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THE VOICE FOR HEALTH CARE CONSUMERS

September 21, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via Medicaid.gov

Re CMS–2452–P: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care Related Taxes

Dear Administrator Oz,

On behalf of Families USA, thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS') proposed rule implementing Public Law 119-21 § 71115.

As the longtime national, non-partisan health care consumer advocacy organization dedicated to achieving high-quality, affordable health care and improved health for all, Families USA is deeply concerned about current federal efforts to impede states' abilities to adequately fund their state Medicaid programs, thus forcing cuts to coverage and care to millions of Americans. Public Law 119-21 (referred to by several different names including the Working Families Tax Cut legislation but referred to as "H.R. 1" throughout this comment letter) imposes major new restrictions on states' ability to generate revenue through provider taxes. CMS' Notice of Proposed Rulemaking (NPRM) proposes to restrict provider taxes even further than required by—or permissible under—H.R. 1 by extending funding restrictions to new tax types and narrowing states' abilities to comply with provider tax limits, which would force major cuts and impacts to key health agencies and functions well beyond Medicaid. **We urge CMS to make significant changes to this proposal before finalizing the rule, including withdrawing portions of the rule that are not permissible by statute.**

Limiting states' ability to raise the funds they need to cover Medicaid expenses is just another way for the federal government to cut its support for state Medicaid programs, a lifeline for over 75 million Americans. States pay, on average, 35% of Medicaid costs, totaling over $325 billion in fiscal year 2024 alone.[1] These costs are often the single biggest program expenditure in a state's budget, with Medicaid representing 30.7% of total state expenditures in fiscal year 2025.[2] State governments need to generate substantial revenue to provide Medicaid coverage to their residents. While provider taxes are not the only method for financing Medicaid expenses, they are an important part, covering about 18% of state Medicaid costs in 2026.[3] The significant provider tax restrictions enacted through H.R. 1 are already estimated by the Congressional Budget Office (CBO) to cut Medicaid by $191 billion over ten years (2025-2034).[4] CMS now estimates that, if the more restrictive approach detailed in this NPRM rule takes effect, federal and state **Medicaid spending would be cut by *$384.0 billion* over the next 10 years (2026-2035), representing a 27% reduction in provider tax revenue across states**.[5] This is on top of CMS' February 2026 final rule implementing a separate provider tax change, which estimated a $15.1 billion reduction in state and federal Medicaid expenditures by 2032.[6]

Cuts to provider taxes mean a major reduction in access to health care coverage and services. CBO estimates **H.R. 1's provider tax changes alone will leave 1.2 million uninsured by 2034 because states will have fewer resources to maintain existing Medicaid eligibility levels and benefits**.[7] If the NPRM moves forward as proposed, states will have even fewer options to support Medicaid and additional patients and populations may be at risk of losing coverage. Notably, CMS does not estimate the impact its proposals will have on the number of uninsured. For those that retain Medicaid coverage, it may become even harder to access needed benefits and services as Medicaid budgets tighten and states look to cut program costs.

Outside of Medicaid, as many states use insurance premium tax revenue to support state-funded subsidies for marketplace coverage, the NPRM's proposed regulation of the "services of health insurers" would make it more difficult for states to support residents in purchasing private coverage on the state marketplace, whether in outreach and navigation, regulation, or affordability assistance. Marketplace enrollees are already facing skyrocketing premiums due to the expiration of federal premium tax credit enhancements and many more may be forced to go uninsured without this state-funded support.

As outlined in our comments, CMS' approach to implementing § 71115 is not only bad policy for states and low-income consumers, but the agency has also overstepped its authority to regulate in two clear ways:

- The *Tax Relief and Health Care Act of 2006* expressly allows states to use the "75/75 test," an important fallback test to determine permissible provider taxes. **CMS does not have the statutory authority to remove this test.**
- **Congress did not give authority to CMS to apply H.R. 1's provider tax restrictions to new tax classes that were not in effect on May 1, 2025.** Regulation of the "services of health insurers" or any other new tax class included under § 433.56(a) must be governed by the preexisting hold harmless framework—the 6% safe harbor plus the 75/75 fallback test.

We respectfully request CMS to withdraw these proposals from the final rule.

Regardless of statutory authority concerns, we urge CMS to reconsider the approaches taken in this rule because of the significant harms they pose to health consumers and state budgets for critical services:

- The 75/75 test is rarely used, but may become increasingly important to state Medicaid solvency as H.R. 1's provider tax moratorium and other restrictions go into effect. Without this important fallback test, states may be forced to artificially lower their taxes even further below H.R. 1's restrictions. **We strongly urge CMS to preserve the flexibility afforded to states by existing statute by retaining the 75/75 test in regulation.**
- Taxes on health insurers are infrequently used to support state Medicaid programs, but this revenue source is critical to fund state departments of insurance, ACA marketplace operating costs, state-funded subsidies for marketplace coverage, and state efforts to maintain a stable insurance market. **Expanding the CMS regulatory authority and framework on Medicaid provider taxes to the "services of health insurers" broadly is beyond the statute and will have significant and detrimental consequences for state insurance markets and for state residents' ability to access affordable health insurance. We strongly urge CMS to withdraw this proposal.**

We cover each of these issues in more detail below and respectfully request that CMS consider our comments in full before issuing a final rule.

I. CMS has overstepped its authority to regulate and must withdraw portions of the proposed rule that are not mandated under Public Law 119-21 § 71115, including proposals to eliminate the "75/75" test, and proposals to extend H.R. 1's provider tax moratorium and restrictions to new classes of taxes, including the "services of health insurers."

Congress has codified the "75/75" test in statute and CMS has no statutory basis for its elimination; CMS must withdraw this proposal from the final rule.

Federal law prohibits "hold harmless" provider tax arrangements; states cannot directly or indirectly guarantee that taxed health care providers will receive their tax money back through increased reimbursement or other offsets. In August 1993, CMS (then, the Health Care Financing Administration), issued a final rule setting up a two-prong test to determine whether a state has a provider tax in place that amounts to an indirect hold harmless arrangement.[8] The rule, under 42 C.F.R. § 433.68(f)(3)(i), states that health care-related taxes are permissible if they meet one of the following:

(A) Safe Harbor. If the health care-related tax is at 6% or less of net patient revenue, it falls in the "safe harbor" and is permissible.
(B) 75/75 Test. If the health care-related tax exceeds the safe harbor threshold, "CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments."[9]

The *Tax Relief and Health Care Act of 2006* (Public Law 109-432) amended the indirect hold harmless regulation by temporarily lowering the safe harbor to 5.5% between 2008 and 2011. The Act also added Section 1903(w)(4)(C)(ii) to the portion of the Social Security Act that governs hold harmless provider tax arrangements, which states: "a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006…"[10] Here, by cross-referencing the regulatory text under § 433.68(f)(3)(i) as it existed on November 1, 2006, Congress incorporated the *entire* two-prong test into statute—both the 6% threshold and the 75/75 fallback test—taking what was once a regulatory requirement and making it a statutory one. **In doing so, Congress prevented CMS from subsequently altering the content of this regulation through rulemaking, because doing so would no longer just be amending a regulation—it would functionally be amending the statute, which only Congress can do.**

Under H.R. 1 § 71115, Congress once again modified the safe harbor threshold (instead of 6%, each state now has a state-specific percentage for each provider class, based on whatever taxes the state had in place as of H.R. 1's passage). However, Congress did not touch the second prong of the hold harmless test. Instead, Congress preserved the regulatory cross-reference it instituted under the *Tax Relief and Health Care Act of 2006* keeping the 75/75 test intact.

Given that the statute expressly allows states to use the 75/75 test, CMS does not have the statutory authority to delete it, as proposed under the NPRM. Under the Administrative Procedures Act (APA), CMS has no discretion to depart from unambiguous statutory instructions.[11] The APA instructs courts to hold unlawful and set aside agency action that is "not in accordance with law" or "in excess of statutory jurisdiction, authority, or limitations."[12]

CMS acknowledges in the NPRM's preamble that the 75/75 test was designed to provide states flexibility and that Congress did not expressly eliminate it: "The changes made by the WFTC [Working Families Tax Cut] legislation do not address the 75/75 test."[13] CMS expresses concern that more states will now rely on the 75/75 test to prove they have a permissible tax given the mechanics of H.R. 1, especially in states that have expanded Medicaid under the Affordable Care Act's (ACA's) Medicaid expansion (because of H.R. 1's required provider tax phase-down in Medicaid expansion states, these states may be more likely to exceed the safe harbor as they adopt required changes). CMS points out that some states may be able to retain taxes above H.R. 1's statutory caps by falling back on the 75/75 test. While this may be a result of H.R. 1's new restrictions, CMS does not have the authority to prevent states from turning to the second prong of the hold harmless test to prove they have a permissible tax, as the 75/75 test remains law. Congress specifically chose not to eliminate or modify the 75/75 test when it passed H.R. 1. Instead, Congress kept the 75/75 test intact in statute, and CMS has overstepped its regulatory authority by proposing to remove state access to this important fallback test.

CMS has no statutory basis for applying H.R. 1's provider tax moratorium and restrictions to tax on the "services of health insurers" and must withdraw this portion of the proposed rule.

The NPRM proposes adding "services of health insurers" as a new class of health care items or services 42 C.F.R. § 433.56(a) subject to federal provider tax oversight, including the new provider tax restrictions established by H.R. 1. While the Social Security Act provides authority for CMS to include new classes of health care items and services under the provider tax framework (42 U.S.C. 1396b § (7)(A)(ix)), the language of H.R. 1 is clear that its new restrictions will not apply to any new classes.

Congress states *twice* under § 71115(a)(2) that the law's provider tax moratorium and restrictions apply only to "a class of health care items or services described in section 433.56(a) of title 42, Code of Federal Regulations (as in effect on May 1, 2025)."[14] On May 1, 2025, 42 C.F.R. § 433.56(a) did not list "services of health insurers" as a regulated tax class. Therefore, Congress' provider tax moratorium and restrictions do not—and cannot—apply to this new class.

CMS concedes in the NPRM that § 71115 applies only to tax classes in effect on May 1, 2025, and that the class of "services of health insurers" did not exist under § 433.56(a) as of that date.[15] Congress knew CMS had general authority to establish additional classes by regulation, yet Congress deliberately selected a historical version of the regulation to set a boundary around the reach of H.R. 1. Nonetheless, CMS treats the statute as if it is silent on this issue and then chooses to extend all of H.R. 1's restrictions to this new tax class anyway. CMS' approach effectively changes the statute from classes described in the regulation as in effect on May 1, 2025, to classes described in the regulation as in effect on May 1, 2025, *plus any classes CMS later creates*. Congress has not given CMS regulatory authority to do this, and the APA instructs that CMS cannot depart from these unambiguous statutory directives.[16]

Without authority to apply H.R. 1's provider tax restrictions to new tax classes, regulation of the "services of health insurers" or any other new tax class included under § 433.56(a) should be governed by the preexisting hold harmless framework—the 6% safe harbor plus the 75/75 fallback test. We strongly urge CMS to withdraw this portion of the proposed rule.

II. The "75/75 test" is an important fallback test to determine permissible provider taxes, increasingly important to state Medicaid solvency as H.R. 1's provider tax moratorium and other restrictions go into effect.

As described above, CMS proposes to eliminate the 75/75 test (despite clear statutory language that requires CMS to preserve this test) for fear that Medicaid expansion states may lean on this fallback test as they adapt to Congress' provider tax restrictions.[17] In CMS' view, continued application of the 75/75 test might allow some states to exceed the new tax limits set by H.R. 1 if they can satisfactorily comply (for example, by ensuring that providers in the class receive less than 75% of their total tax costs back). In reality, without the 75/75 test as a fallback, H.R. 1's thresholds become a *hard cap*, and states may be forced to artificially lower their taxes even further below H.R. 1 thresholds to stay in good standing.

Historically, states have calibrated their tax rates comfortably under the 6% threshold to avoid having to demonstrate compliance with the 75/75 test and, according to CMS, the fallback test has been used "extremely rarely," with only one state ever having used the second prong to validate their health care-related tax.[18] Congress' new statutory caps are likely to lead to states pursuing a similar strategy to ensure their taxes stay within required limits, meaning the actual tax rate levied in a given state is likely to remain below the cap imposed by H.R. 1. The substantial penalties for exceeding the cap proposed in the NPRM—a proposed requirement to return *all* federal matching funds associated with the entirety of that provider tax, not just the amount of the overage—add an additional and strong incentive for states to stay below their cap or to issue frequent refunds to providers to avoid getting too close.

However, as states adopt new statutory and regulatory requirements and recalibrate provider taxes accordingly, there could be times when they exceed their cap and reasonable moments for states to rely on the flexibility of the 75/75 test granted to them by the Social Security Act to help preserve provider tax revenue:

- For example, Medicaid expansion states must adjust their taxes downward under H.R. 1's multi-year phase down, and states could be at risk of running afoul of new caps as they work toward making these modifications.
- In addition, if the NPRM's proposed changes to provider tax data reporting take effect, states will have to submit frequent and detailed reports using actual data on net patient revenue and total tax collected for each provider class. This is a proposed shift from prior regulation (which permitted states to report estimates or prior-period figures to substantiate that taxes fall within the hold harmless threshold[19]), and it may take states time to properly adjust their data collection and reporting, running the risk of tax overages in the meantime.

These new scenarios created in the aftermath of H.R. 1 would seem to fit within the original regulatory intention of the 75/75 test, which, as CMS states in the NPRM, was "designed to allow some flexibility for States if the need arose for a health care-related tax to be imposed at a higher overall tax level." In short, CMS has long recognized (and Congress has affirmed through statutory reference, as described previously) that states may need wiggle room to use the alternative test to prove their taxes do not amount to a hold harmless arrangement. Unprecedented shifts in provider tax policy would seem to justify tax overages where they occur and justify the use of the test, even if it has rarely been invoked previously.

For these many reasons, we believe CMS' concerns that states will improperly lean on the 75/75 test is unfounded. **We strongly urge CMS to retain the flexibility afforded to states by statute by keeping the 75/75 test.**

III. Including taxes on the "services of health insurers" within the CMS-regulated provider tax framework, as proposed in the NPRM, is beyond the statute and will have devastating impacts on states' abilities to support and finance state departments of insurance and ACA marketplaces.

CMS proposes to expand its authority to treat "services of health insurers" as any other provider class, subject to all provider tax regulation and oversight, including H.R. 1's provider tax moratorium and restrictions. As explained above, we do not believe it is permissible to apply H.R. 1's provider tax moratorium and restrictions to this class, but we also strongly alert CMS that this approach has significant negative implications for state health care system financing far beyond Medicaid.

Every state imposes some form of general insurance premium tax on health insurers licensed to do business there, typically running somewhere in the range of 1-4% of gross premiums depending on the state.[20] The Affordable Care Act specifically requires state marketplaces to be self-sustaining and allows states to rely on user fees to fund marketplace operations: "In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."[21]

Taxes on health insurers are infrequently used to support state Medicaid programs, but these revenue sources are critical to fund state departments of insurance, ACA marketplace operating costs in the 22 states that operate their own state marketplace, state-funded subsidies and affordability assistance for marketplace coverage, and state efforts to maintain a stable insurance market (such as reinsurance programs that reimburse health insurance companies for a portion of high-cost medical claims).[22] If the NPRM moves forward as proposed, these key revenue sources are at risk of being restricted or barred by CMS, even if they have little or no connection to Medicaid.

While we acknowledge that federal law does not require that a tax ultimately supports Medicaid for it to be regulated by CMS as a provider tax,[23] **we urge CMS to consider the cascading ramifications of this proposed policy on health care system financing far beyond Medicaid, resulting in severe, negative consequences for state budgets and for state residents' ability to access affordable health insurance**, including:

- **Disrupting states' ability to deliver on key insurance regulation functions:** States will have trouble budgeting and running their state insurance systems because they will have no way to know in advance whether their taxes will meet strict new regulatory standards. This introduces significant and unnecessary uncertainty into states' fiscal planning that could jeopardize critical investments in the infrastructure needed to regulate and conduct oversight of health insurers. For example,
    - In states that operate their own marketplaces, without the ability to impose or increase a user fee on insurers who sell plans on the marketplace, states will not have the funding needed to offer state subsidies that make marketplace coverage more affordable for state residents. Currently, Colorado, Maryland, New Jersey, and New Mexico all rely on user fees to fund additional subsidies to lower marketplace premiums, and these investments have helped preserve marketplace enrollment at a time when it is generally declining.[24]
    - Many states also rely on user fees and other taxes on insurers to fund reinsurance programs that help stabilize marketplace premiums by paying high-cost claims. These

programs reduced premiums for unsubsidized marketplace enrollees by an average of 16% in 2023.[25]
    - Restricting state-based marketplaces' ability to collect user fees could also limit their ability to invest in marketing and outreach and fund enrollment assisters. These best practices help marketplaces attract a balanced mix of consumers (including healthier individuals who may not otherwise seek out insurance through the marketplace) and connect underserved communities and people with complex health care needs to application and plan-comparison support.[26]

- **Erecting barriers to enrollment that could drive up future costs.** Limiting states' ability to fund state premium subsidies, reinsurance programs, and enrollment assistance will result in new barriers to enrollment (some financial, some administrative), adding more complexity to a system that needs barriers to care removed. Making it more difficult for people to afford coverage and more difficult to complete the enrollment process will result in younger, healthier individuals exiting the marketplace while people with chronic conditions or higher health care needs stay enrolled.[27] With fewer healthy individuals to balance the risk pool, these proposed limits on states' ability to utilize user fees and taxes to fund marketplace operations will result in higher premiums for all marketplace enrollees over time. Marketplaces are already facing historic enrollment declines following the expiration of premium tax credit (PTC) enhancements and corresponding premium increases. Additionally, a growing number of insurers are exiting the marketplaces for 2027.[28] The changes in this proposed rule would exacerbate these trends.

- **Hampering states' ability to respond to future marketplace challenges.** Locking taxes in at their July 4, 2025 rate means states will not be able to adjust their tax rates to account for changes in projected enrollment and fluctuations in ACA marketplace operating costs in the future. Marketplace enrollment has been extremely volatile since the expiration of PTC enhancements at the end of 2025. State policymakers interested in making investments to stabilize their marketplace (through reinsurance, state subsidies, or other mechanisms) will no longer be able to nimbly respond to these pressures if this rule is finalized as proposed.

- **Creating significant operational challenges would create confusion and force states to defund key functions or make severe cuts and changes well beyond what may be required.** CMS proposes that they would not calculate and provide the initial limits on provider taxes to states until October 2028, however, these limits would apply to taxes enacted and imposed as of October 1, 2026. Under this proposed framework, state officials would not know whether their taxes are allowed at current levels for *two years* after they have already been collected, at which point the state could learn that its tax rates exceeded allowable thresholds. This lag places states in the impossible position of guessing how much of their current taxes and fees on the services of health insurers can remain in place for the next two years without risking exceeding the new limits—and facing the immense consequence of losing *all* federal matching Medicaid funds associated with the tax. As states have no apparatus in place to return funds to taxpayers (especially two or more years after the funds were collected), some states might cut back preemptively on these taxes to avoid getting too close to their cap (particularly without the option of the 75/75 test, described above). This could truly devastate state programs that give people with low and moderate incomes the ability to obtain affordable marketplace health coverage.

In addition, if finalized as proposed, many of the current taxes that would be classified as "services of health insurers" would not meet current statutory or regulatory provider tax requirements for being broad-based and uniform, and so states would not be permitted to maintain them at all. Such an interpretation would have devastating consequences for state-based marketplaces, which would be unsustainable without user fees. Although CMS allows waivers of the broad-based and uniform requirement, the deadline for requesting such a waiver for taxes in place as of July 4, 2025 passed nearly a year ago on September 30, 2025. States would have had no way of knowing it would be necessary to request a waiver from a requirement that was not in place at that time or even hinted at in the H.R.1 text.

Given the many detrimental consequences on state insurance markets and low-income consumers who depend state marketplaces for affordable coverage, we strongly urge CMS to withdraw its proposal to include taxes on the "services of health insurers" within the CMS-regulated provider tax framework.

Conclusion

H.R. 1's provider tax restrictions slash federal funding to states without addressing underlying health care costs for consumers and state programs. CMS' proposed rule would narrow state funding options—in ways clearly beyond its authority—at a time when states are already navigating significant Medicaid budget shortfalls and fiscal uncertainty post-H.R. 1.

The stakes are incredibly high if states do not get this right: Exceeding the provider tax threshold is not just a proportional trim — it is a structural disqualification of the entire tax's revenue from counting as valid state Medicaid share, which translates into losing the entire associated federal match (not just match on the overage) and carries a significant risk of CMS retrospectively clawing back federal funds already paid out. Without the possibility of the 75/75 test, states have no regulatory safeguard to protect them even if they are just off by *a hundred-thousandth of a percent*. This proposal endangers all states, with even state leaders enthusiastic about the policy goals of H.R.1 having to struggle to accurately calibrate taxes and fees in order avoid an overpayment.

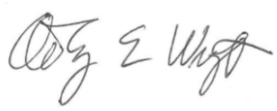
Not only does CMS propose to gut an important fallback test for states to maintain Medicaid funding, but it also proposes to extend its strict Medicaid funding restrictions to the private state insurance market. This proposed policy would bring untold consequences for state insurance markets and the low-income residents that depend on the supportive infrastructure built by their states to access affordable health insurance.

Eliminating the 75/75 test and extending H.R. 1's provider tax restrictions to the "services of health insurers" are bad policies and in opposition to clear statutory instructions that prevent both proposals. We emphatically urge CMS to withdraw these portions of the proposed rule and retain both the statutory flexibility afforded to state Medicaid programs by preserving the 75/75 test and the stability of state insurance markets by leaving taxes on the "services of health insurers" out of the Medicaid provider tax regulatory framework.

We thank you for the opportunity to comment on CMS' implementation of Public Law 119-21 § 71115. For questions or comments regarding the recommendations in this letter, please contact Mary-Beth Malcarney, Senior Advisor on Medicaid Policy, Families USA at mmalcarney@familiesusa.org.

Thank you for your time and consideration.

Sincerely,



Anthony Wright

Executive Director

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[1] "Federal and State Share of Medicaid Spending," KFF, n.d., https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22State%22,%22sort%22:%22desc%22%7D.

[2] National Association of State Budget Officers, "2025 State Expenditure Report: Fiscal Years 2023–2025," 2025, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2025_SER/2025_NASBO_State_Expenditure_Report_S.pdf

[3] Elizabeth Williams, Anna Mudumala, Elizabeth Hinton, and Robin Rudowitz, "Medicaid Enrollment & Spending Growth: FY 2025 & 2026," KFF, November 13, 2025, https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2025-2026/.

[4] Congressional Budget Office. 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. 21 July 2025, www.cbo.gov/publication/61570.

[5] Centers for Medicare & Medicaid Services. "Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes." *Federal Register*, 23 July 2026, CMS-2452-P, at 46591, www.federalregister.gov/d/2026-14897.

[6] Centers for Medicare & Medicaid Services, "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care–Related Tax Loophole," Department of Health and Human Services, 4794 Fed. Reg. 91, no. 21 (February 2, 2026), https://www.govinfo.gov/content/pkg/FR-2026-02-02/pdf/2026-02040.pdf.

[7] Swagel, Phillip L. "Distributional Effects of Public Law 119-21." Letter to the Honorable Brendan F. Boyle et al. Congressional Budget Office, August 11, 2025. https://www.cbo.gov/system/files/2025-08/61367-Distributional-Effects.pdf.

[8] Health Care Financing Administration. "Medicaid Program; Health Care-Related Taxes and Provider-Related Donations." Federal Register 58, no. 155 (August 13, 1993): 43156–43183, https://archives.federalregister.gov/issue_slice/1993/8/13/43152-43183.pdf#page=5.

[9] 42 C.F.R. § 433.68(f)(3)(i)(B), https://www.law.cornell.edu/cfr/text/42/433.68.

[10] Enacted in the Tax Relief and Health Care Act of 2006 (P.L. 109-432), 109th Congress (2005-2006), https://www.congress.gov/bill/109th-congress/house-bill/6111. *See* Social Security Act § 1903 (w)(4)(c)(ii)).

[11] 5 U.S.C. § 706(2)(A); Brannon VC, "Statutory Interpretation: Theories, Tools, and Trends," Congressional Research Service, March 10, 2023, https://www.congress.gov/crs-product/R45153.

[12] 5 U.S.C. § 706(2)(A), (C).

[13] Centers for Medicare & Medicaid Services. "Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes." 91 Federal Register 46581, July 23, 2026,

www.federalregister.gov/documents/2026/07/23/2026-14897/medicaid-program-amending-the-indirect-hold-harmless-threshold-of-health-care-related-taxes.

[14] Pub. L. No. 119-21 § 71115 (2025).

[15] 91 Federal Register at 46567.

[16] 5 U.S.C. § 706(2)(A); Brannon VC, "Statutory Interpretation: Theories, Tools, and Trends," Congressional Research Service, March 10, 2023, https://www.congress.gov/crs-product/R45153.

[17] Centers for Medicare & Medicaid Services. "Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes." 91 Federal Register 46581, July 23, 2026, www.federalregister.gov/documents/2026/07/23/2026-14897/medicaid-program-amending-the-indirect-hold-harmless-threshold-of-health-care-related-taxes.

[18] Centers for Medicare & Medicaid Services. "Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes." *Federal Register*, 23 July 2026, CMS-2452-P, at 46581, www.federalregister.gov/d/2026-14897; Medicaid and CHIP Payment and Access Commission. "Health Care-Related Taxes in Medicaid." Issue Brief. Washington, DC: MACPAC, May 2021. https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf.

[19] Mitchell, Alison. *Medicaid Provider Taxes.* CRS Report RS22843. Washington, DC: Congressional Research Service, August 5, 2016, https://www.congress.gov/crs-product/RS22843.

[20] National Association of Insurance Commissioners. "Premium Tax Rate by Line." State Insurance Charts. Retaliation series. December 2025. https://content.naic.org/sites/default/files/model-law-chart-zz-1-premium-tax-rate-by-line.pdf.

[21] 42 U.S.C. § 18031 (d)(5)(A)

[22] Levitis, Jason, Claire O'Brien, Caitlin Rowley Gallamore, and Rachael Totz. "State Marketplace Subsidies to Support Health Insurance Affordability." State Health and Value Strategies, Princeton University School of Public and International Affairs, March 2026. https://shvs.org/wp-content/uploads/2026/03/SHVS_State-Marketplace-Subsidies-to-Support-Health-Insurance-Affordability_Final.pdf; National Association of Insurance Commissioners. "State Insurance Regulation: Key Facts and Market Trends." NAIC Publications, 2025. https://content.naic.org/publications?name=State+Insurance+Regulation%3A+Key+Facts+and+Market+Trends&field_publication_category_target_id=All; Lueck, Sarah. "Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges: States Should Do So Only With a Clear Plan to Increase Coverage." Center on Budget and Policy Priorities, February 6, 2020. https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges; KFF. "Tracking Section 1332 State Innovation Waivers." Last modified August 9, 2025. https://www.kff.org/affordable-care-act/tracking-section-1332-state-innovation-waivers/.

[23] Social Security Act § 1903(w)(3)(A); 42 C.F.R. § 433.55 and 433.56 Health care-related taxes defined.

[24] Justin Lo, Matt McGough, and Cynthia Cox. "How Has ACA Marketplace Enrollment Changed Across States in 2026?" KFF, July 28, 2026. https://www.kff.org/affordable-care-act/how-has-aca-marketplace-enrollment-changed-across-states-in-2026/.

[25] Centers for Medicare and Medicaid Services, "CCIIO Data Brief Series: Data Brief on State Innovation Waivers: Section 1332 Waivers." April 2024. https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

[26] Issue Brief No. HP-2021-21 "Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment Strategies. https://aspe.hhs.gov/reports/reaching-remaining-uninsuredoutreach-enrollment. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October, 2021.

[27] Keith Marzilli Ericson, Timothy J. Layton, Adrianna McIntyre, Adam Sacarny. "Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment." *The Review of Economics and Statistics* 2025. https://doi.org/10.1162/rest_a_01573; Shepard, Mark, and Myles Wagner. 2025. "Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment." *American Economic Review* 115 (3): 772–822.

[28] "State Marketplace Network: Summer 2026 Enrollment Update." State Marketplace Network. August 31, 2026. https://statemarketplacenetwork.org/state-marketplace-network-summer-2026-enrollment-update/