KHA's Federal Advocate
June 26, 2025

The Saga Continues on One Big Beautiful Bill
The Senate continues to hurdle toward a vote on the One Big Beautiful Bill even though its final text is currently unsettled. In order to meet President Trump's deadline of sending a bill to his desk by July 4, Senate GOP leadership intends to bring the bill directly to the floor without going through a committee process. Their hope is to schedule floor time for the bill's consideration while negotiations continue so that there is a sense of urgency. Once final deals have been made, they will insert the final text as part of a "wrap around" amendment before voting on final passage.

Complicating matters is the fact that the Senate Parliamentarian, Elizabeth MacDonough, has been deeming many provisions of the Senate's nascent bill as not adhering to rules for reconciliation bills under the Budget Act of 1974. In order for a provision to meet the Budget Act's standards, it must not make changes to the federal budget that are incidental to the purpose of the provision. In other words, if the Parliamentarian discerns that your goal is to change the Medicaid program rather than save or spend federal dollars as part of such changes, she will deem it ineligible. All provisions deemed ineligible are subject to a budget point of order which can only be waived by a 3/5 majority vote, a sizable majority currently beyond Senate Republicans' grasp.

Earlier today, the Parliamentarian deemed the Senate bill's provider tax language to be ineligible, or technically speaking, subject to a budget point of order. This means that Senate GOP leadership has three options: 1) strip the language from the bill; 2) change the language to try and make it reconciliation compliant; 3) challenge the Parliamentarian's ruling, which can be overridden with a majority vote. Option 1 is currently unacceptable to Senate Republicans. Option 3 is fraught with danger because this would set a precedent that all such future points of order can be overridden by a majority vote; this is commonly referred to as the "nuclear option" because it essentially changes the rules permanently.

So, Senate GOP leadership is angling for option 2. The Kansas Hospital Association has been clear that, while not perfect, we prefer the House's position on provider assessments and state directed payments to the Senate position because it would allow both Kansas' full provider tax at 6% as approved by the state legislature and our state directed payment program to go

forward. The House position has not yet, as far as we know, been tested by the Parliamentarian. All of this could change rapidly, but we have been and continue to work with Senator Jerry Moran's office on this issue to ensure that the technical language in the bill is favorable to Kansas hospitals. KHA has appreciated Sen. Moran and his staff reaching out to us on the numerous policy issues being considered that may impact Kansas hospitals. We will keep you posted as more information becomes available – stay tuned.

Insurers Pledge Prior Authorization Reform

On Monday, some of the nation's largest insurers officially pledged to make various actions to address problems caused by prior authorization. The announcement, shared in coordination with leadership from Centers for Medicare & Medicaid Services and the Department of Health and Human Services, identifies six areas of reforms that aim to enhance transparency with prior authorization decisions.

The reforms will apply to patients covered by Medicare Advantage, Medicaid managed care plans, Marketplace plans and commercial plans from companies that were represented as part of this handshake agreement which include Aetna, Inc., Blue Cross Blue Shield Association, Centene Corporation, The Cigna Group, Elevance Health, Humana, Inc., and UnitedHealthcare. The insurers have pledged to:

- Standardize electronic prior authorization submissions using Fast Healthcare Interoperability Resources (FHIR®)-based application programming interfaces.
- Reduce the volume of medical services subject to prior authorization by Jan. 1, 2026.
- Honor existing authorizations during patient insurance transitions to ensure continuity of care.
- Enhance transparency and communication around authorization decisions and appeals including by providing clear explanations of the decision and support for appeals and guidance on next steps.
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
- Ensure medical professionals review all clinical denials.

It is important to note that CMS cannot enforce violations of these items as it is a voluntary pledge. CMS stated that they reserve the right to pursue additional regulatory actions if necessary.

U.S. Senator Roger Marshall was the sole senator invited to participate, underscoring his prominent role in shaping prior authorization reform. We appreciate Senator Marshall's leadership and continued advocacy on behalf of Kansas hospitals, clinicians and the patients they serve.

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