medicaid Cuts, States Reduced Support for Older Adults and Disabled People,* HEALTH AFF. (Apr. 16, 2025), https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.

typically referred to as Medicaid provider taxes.[23] Specifically, the Department targets taxes on health insurance premium revenue or covered lives, which are widely used by states to raise revenue for purposes unrelated to Medicaid.[24] The Department goes even further in preamble text, asserting that "all health care-related taxes are impermissible" unless they are specified in § 1903(w)(7) of the Social Security Act (the Act) and 45 C.F.R. § 433.56 as part of a permissible class.[25] If finalized as proposed, the Department would newly enforce provider tax rules against a far wider array of state taxes, placing states at risk of a retroactive clawback of federal Medicaid funding through a reduction in the state expenditures used to calculate Federal Financial Participation (FFP).[26]

Congress has the authority to impose reasonable conditions on the receipt of federal Medicaid funds, provided such conditions apply to those who have knowingly and voluntarily agreed to them.[27] But Congress did not authorize the Department's radical proposal to extend Medicaid provider tax rules to an unknown but far greater set of state taxes, and the Department has provided no reasonable justification for a dramatic expansion of the scope of its enforcement. Given that the taxes that would be newly implicated by the Proposed Rule are not generally used to support the Medicaid program, HHS fails to make the case that its proposal would address Medicaid financing concerns that provide the basis for existing statutory and regulatory guardrails. Yet, states that are unable to bring these non-Medicaid taxes into compliance with Medicaid rules would be subject to significant reductions in their federal Medicaid funding.[28] This approach is coercive, interferes with state authority to levy taxes and regulate the business of insurance, and fails to acknowledge the legal obligation shared by states and the federal government to ensure that Medicaid beneficiaries can access necessary covered services.[29] If finalized as proposed, the Department would effectively force states to choose between Medicaid funding and funding for other crucial state needs, pitting Medicaid beneficiaries against their fellow state residents for a significantly reduced funding pool.

As set forth below, this proposal conflicts with statutory requirements in key respects. However, we also emphasize that the proposal is fundamentally bad policy that would harm states, Medicaid beneficiaries, and other health care consumers in an effort to pursue the Administration's single-minded goal of reducing federal Medicaid funding. The proposal is

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[23] Proposed Rule at 46567.
[24] Lina Rashid, et al., HMA, *Issue Brief: CMS Proposed Indirect Hold Harmless Rule Would Affect Medicaid Financing, with Implications for ACA Marketplaces and the Individual Market*, https://www.healthmanagement.com/wp-content/uploads/Proposed-Rule-Implications-for-Medicaid-and-Other-Insurers.pdf ("Many [State Based Marketplaces], reinsurance programs, and Section 1332 waiver initiatives are financed through various mechanisms, including state assessments on commercial insurance premiums. These assessments are typically designed to support the commercial insurance market—not Medicaid financing.")
[25] *Id.* at 46565.
[26] *Id.* at 46578, T. 1, "Dates and Timeframes Associated With Proposals"; § 1903(w)(1)(A)(ii) of the Act.
[27] *See Landor v. Louisiana*, 609 U.S. ___ (2026), *citing National Federation of Independent Business v. Sebelius*, 567 U. S. 519, 581-582 (2012).
[28] Proposed Rule at 46577-46578.
[29] *See* 15 U.S.C. § 1012 (McCarran-Ferguson Act); § 1902(a)(30)(A); § 1903(m)(2)(A)(iii); § 1932(b)(5) of the Act.

unjustified, inconsistent with Department practice, and untenable for states, and it should not be finalized in any part.

A. The Proposed Rule Conflicts with Statutory and Regulatory Requirements

First, the Department asserts that "examples of metrics that could be used to assess a tax on services of health insurers include health insurance premium revenue or covered lives."[30] Neither of these types of taxes meets the statutory definition of a "health care-related tax," as acknowledged by longstanding Department regulations.

Section 1903(w)(3)(A) of the Act creates 2 pathways for a tax to qualify as a "health care-related tax". The first pathway, under § 1903(w)(3)(A)(i), establishes that a tax is a "health care-related tax" if it "is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services". The statute further specifies that, for purposes of this first pathway, "a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers." Alternatively, under § 1903(w)(3)(A)(ii), a tax is "health care-related" if it is *not* limited to health care items or services but treats health care providers differently than other taxpayers.

The Department claims that "a tax on the services of health insurers, which provide for the payment of health care items or services, is a health care-related tax." This conclusory statement fails to make its case with respect to the 2 examples offered in the Proposed Rule: taxes on premiums and taxes on covered lives. A tax on *health insurance premiums* is not a tax on *payments for items and services.* HHS acknowledges this in its own regulations at 42 C.F.R. § 433.55(e).[31] In the preamble to the interim final rules codifying this exclusion, the Department explained:

> We included this provision to make clear that, for purposes of defining the term "health care-related tax," we will not consider individual and group payments for such premiums as payments for health care items and services. Payments for health care insurance and HMO enrollment premiums are made to the insurer or HMO, for their use and to ensure coverage. Such payments may or may not be used to purchase or provide health care items or services for that individual or group.[32]

Similar reasoning would apply to taxes on "covered lives," which reflect overall enrollment, rather than actual payments for health care items or services.

Taxes specific to health insurance premium revenues and covered lives also seem likely to fail the second definitional prong, which refers to a tax that applies to both providers and/or payers of health care and other entities that are not providers or payers. (The example

[30] Proposed Rule at 46567.
[31] 45 C.F.R. 433.55(e).
[32] 55 Fed. Reg. 55118, 55121 (Nov. 24, 1992).

provided in previous rulemaking is a professional tax that is levied on both physicians and attorneys, but at different rates).[33] In the absence of a more general tax and proof of differential treatment for providers and payers compared to other taxpayers, the second prong of the definition would not apply to taxes on health insurance premiums or covered lives.[34]

Second, even if the Department were to identify a tax on "the services of health insurers" that meets the definition of a "health care-related tax," OBBBA's changes to hold harmless requirements do not apply to permissible classes added after May 1, 2025

Section 71115(a)(2) of OBBBA prohibits states from implementing new provider taxes or increasing existing taxes and reduces the hold harmless threshold from 6% to 3.5% in states that have expanded Medicaid to low-income adults. However, Congress clearly restricts the application of these cuts to the 19 provider classes identified in 42 C.F.R. § 433.56(a) "as in effect on May 1, 2025."[35]

In the preamble to the Proposed Rule, HHS claims the statute is "silent" on the issue of how to address provider classes that may be added by the Secretary after the May 1, 2025 statutory deadline.[36] This is simply false. The May 1, 2025 date and specific regulatory citation are unambiguous. Further, Congress references "successor" regulations in no fewer than 9 places elsewhere in OBBBA's text, including 6 times in the immediately subsequent section related to state-directed payments. Clearly, if lawmakers wanted to allow the Secretary to extend changes to classes of providers added after the law was enacted, they could have expanded the scope of the change, including to "successor regulations". The Department's cited "general authority" to implement § 1903(w) of the Act does not override OBBBA's clear directive to apply changes under § 71115(a) only to classes of providers included in the regulatory list that was "in effect on May 1, 2025".[37]

B. The Department's Proposal is Unjustified, Inconsistent With Longstanding Practice, and Untenable for States

i. The Department fails to justify its vast expansion of federal oversight of state taxes

States have a legal obligation to ensure that Medicaid beneficiaries have adequate access to covered services, and the right and responsibility to raise sufficient revenue to do so.[38] Provider taxes represent a crucial source of legitimate state funding for Medicaid programs

[33] *Id*.
[34] Some states may levy a general tax that applies to issuers of health insurance as well as issuers of other types of insurance (*e.g.*, life or property insurance). HHS does not address these taxes in the Proposed Rule and it is unclear whether the Department considers such taxes "health care-related taxes".
[35] § 71115(a)(2)(D)(i) of OBBBA.
[36] Proposed Rule at 46569.
[37] § 71115(a)(2)(D)(i) of OBBBA.
[38] *See* § 1902(a)(30)(A); § 1903(m)(2)(A)(iii); § 1932(b)(5) of the Act.

in nearly every state.[39] Statutory and regulatory requirements related to provider taxes affirm their important funding role, but also reflect federal concern that guardrails are necessary to prevent the aggressive use of provider taxes to draw down FFP without commensurate state investment in Medicaid.[40] Indeed, the Proposed Rule repeatedly emphasizes the importance of reasonable limits on provider taxes that are used to fund the state share of Medicaid expenditures.[41]

However, the Department's actual proposal departs significantly from this logic, without providing an alternative justification for a significant expansion of federal oversight over state taxation. HHS proposes to sweep state taxes that have no relationship to the Medicaid program under the umbrella of Medicaid provider taxes. Additionally, preamble text indicates that the Department will treat taxes on health-adjacent business that are not specified in regulation as "impermissible" Medicaid provider taxes. Yet, these changes would do nothing to address HHS' concerns related to Medicaid funding, because these taxes are not generally used to fund Medicaid.

The consequences of finalizing such a policy could have a devastating effect on Medicaid beneficiaries and other individuals and families, requiring states to re-examine and potentially eliminate or reduce longstanding, non-controversial taxes and fees whose revenues support necessary state functions. Examples of widely-adopted taxes that could be implicated if the Proposed Rule is finalized include Marketplace user fees to fund state-based exchange (SBE) operations, a practice explicitly endorsed by Congress in the Affordable Care Act (ACA)[42]; taxes on private health insurers for which states currently have a variety of uses unrelated to the Medicaid program, ranging from support for state general funds, Department of Insurance operations, and consumer affordability initiatives like state-funded subsidies for private insurance[43]; and taxes that fund the state share of

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[39] Alice Burns, et al., KFF, *5 Questions and Answers about Medicaid Provider Taxes* (Aug. 20, 2026), https://www.kff.org/medicaid/5-questions-and-answers-about-medicaid-and-provider-taxes.

[40] *See, e.g.,* Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, P.L. 102-234 (Dec. 12, 1991); 55 Fed. Reg. 55118 (Nov. 24, 1992); HHS, *Limitations on Provider-Related Donations and Health Care-Related Taxes*, 58 Fed. Reg. 43156 (Aug. 13, 1993); Allison Mitchell, Congressional Research Service, *Medicaid Provider Taxes* (Dec. 30, 2024). https://www.congress.gov/crs-product/RS22843.

[41] *See* Proposed Rule at 46567-46568 (""[W]e would add services of health insurers…to the definition of classes of health care services and providers, *which would permit States and units of local government to use revenue collected from taxes imposed on these services as the non-Federal share*…We are aware that several States utilize taxes imposed on health insurers as the source of non-Federal share *to finance Medicaid expenditures*…[S]ome States may not have understood that certain taxes imposed through their insurance commissions, *which possibly provided the non-Federal share for Medicaid expenditures*, could constitute health care-related taxes under section 1903(w) of the Act") (emphasis added).

[42] Section § 1311(d)(5)(A) of the ACA (requiring that SBEs be "self-sustaining, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers"); Justin Giovannelli, et al., Commonwealth Fund, *What Are States Doing to Support ACA Marketplace Coverage?* (Updated Aug. 21, 2026), *available at* https://www.commonwealthfund.org/publications/maps-and-interactives/what-are-states-doing-support-aca-marketplace-coverage (see supporting data identifying use of state premium assessments to support SBEs).

[43] *See,* Nat'l Assn. of Ins. Commissioners (NAIC), *Premium Tax and Other Assessments,* https://content.naic.org/sites/default/files/model-law-chart-zz-3-premium-tax-and-other-assessments-non-profit-health-plans-bcbs-plans.pdf; *see, e.g.*, Cal. State Board of Equalization, *Tax on Insurers (Insurance Tax),* https://www.boe.ca.gov/sptaxprog/tax_on_insurers.htm; Univ. of Penn., Div. of Finance, *Pennsylvania Gross Premium Tax*, https://finance.upenn.edu/payroll-taxes/university-tax-compliance/pennsylvania-gross-

reinsurance programs approved by HHS.[44] Indeed, if the Proposed Rule is finalized as written, nearly any tax associated with a provider or payer of health care could be subject to Medicaid provider tax rules, implicating long-established fees such as the licensing fees that apply to third party administrators as well as taxes on pharmacy benefit managers and pharmaceutical manufacturers that states have adopted to respond to a variety of state needs including the opioid epidemic and the growing health care affordability crisis.[45]

ii. The Proposed Rule is inconsistent with longstanding practice and would place states in an untenable position

Both the proposed addition of "services of health insurers" to the list of permissible classes under 45 C.F.R. § 433.56 and the broad restriction on all other health-related taxes are inconsistent with the Department's longstanding approach towards provider tax enforcement. Combined with efforts to retroactively eliminate the opportunity for states to seek waivers of uniform and broad-based standards and the proposed elimination of the 75/75 test in conflict with statutory requirements, the Proposed Rule places states in an untenable fiscal position that will ultimately cause significant harm to Medicaid beneficiaries and other individuals and families that rely on programs funded by tax revenue that would now be subject to new limitations that previously applied only to Medicaid-related taxes.

Despite language in the Proposed Rule suggesting that the Department is newly cognizant of state taxation of health insurers, HHS has long been aware that states levy taxes on a wide array of providers, payers, and other entities related to health care.[46] Today, the Department routinely requires states to report on such taxes, without taking action to subject them to provider tax requirements. For example, states seeking waivers under § 1332 of the ACA to implement private market reinsurance programs typically include information about taxes on health insurers in applications and renewals. The Department is fully aware of these taxes, citing them in official publications related to § 1332.[47] Similarly,

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premiums-tax/; *see also,* N.M. Leg. Finance Comm., *Program Evaluation No. 25-01: The Health Care Affordability Fund* (June 25, 2025), https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%2011%20HCAF.pdf.

[44] Joel Ario and Jessica Nysenbaum, Manatt Health, *State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States*, T. 2, "Overview of Approved 1332 Reinsurance Waiver Funding," *available at* https://shvs.org/resources/state-reinsurance-programs-design-funding-and-1332-waiver-considerations-for-states.

[45] NAIC, *Third Party Administrator Licensure and Bond Requirements* (Updated Spring 2025), https://content.naic.org/sites/default/files/model-law-chart-pl-20-third-party-administrator-licensure-and-bond-requirements.pdf; Rebecca Arden Harris, et al., JAMA, *A National Opioid Tax for Treatment Programs in the US: Funding Opportunity But Problems Ahead* (Jan. 17, 2022); My Benefit Advisor, *Illinois PBM Law Taking Effect January 1, 2026* (Oct. 28, 2025), https://www.mybenefitadvisor.com/articles/compliance/2025/q4/illinois-pbm-law-takes-effect-january-1-2026.

[46] *See* Proposed Rule at 46565; *but see* discussion in 55 Fed. Reg. 55118, 55121-55123 (Nov. 24, 1992); 58 Fed. Reg. 43156, 43157 (Aug. 13, 1993); and *Medicaid Fiscal Accountability Regulation (MFAR)*, 84 Fed. Reg. 63722, 63735 (Nov. 18, 2018). The Proposed Rule includes language identical to that in the 2018 MFAR stating that "[o]ver the past several years" it had "become aware" of state taxes on health insurers; it is unclear to what period prior to 2018 the Department is referring.

[47] HHS, CMS, *State Innovation Waivers: State-Based Reinsurance* Programs (Aug. 2021), https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-aug2021.pdf.

Congress endorsed the collection of state user fees to meet requirements under the ACA that SBEs be self-sustaining. Not only has the Department codified this requirement in its own regulations, it requests information about such fees on the "Blueprint" application states must complete to establish an SBE.[48] And yet, there is no evidence that HHS has historically alerted states to their potential interactions with Medicaid FFP calculations.

Because HHS has never treated these taxes as provider taxes, states have had no reason to design them to comply with provider tax-specific limits. Therefore, few are likely to comply with the requirements to be uniform and broad-based or meet a specific hold harmless threshold.[49] However, under the Proposed Rule, states would also be barred from other longstanding pathways to compliance. The Department would require states to have requested a waiver of uniform and broad-based standards no later than September 30, 2025, nearly a year prior to the publication of the Proposed Rule, to be grandfathered under § 71115 of OBBBA. Again, because the Department has never actively regulated these taxes as provider taxes, there is little reason why a state would have sought a waiver prior to the publication of the Proposed Rule. In a separate proposal that clearly exceeds its regulatory authority, HHS would also eliminate the 75/75 test that provides states with a mechanism for meeting the hold harmless threshold when revenues associated with a tax are not returned to taxpayers.[50] Given that many taxes that would be newly categorized as provider taxes may fund non-Medicaid programs and priorities, the 75/75 test offers an important compliance pathway for states. Eliminating it would not only be inconsistent with the statute but would foreclose an opportunity for states to maintain key revenues.

Finally, the Proposed Rule ignores the devastating consequences of permanently extending provider tax requirements to virtually any tax with a relationship to health care. Under the punitive reporting and enforcement regime set forth in the Proposed Rule, states could be forced to refund tax payments associated with a non-Medicaid tax up to two years after the fact, or risk significant cuts to FFP. Not only would this impose a retroactive punishment on states with respect to longstanding taxes the Department has never previously treated as Medicaid provider taxes, but it will also encourage states to underestimate allowable tax revenues to avoid refund obligations or Medicaid clawbacks. Further, because § 71115 of OBBBA essentially prohibits states from implementing new provider taxes or increasing existing provider taxes, the Proposed Rule would permanently

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[48] § 1311(d)(5)(A) of the ACA (requiring that SBEs be "self-sustaining, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers"); 45 C.F.R. § 155.160(b)(1); *see, e.g., OK Blueprint for Approval for State-Based Health Insurance Exchanges*, section 1.4, https://www.cms.gov/files/document/oklahoma-oid-sbe-blueprint.pdf; *OR Blueprint for Approval for State-Based Health Insurance Exchanges*, section 1.4, https://www.cms.gov/files/document/or-sbe-blueprint-application-07-20-26.pdf.

[49] Pursuant to § 1311(d)(5)(A) of the ACA, many SBEs fund operations in part through a user fee assessed on issuers that sell products on the SBE, rather than on all health insurers. If finalized as proposed, the Proposed Rule would treat these fees as impermissible provider taxes, because they are not broad-based and uniform.

[50] See Proposed Rule at 46581-46582. The Department lacks the authority to eliminate the 75/75 test, which was codified by Congress in the Tax Relief and Health Care Act of 2006. Therefore, the Department should not finalize its proposed removal of the 75/75 test and should clarify in any final rule that the test remains in effect.

prevent states from responding to the needs of their state by imposing new taxes or increasing existing taxes on many health-related businesses, or risk significant cuts to Medicaid funding. The effects of these policies will be as predictable as they are ill-timed. Depriving states of revenue at the same time they are contending with OBBBA implementation will only accelerate coverage loss, benefit reductions, and provider reimbursement cuts that will harm Medicaid beneficiaries and other vulnerable state residents.

III. Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act.

Thank you for your attention to our comments. If you have any questions or need further information, please contact doetzer@healthlaw.org.

Sincerely,

Geraldine M. Doetzer
Senior Attorney