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Legislative Update: Senate Finance Committee Releases Reconciliation Bill Text

Following House passage of congressional Republican's budget reconciliation package, the One Big, Beautiful Bill Act (H.R. 1), Senate Republicans took to their respective committees to provide edits and changes to the massive tax-cut, border security, energy reform, and health care package. A significant portion of the bill's tax and health care policies fall under the jurisdiction of the Senate Committee on Finance, chaired by Senator Mike Crapo (R-ID). On Monday, June 6, Senator Crapo unveiled his committee's 549 pages of legislative text, which includes several significant deviations from policies outlined in the House-passed version of H.R. 1. The respective Senate committee texts now face review under the Byrd Rule, which roots out extraneous provisions from the budget reconciliation package. Following the 'Byrd Bath,' Senate Republicans will compile the individual committee texts and vote on passage of the entire package. Although it only requires a simple majority to pass, House and Senate Republicans on both sides of the political spectrum are already signaling their displeasure with several components of the Senate Finance Committee text. The bill faces another test in the House of Representatives, where Members must agree to the Senate's changes or submit their own compromise in response.

The following is a summary of certain health care provisions included in the Senate Finance text for H.R. 1 that may impact managed care pharmacy. Subtitles and Subchapters in this summary reflect language provided by the Senate Committee on Finance.

Subtitle B. – Health Care

Chapter 1 – Medicaid

As with the House-passed version of H.R. 1, the Senate Finance Committee proposes significant reductions in spending for the federal/state safety net health insurance program. In conjunction with the release of the Senate Finance text, Senator Crapo released a summary memo outlining the increase of federal Medicaid outlays by 207% since 2008, representing a 3% rise in its share of total

federal outlays. Opponents of these proposals argue that work requirements (also called "community engagement" requirements) alone may threaten insurance coverage for millions of Americans. Specifically, a Congressional Budget Office study of the House bill finds that Medicaid and Affordable care Act marketplace reforms could leave 10.9 million Americans uninsured, while the proposed tax cut extensions may increase the federal deficit by up to $2.4 trillion.[1] In an attempt to further offset the tax cut extensions proposed in "Subtitle A. – Tax," the Senate Finance Committee proposes deeper cuts to Medicaid, including more stringent work requirements and a significantly smaller cap on the tax rate that states may charge Medicaid providers.

Subchapter A – Reducing Fraud and Improving Enrollment Processes

- Subchapter A contains several provisions aimed at limiting erroneous payments, increasing oversight of enrollment processes, and repealing Biden-era rules and regulations. Sections 71101 and 71102 specifically prevent implementation of Biden-administration rules simplifying the enrollment process for the Medicare Savings Programs, as well as Medicaid and the Children's Health Insurance Program (CHIP). Other provisions, such as Sections 71103, 71104, and 71105 aim to reduce duplicate or unnecessary enrollment, requiring states to regularly obtain demographic data and swiftly remove: beneficiaries enrolled in more than one state Medicaid program, deceased beneficiaries, and deceased providers.
    - The House-passed version of H.R. 1 delayed implementation of the Medicare Eligibility and Enrollment Final Rule until Jan. 31, 2035, while the Senate bill prohibits implementation entirely.

- A significant portion of this Subchapter reflects proposals to prevent undocumented immigrants from accessing Medicaid coverage. Section 71109 would prohibit federal funds from covering individuals without verified citizenship, nationality, or satisfactory immigration status. While states would no longer be required to provide coverage to individuals during the reasonable opportunity period, states that elect to provide coverage must do so without the support of federal funds. Sections 71111 and 71112 reflect changes in the federal medical assistance percentage (FMAP) for states who provide Medicaid coverage to individuals not considered "qualified aliens" under the Personal Responsibility and Work Opportunity

[1] Estimated Budgetary Effects of H.R. 1, the One Big Beautiful Bill Act. Congressional Budget Office. June 4, 2025. https://www.cbo.gov/publication/61461

Reconciliation Act. Specifically, states that provide Medicaid coverage to non-qualified aliens would find their FMAP rate reduced from 90% to 80%. Similarly, the bill would equalize the FMAP for non-qualified aliens receiving emergency Medicaid with the FMAP offered to the traditional Medicaid population.

- As with the House-passed version, Section 71107 of the Senate Finance text proposes a requirement for states to conduct Medicaid eligibility redetermination every six months for patients who received coverage through ACA expansion. Current law requires states to determine program eligibility every 12 months.
    - This provision falls in step with the six-month eligibility redetermination proposed in the House of Representatives bill.

Subchapter B – Preventing Wasteful Spending

- H.R. 1 includes a provision (Sec. 71116) banning the use of spread pricing, where PBMs charge pharmacies prices higher than a drug's acquisition cost and keep the difference as profit, by Pharmacy Benefit Managers (PBM) operating under Medicaid contracts. The provision requires PBMs to implement pass-through rebate structures, where the PBM reimburses the pharmacy at the drug's ingredient cost plus a professional dispensing fee. This provision also limits PBM compensation to a flat, fair market fee, while any manufacturer rebates are passed through to the pharmacy in their entirety. For 340B drugs subject to the cost-plus model, ingredient costs may exceed the actual acquisition cost paid by the covered entity.
    - Section 71116 stands as one of the many PBM reform provisions proposed by Congress over the past year. However, the Seante Finance text omitted a similar provision, known as "de-linking," which would have cut a PBM's compensation from the price of a drug in Medicare, as well as additional transparency requirements for PBMs operating in Medicare.

- Section 71115 reflects significant changes to the National Average Drug Acquisition Cost (NADAC) survey, which is used to compile trends in *retail* drug acquisition costs, as well as estimates of the prices *retail* pharmacies pay for outpatient drugs covered by Medicaid. This section proposes expanding the survey to include non-retail pharmacies, such as specialty pharmacies and mail-order pharmacies. The proposal mandates survey

participation by these additional non-retail pharmacies and would implement civil monetary penalties for noncompliance. Respondents would be required to report the net total of all price concessions, including discounts and manufacturer rebates.

- A significant portion of Subchapter B follows through on the Trump administration initiative to repeal Biden-era regulations deemed unnecessary, with a focus on rooting out Diversity, Equity, and Inclusion programs and policies. Section 71113 prohibits implementation of a rule that establishes minimum staffing standards for Medicare and Medicaid long-term care facilities. Sections 71117 and 71118 specifically prohibit federal Medicaid or CHIP funding for gender-affirming care, as well as items and services provided by prohibited entities. Under this statute, prohibited entities are nonprofit community providers that provide family planning or abortion services, except for those allowable under the Hyde amendment.

Subchapter C – Stopping Abusive Finance Practices

- Under existing law, states may generate Medicaid expenditures through health care-related taxes, often referred to as provider taxes. The federal government defines provider taxes as those for which at least 85% of the tax burden falls on health care items or services or entities that provide or pay for health care. Current law allows the federal government and states to reimburse providers for up to 6% of net patient revenue. Section 71120 prohibits non-Medicaid expansion states from increasing the provider tax rate and gradually decreases the maximum allowable provider tax rate for expansion states by 0.5% annually, until the maximum rate reaches 3.5% in 2031. However, provider taxes levied on nursing homes and intermediate care facilities would be exempt.
    - Of note, the House version of H.R. 1 specifically prohibits states from implementing new provider taxes or increasing provider taxes above the current rate. The Senate Finance text actively reduces the provider tax cap for expansion states on an annual basis.

- In addition to federal funding and provider taxes, states may offer state directed payments to providers under managed care contracts. Under current law, these payments may not exceed the average commercial rate. Section 71121 would reduce the state directed payment limit to 100% of the existing Medicare payment rate (for ACA Medicaid expansion states) or 110%

of the existing Medicare payment rate (for non-ACA Medicaid expansion states).
    - Of note, the House-passed version of H.R. 1 allows for existing state directed payments to continue if enacted before the bill's passage, while the proposed Senate version reduces directed payments by 10% each year until they reach the requisite threshold.

- Additionally, Section 71119 sunsets the 5% FMAP increase offered to expansion states for the eight quarters following expansion.

Subchapter D – Increasing Personal Accountability

- Federal law does not require Medicaid beneficiaries to demonstrate employment in order to receive coverage. However, Section 71124 would implement significant community engagement requirements for certain nonpregnant, nondisabled, childless adults aged 19 to 35. These requirements mandate eligible individuals to demonstrate 80 hours of activity per week through: work, a work program, community service, or educational and vocational programs. The provision exempts certain individuals from these work requirements, including disabled veterans, significantly disabled individuals, parents and guardians of disabled individuals or children under 14, Indians eligible for the Indian Health Service, and certain inmates of public institutions. States may also exempt certain individuals who are experiencing short term hardships, such as inpatient hospital stays, natural disasters or emergencies, or persistently high unemployment rates in their home region. States must verify compliance with these work requirements at least every 6 months, and develop procedures for identifying, notifying, and removing non-compliant individuals from the program. The provision also outlines a standard timeline for enrollees to be notified of upcoming work requirements, while providing a 30-day window for non-compliant individuals to demonstrate compliance.
    - Of note, the House version of H.R. 1 granted requirement exceptions to parents of dependents aged 18 or younger, while the Senate Finance text limits exemptions only to guardians whose children are 14 years old or younger.

- Current law limits the amount of premiums, co-payments, coinsurance, or deductibles that states may impose on certain Medicaid beneficiary populations. Under H.R. 1's Section 71125, Medicaid expansion enrollees

earning 100% or more of the federal poverty level must pay copays of up to $35 per service. Primary, prenatal, pediatric, and emergency care are exempt from the $35 per service copay requirement.

Chapter 2 – Medicare

- Despite significant rumblings of Senate-directed cuts to the Medicare program, it remains largely untouched in the Senate Finance Committee's reconciliation bill text. However, Section 71201 proposes more stringent limits on the categories of non-citizens eligible for Medicare benefits. The provision would limit eligibility to lawful permanent residents, certain Cuban immigrants, and Citizens of Freely Associated States lawfully residing in the United States, while refugees, aliens granted parole for a year or more, certain trafficking victims, and aliens granted asylum would no longer be eligible. The provision would mandate the Social Security Commissioner to identify and notify ineligible aliens of their status within six months of passage.
    - Of note, the Senate Finance Committee text omitted a Medicare Drug Price Negotiation exemption for certain orphan drugs, which was originally included in the House-passed version of H.R. 1. This provision would have exempted drugs with one or more orphan indication from negotiation, while the period of time a drug retains such designation will not count towards the time frame for determining small-molecule drug eligibility.
    - Similarly, delayed payment cuts to Disproportionate Share Hospitals and reforms of Medicare physician payment schemes, whose annual increases would be tied to the Medicare Economic Index, found space in the House version of H.R. 1 but were not included in the Senate Finance Committee text.

Chapter 3 – Health Tax

Subchapter A – Improving Eligibility Criteria

- The Senate Finance reconciliation text extends similar eligibility limits to those seeking a premium tax credit (PTC) to offset the costs of plans offered through ACA exchanges. As with Section 71202, Section 71301 defines aliens eligible for the PTC as lawful permanent residents, certain Cuban immigrants, and Citizens of Freely Associated States lawfully residing in the United States.

Section 71302 disallows lawfully present individuals with incomes below the federal poverty level from receiving the PTC.

Subchapter B – Preventing Waste, Fraud, and Abuse

- Chapter 3, Subchapter B contains several additional provisions restricting the use of the PTC. Section 71303 would require any enrollee to verify information on household income, immigration status, health coverage status, place of residence and family size. Section 71304 disallows the PTC for individuals enrolled in an exchange plan during a special enrollment period, while Section 71305 requires taxpayers to repay the full amount of any excess advanced PTC awarded.