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Build Back Better Act: Health Coverage Provisions Explained

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On November 19, 2021, the House of Representatives passed the Build Back Better Act, the budget reconciliation bill, with the Senate expected to consider the legislation in coming weeks. The Build Back Better Act includes numerous provisions that would dramatically strengthen and expand both public and private health insurance coverage. Some of the new provisions would build on actions Congress previously took in the American Rescue Plan Act, enacted earlier this year.[1]

Among its Medicaid and the Children's Health Insurance Program (CHIP) provisions, the Build Back Better Act would permanently require states to provide 12 months of postpartum health coverage and 12 months of continuous coverage for children, make federal funding for CHIP permanent, and provide a permanent, significant increase in federal Medicaid funding for Puerto Rico and the other territories. Among its private insurance provisions, the Build Back Better plan would temporarily extend marketplace subsidies to those in the "coverage gap" in the 12 states that have not yet expanded Medicaid and also extend the availability of the enhanced marketplace subsidies enacted in the American Rescue Plan Act.

This issue brief explains the Build Back Better Act's Medicaid, CHIP and private insurance provisions.

Medicaid and CHIP Provisions in the Build Back Better Act

Most notably, the Build Back Better Act would finally provide coverage to low-income adults stuck in the Medicaid "coverage gap" in states that continue to refuse to adopt the Medicaid expansion. (See page 11 for discussion of how the Build Back Better Act would temporarily extend marketplace subsidies to this group.) It also includes numerous Medicaid and CHIP provisions that would expand coverage and access in the following areas:

- Children's coverage
- Maternal health
- Coverage stability during and after the COVID-19 pandemic
- Medicaid in Puerto Rico and the other territories
- Long-term services and supports and home- and community-based services
- Behavioral health
- Criminal justice reform
- Indian and Native Hawaiian health care
- Drug pricing, prescription drug and vaccine coverage

Some of these provisions would place new federal requirements on states while other provisions would offer states new or expanded options in their Medicaid and CHIP programs. Many provisions would require significant state implementation efforts. **See Table 1.**

Children's Coverage

Requirement for Medicaid and CHIP 12-Months Continuous Eligibility for Children

While there is a longstanding option for states to provide up to 12 months of continuous eligibility for children in their Medicaid and CHIP programs, only 24 states do so in both Medicaid and CHIP. (Some additional states provide continuous eligibility only for some children or only for children in separate state CHIP programs. 17 states and the District of Columbia do not have continuous eligibility for Medicaid or CHIP for any children. **See Appendix Table 1.**)[2] The Build Back Better bill would require all states to implement 12 months of continuous eligibility for children under age 19 in both Medicaid and CHIP. This requirement would take effect one year from date of enactment.

This provision would significantly reduce the risk that children face periods of uninsurance over the course of a year. Nearly 10 percent of children are uninsured for at least part of the year. But among children with incomes below 250 percent of the federal poverty line, 13 percent of children experience a gap in coverage at some point during a year or are uninsured for the entire year. These gaps in coverage are even more prevalent among children in communities of color: 14 percent of Latino children and nearly 12 percent of Black children experience uninsurance over the course of a year.[3]

Mandatory continuous eligibility for children would reduce the risk of gaps in coverage and limit the impact of churn when children cycle on and off coverage due to temporary changes in family income. This, in turn, would improve health status and well-being as research shows that individuals with continuous coverage experience fewer unmet health care needs and are in better health. It would also promote health equity, mitigate the financial impact of income volatility on families, drive more efficient health care utilization and spending, reduce administrative burden and costs for states, enhance measurement of quality of care and increase accountability for managed care.[4]

Permanent Extension of Federal CHIP Funding, Other CHIP Provisions

CHIP serves a vital role in America's health care system by providing comprehensive, affordable health coverage to 6.8 million people (mostly children) each month whose family incomes are over income eligibility levels for Medicaid but may otherwise be uninsured.[5] First enacted in 1997, CHIP has been a success story in advancing children's coverage. However, due to the temporary and capped nature of the program's federal funding structure, Congress has had to repeatedly act to provide additional years of federal funding.

Table 1. Medicaid and CHIP Provisions

Provision	Federal Requirement for States or State Option	New State Implementation Required
Children's Coverage		
Medicaid and CHIP 12-Months Continuous Eligibility for Children	Requirement	Y*
Extension of Federal CHIP Funding	N/A	N
Extension of Express Lane Eligibility Option for States	Option	Y**
Maternal Health		
Medicaid and CHIP 12-Months Postpartum Coverage	Requirement	Y*
Maternal Health Homes	Option	Y**
Stability of Coverage During and After Pandemic		
Transition from Medicaid Continuous Coverage Requirement	Requirement***	Y
Temporary New Medicaid Stability Protection	Requirement	N
Medicaid in the Territories		
Federal Medicaid Funding for Puerto Rico and the Other Territories	N/A****	N****
Long-Term Services and Supports and Home- and Community-Based Services		
Federal Medicaid Support for Home- and Community-Based services (HCBS)	Option	Y**
Extension of Spousal Impoverishment Protections for Individuals Receiving Home and Community-Based Services	Requirement	N
Extension of the Medicaid Money Follows the Person Demonstration	Option	Y**
Behavioral Health		
Expansion of the Medicaid Certified Community Behavioral Health Clinic Demonstration Program	Option	Y**
Extension of State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services	Option	Y**
Criminal Justice Reform		
Improved Continuity of Care and Health Care Access for People Involved in the Criminal Justice System	Requirement	Y
Indian and Native Hawaiian Health		
Extension of Federal Support for Certain Indian Health and Native Hawaiian Health Providers	Requirement	N
Drug Pricing, Prescription Drug and Vaccine Coverage		
Extension of Medicaid Drug Rebate Program to Separate State CHIP Programs	Requirement	Y
Improvements to Accuracy of Medicaid Drug Pricing Survey of Pharmacies	Requirement	Y
Permanent Prohibition Against Implementation of Rebate Rule	N/A	N
Requirement for Medicaid and CHIP to Cover Vaccines for Adults	Requirement	Y*

* Only if states have not already adopted existing options

** Only if option newly adopted by states

*** As condition of increased federal Medicaid matching rate (FMAP) from April-September 2022

**** Puerto Rico would be required to comply with a physician payment floor but it currently meets that requirement

During the most recent funding extension, Congress actually let annual funding for CHIP lapse entirely from September 30, 2017 until January 22, 2018 — forcing states to rely on carryover funding and, in some cases, to notify families that they were planning to close enrollment. While Congress ultimately acted to provide federal CHIP funding for ten years, no additional funding is available after fiscal year 2027.

The Build Back Better Act would permanently extend federal funding for CHIP, thereby removing financial uncertainty and ensuring stability for states and families that depend on the CHIP program. The Build Back Better Act would also permanently extend a number of related CHIP financing provisions including redistribution (which transfers unspent funds after two years to states facing federal funding shortfalls), the Child Enrollment Contingency Fund (which provides additional federal CHIP funds to states that have higher-than-expected enrollment and have exhausted their available CHIP funding) and the qualifying state option (which allows states that expanded children's coverage in Medicaid prior to enactment of CHIP to fund a portion of such Medicaid child expansions).

The Build Back Better Act would also extend other related child health provisions including the Pediatric Quality Measures Program (PQMP) and grants for child-specific outreach and enrollment. Federal funding for the PQMP, which supports the advancement and reporting of evidence-based, consensus-driven pediatric quality measures, would be made permanent. The PQMP would receive $15 million in fiscal year 2028, with annual adjustments for general inflation thereafter. In addition, federal funding for outreach and enrollment grants would be made permanent. $60 million would be appropriated over a three-year period (fiscal years 2028-2030) and then subsequently adjusted for general inflation for additional three-year periods. These grants serve an important role in helping to ensure eligible children can access and maintain Medicaid and CHIP coverage.

The Build Back Better Act would also permanently extend the existing Medicaid and CHIP stability provision for children, which prohibits states from cutting eligibility or making it harder for eligible children to enroll. Originally included in the ACA and subsequently extended in CHIP funding reauthorization legislation, the stability provision prohibits states from making their eligibility standards, methodologies and procedures more restrictive, such as cutting income eligibility or imposing new barriers to enrollment such as increased premiums.

Finally, the Build Back Better Act includes a technical provision that would allow certain states to increase children's income eligibility through a state plan amendment, rather than through a waiver. This would make it easier for some states to expand their CHIP programs and cover more children who would otherwise be uninsured. It would also ensure that territories that take up this new state plan option would be able to have their CHIP allotments increased to account for any expansion as is the case for states. (States have their allotments "rebased" every two years to account for their actual spending but prior to the Build Back Better Act, states, but not territories, could have their allotments adjusted between rebasing years if they expand their CHIP programs.)

Permanent Extension of Express Lane Eligibility Option for States

Express Lane Eligibility (ELE) is a state option that allows states to use the eligibility findings from other public programs like the Supplemental Nutrition Assistance Program (SNAP) to streamline enrollment and/or renewal for children in Medicaid and CHIP. Seven states currently use ELE in their Medicaid programs or in both their Medicaid and CHIP programs.[6] The ELE state option is currently set to expire at the end of fiscal year 2027. The temporary nature of the option has been a factor in discouraging states from implementing it, due to the need for an upfront investment of time, spending and technology to maximize its efficiency and effectiveness. The Build Back Better Act would permanently extend the ELE state option, which would not only allow existing use of ELE to continue over the long run but also could spur adoption of ELE by additional states.

Maternal Health

Requirement for Medicaid and CHIP 12-Months Postpartum Coverage

The Build Back Better bill would permanently require all

states to extend full-benefit postpartum Medicaid and CHIP coverage from 60 days after the end of pregnancy to one year postpartum, starting in the first fiscal year quarter beginning one year after date of enactment (which could be as early as January 1, 2023). This permanent and mandatory extension of coverage to one year postpartum would thus establish a new national standard for Medicaid and CHIP coverage, which covers about 43 percent of births each year. This is a critical step in responding to the alarming maternal mortality crisis in the U.S., which disproportionately affects women of color.[7] When Medicaid and CHIP coverage currently ends at 60 days postpartum, many women are at risk of becoming uninsured and missing out on critical access to care that can prevent pregnancy-related deaths. The Congressional Budget Office (CBO), for example, has previously estimated that about 45 percent of women covered by Medicaid on the basis of pregnancy now become uninsured after the end of the 60-day postpartum coverage period.[8]

In the interim, until the requirement to implement 12 months of postpartum coverage takes effect as early as January 1, 2023, states can continue to take up the American Rescue Plan's state plan option to provide 12 months of postpartum coverage in both Medicaid and CHIP and receive federal matching funds starting on April 1, 2022. A number of states have already implemented waivers to provide extended postpartum coverage or plan to implement the American Rescue Plan state plan option next year, although these postpartum expansions may be limited.[9] **See Appendix Table 2.**

New Medicaid Option for Maternal Health Homes

The Build Back Better bill would establish a new permanent Medicaid state plan option for maternal health homes, which provide team-based care to pregnant and postpartum people. This maternal health home option would take effect two years (24 months) after the date of enactment.

The maternal health home option builds on the requirement for 12 months of postpartum coverage to provide coordinated, culturally competent and linguistically appropriate team-based care to pregnant and postpartum people and provide linkages to care for medical and social needs. In addition to medical providers, the team can include doulas, community health workers, behavioral health specialists, social workers, interpreters, and many other partners who can support the medical and social needs of pregnant and postpartum people.

Maternal health homes would also be required to collect and report quality metrics, including measures in the Centers for Medicare and Medicaid Services' Child Core Set and Adult Core Set, and conduct risk assessments and create care plans for patients. Services provided by maternal health homes that meet these and other criteria would be eligible to receive a 15 percentage point increase in the federal Medicaid matching rate (FMAP) for the first two years after the state plan amendment takes effect, not to exceed 90 percent. The Build Back Better bill would also appropriate $5 million for planning grants to interested states, available one year after date of enactment.

The provision includes early intervention providers and pediatricians as potential connections for patients, which would help encourage two-generation care that supports the healthy development of mothers and infants together. It also would create an opportunity to bring peer support providers, such as doulas and community health workers, into Medicaid care models.

Other Investments in Maternal Health

The bill also includes significant investments in training and diversification of the perinatal workforce, including developing providers of color who treat maternal mental health conditions and substance use disorders. Based on the bills from the Black Maternal Health Momnibus package, the Build Back Better bill includes new funding for maternal health quality improvement, better data systems to track and identify causes of maternal mortality, investments in historically Black colleges and universities to conduct research into maternal health disparities and grants to support implicit bias training for frontline health care professionals. Every eligible provision from the 12 bills that made up the Black Maternal Health Momnibus package is included in the Build Back Better Act.

Stability of Coverage During and After the Pandemic

Transition from Medicaid Continuous Coverage Requirement

Under current law, as enacted by the Families First Coronavirus Response Act, states are receiving a 6.2 percentage point increase in their federal Medicaid matching rates for the duration of the COVID-19 public health emergency. As a condition of the increase, states cannot cut eligibility or make it harder for eligible families to enroll. They must also provide continuous coverage: they cannot involuntarily disenroll any Medicaid beneficiary who was already enrolled or has newly enrolled during the public health emergency. The bill would begin phasing out the matching rate increase starting April 1, 2022, with the increase fully eliminated after September 30, 2022. Specifically, the FMAP increase would decline to 3 percentage points for April-June 2022 and then decline to 1.5 percentage points for July-September 2022. (This would also have the effect of reducing the Families First increase in the CHIP matching rate from 4.34 percentage points to 2.1 percentage points for April-June 2022 and to 1.05 percentage points for July-September 2022.) **See Table 2.**

Table 2. Phase-Down of Families First FMAP Increases

	Medicaid Matching Rate Increase (Percentage Points)	CHIP Matching Rate Increase (Percentage Points)
Present - March 31, 2022	6.2	4.34
April 1, 2022 - June 30, 2022	3.0	2.1
July 1, 2022 – September 30, 2022	1.5	1.05

In addition, *the continuous coverage protection would be effectively ended April 1, 2022* but as a condition of receiving the phased-down FMAP increase, states would have to satisfy a number of procedural requirements before they can terminate Medicaid beneficiaries who have been enrolled for at least 12 consecutive months (during the period between April 1 and September 30, 2022). In addition existing federal guidance from August 2021 allowing states to take up to a full year to catch up on delayed renewals and pending actions, states will be limited to initiating renewals or processing changes in circumstances for no more than 1/12th of enrollees in each month between April and September 2022. States will also be required to make a good faith effort to update contact information including mailing addresses, phone numbers or email addresses, including by coordinating with managed care plans and other state programs. States would be barred from disenrolling anyone on the basis of returned mail until they make at least two attempts to contact the beneficiary through at least 2 modalities and provide at least a 30-day notice, through at least 2 modalities, before terminating coverage. States will also be required to collect key data monitoring the impact on enrollees and make reports to the Secretary of Health and Human Services, including call center statistics and disenrollment data.[10] States would not need to meet these new procedural requirements if they refused the increased federal matching rates from April to September 2022.

Temporary New Medicaid Stability Protection

While the Build Back Better bill would end the continuous coverage requirement, health coverage is likely to remain volatile for a considerable period of time. The COVID-19 pandemic demonstrated the importance of Medicaid as a critical source of coverage. The bill therefore would continue to encourage states to maintain their current Medicaid eligibility standards, methodologies and procedures between October 1, 2022 and December 31, 2025. States that cut Medicaid eligibility or make it harder for eligible individuals to enroll — compared to the eligibility standards, methodologies and procedures in effect as of October 1, 2021 — would be subject to a 3.1 percentage point reduction in their regular FMAP. States, however, could seek an exemption from this requirement for non-pregnant, non-disabled adults with incomes above 138 percent of the federal poverty line if the state certifies to the Secretary of Health and Human Services that the state has a budget deficit or is projected to have a budget deficit in the upcoming state fiscal year.

Medicaid in Puerto Rico and the Other Territories

Permanent, Significant Increase in Federal Medicaid Funding for Puerto Rico and the Other Territories

Federal Medicaid funding for Puerto Rico and the other territories — American Samoa, Guam, the Northern Mariana Islands and the U.S. Virgin Islands — is capped, with the block grant amounts set at highly inadequate levels that have forced the territories to operate Medicaid programs that are far less generous than those in the states.[11] In addition, the regular matching rate for the territories is officially 55 percent, even though the FMAPs for the territories would equal 83 percent if they were calculated in the same way the matching rate for states is determined, due to the territories lower per-capita income. Over the last decade, Congress has provided additional federal Medicaid funding and FMAP increases over the last decade in order to avoid draconian cuts, respond to recent natural disasters, and to institute modest eligibility, benefit and provider rate improvements. But those increases have always been temporary.

The Build Back Better bill provides a permanent, significant increase in the territories' block grant amounts. In fiscal year 2022, for example, Puerto Rico's base block grant amount would be set at $3.6 billion, well above the $2.8 billion level for 2021 that was provided under the latest temporary increase enacted by Congress two years ago. These higher block grant amounts would then be adjusted annually by the percentage increase in national Medicaid spending in the preceding year (as determined using the most recent National Health Expenditure data). In addition, the FMAP for the territories would be permanently increased to 83 percent. The most recent federal funding increase for the territories temporarily raised the FMAP for Puerto Rico to 76 percent and the FMAP for the other territories to 83 percent. Unlike for the other territories, for which the 83 percent FMAP would take effect in fiscal year 2022, Puerto Rico's matching rate would remain at 76 percent for one year and then rise to 83 percent in 2023.

The Build Back Better Act would also require Puerto Rico to maintain physician reimbursement rates at certain minimum levels.[12] Otherwise Puerto Rico would see its FMAP reduced by 0.5 percentage points in the first quarter it is out of compliance and then by an additional 0.25 percentage points in subsequent quarters, but not to exceed a total of 5 percentage points.

Based on spending projections from the territories, the Build Back Better provision should ensure that Puerto Rico and the other territories have sufficient federal financial support to sustain their existing Medicaid programs and make further improvements to expand coverage and access over time. In the case of Puerto Rico, this would disproportionately benefit children: more than 60 percent of Puerto Rico's children are enrolled in Medicaid or CHIP-funded Medicaid. The territories, however, will not be able to come into fuller compliance with federal eligibility and benefit requirements without elimination of their block grant structure and a switch to permanent state-like financial treatment under which the federal government picks up a fixed percentage of the territories' Medicaid costs.

Long-Term Services and Supports and Home- and Community-Based Services

Additional, Permanent Federal Medicaid Support for Home- and Community-Based services (HCBS)

Medicaid is the largest payer of long-term services and supports (LTSS) in the United States, providing coverage for LTSS for millions of individuals including children with special health care needs.[13] However, due to a longstanding structural bias towards institutional care settings under Medicaid, many states have limits on access to home- and community-based services (HCBS). For example, as of 2018, 41 states reported having a HCBS waiting list.[14]

The Build Back Better Act would provide states the option of permanently receiving a six-percentage point increase in their Medicaid matching rate for home- and community-based services furnished to Medicaid beneficiaries with LTSS needs if they improve and expand HCBS services and access. (This provision builds on an American Rescue Plan Act provision offering states a one-year FMAP increase of 10 percentage points for HCBS improvements and expansions.) The federal funding caps for the territories would not apply to this HCBS matching rate increase.

HCBS services eligible for the matching rate increase include home health, private duty nursing, personal care, HCBS services provided through several types of Medicaid waivers, case management, rehabilitative services (including behavioral health), services provided through PACE programs (Programs of All-Inclusive Care for the Elderly), and other services specified by the Secretary of Health and Human Services. States would be required to use the increased federal funding to supplement, not supplant their current level of HCBS spending and maintain their existing HCBS eligibility, benefits and provider reimbursement rates so they are not more restrictive than what was in place as of the date when states received planning grants (which is discussed below). They must also implement a federally approved plan to expand access including reducing wait lists, expanding eligibility, lowering disparities in using HCBS and newly covering personal care; strengthen the HCBS workforce including adopting processes to ensure that HCBS payment rates are sufficient and updating qualification standards' and increase HCBS payment rates to support recruitment and retention of the direct care workforce and raise payment rates to direct care workers. States would no longer be eligible for the FMAP increase if they are out-of-compliance with these requirements or, after 7 years, they fail to demonstrate that they have increased HCBS availability and that at least half of their total LTSS spending is for HCBS (or if the percentage was higher before the improvement plan was approved, no less than such percentage).

States would also receive $130 million in federal funding for planning grants to develop their HCBS improvement plans. States would not be able to receive the FMAP increase for HCBS (discussed above) until they have been awarded a planning grant and their improvement plan has been approved by the federal government. They would also be eligible to receive an additional two percentage point FMAP increase for six fiscal year quarters if they facilitate the use of self-directed care by Medicaid beneficiaries with LTSS needs. States would also receive a higher administrative matching rate of 80 percent (instead of the regular 50 percent administrative matching rate) for costs related to implementing HCBS improvements for the next 10 years. Finally, state would also receive a permanent administrative matching rate of 80 percent for costs related to reporting new mandatory HCBS quality measures (which would be added to the Medicaid child and adult core sets of quality measures). The bill would thus significantly improve HCBS services over time, including for children with special health care needs.

Permanent Extension of Spousal Impoverishment Protections for Individuals Receiving Home and Community-Based Services

Under Medicaid's spousal impoverishment rules, a portion of a married couple's combined resources is protected for the spouse living in the community when determining financial eligibility for an individual seeking long term care. Section 2404 of the Affordable Care Act (ACA) expanded these protections beyond institutional care to also require states to apply the protections to community spouses of individuals receiving Medicaid home and community-based services. However, due to the temporary nature of the provision, Congress has had to act multiple times to extend spousal impoverishment protections for individuals receiving home and community-based services including most recently in 2021, which extended the protections through September 30, 2023. The Build Back Better Act would finally extend the ACA spousal impoverishment protections on a permanent basis.

Permanent Extension of the Medicaid Money Follows the Person Demonstration

The Medicaid Money Follows the Person (MFP) demonstration is a federal grant program that provides states with enhanced federal matching funds to help transition individuals receiving long term services and supports from institutional settings to community-based settings. The program was first authorized 2005 under the Deficit Reduction Act and has subsequently been amended and extended a number of times. As of 2019, 44 states participated in the MFP demonstration.[15] Funding for the program currently extends through September 30, 2023. The Build Back Better bill would permanently extend funding for the Medicaid Money Follows the Person demonstration at current funding levels of $450 million per year. It would also modify program rules to require a state to use demonstration grant funds within four years of receipt

or have any unused portion of the funds rescinded by the Secretary. Any such rescissions would then be added to the mandatory program appropriation for the following year.

Behavioral Health

Expansion of the Medicaid Certified Community Behavioral Health Clinic Demonstration Program

The Protecting Access to Medicare Act (PAMA) of 2014 created the Medicaid Certified Community Behavioral Health Clinic (CCBHC) demonstration program (also referred to as the Community Mental Health Services Demonstration Program) under which the Secretary of Health and Human Services was authorized to award planning grants to states and provide states selected to participate in the demonstration with enhanced federal matching funds (equal to the CHIP matching rate) for services provided to Medicaid beneficiaries at certified behavioral health clinics. The demonstration was initially limited to 8 states for a length of two years but Congress has subsequently expanded and extended the CCBHC demonstration. Today, the demonstration is limited to 10 participating states with the states able to receive the enhanced FMAP for CCBHC services through September 30, 2023. The Build Back Better Act would expand access to the CCBHC demonstration to all states by authorizing the Secretary to award additional planning grants to interested states, and allowing any state that meets the requirements of the demonstration program to participate for a two year period. The territories would also be allowed to participate if they meet the demonstration requirements and any amounts attributable to the increased matching rate under the demonstration would not be subject to their block grants.

Permanent Extension of State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services

Under the American Rescue Plan Act, Congress created a new option for states to provide qualifying community-based mobile crisis intervention services to individuals experiencing mental health or substance use disorder crises and receive an enhanced 85 percent federal matching rate for such services for the first three years. Under current law, the new state plan option is available starting April 1, 2022 but is only available for a five-year period. The Build Back Better Act would permanently extend the state option, removing the five-year sunset. The 85 percent enhanced matching rate would continue to remain available for the first three years that a state takes up the option.

Criminal Justice Reform

Improved Continuity of Care and Health Care Access for People Involved in the Criminal Justice System

The Build Back Better Act would permanently require state Medicaid and CHIP programs to cover incarcerated individuals, who are otherwise eligible, 30 days before their release from jail or prison. (In Medicaid, it would do so by modifying an existing limitation that generally bars federal Medicaid funding for incarcerated individuals, although federal Medicaid matching funds are already available for certain outside hospital inpatient services.) This would ensure better care transitions and improved health outcomes, including for those with behavioral health issues, substance use disorders and complex, chronic conditions, as they reenter their communities.[16] The provision would take effect on the first day of the first fiscal year calendar quarter that begins two years after date of enactment, which would be as soon as January 1, 2024.

Indian and Native Hawaiian Health

Increased Federal Support for Certain Indian Health and Native Hawaiian Health Providers

The American Rescue Plan Act temporarily applied for two years the 100 percent FMAP available to Indian Health Service (IHS) providers for furnishing care to Medicaid beneficiaries to services furnished by Urban Indian Health Programs. Such providers are grantees of the IHS and serve IHS-eligible patients on Medicaid, but they are not formally part of the IHS and as a result, payments to these providers do not otherwise receive the 100 percent FMAP that other IHS providers do. The American Rescue Plan Act also provided for two years 100 percent FMAP for services furnished by Native Hawaiian Health Centers and other qualified entities. The American Rescue Plan Act provision

became effective April 1, 2021. The Build Back Better Act would further extend this enhanced funding for both groups of providers an additional two years through March 31, 2025.

Medicaid and CHIP Drug Pricing, Prescription Drug and Vaccine Coverage

Extension of Medicaid Drug Rebate Program to Separate State CHIP Programs

Under the highly effective Medicaid Drug Rebate Program, drug manufacturers are required to pay substantial rebates to state Medicaid programs.[17] According to the Congressional Budget Office, because of the success of the Medicaid rebate program, Medicaid obtains the lowest prices, net of rebates and discounts, compared to other federal programs and agencies including the Department of Veterans Affairs.[18]

The Medicaid Drug Rebate Program, however, does not apply to separate state CHIP programs. (Under CHIP, states can use federal CHIP funds to expand Medicaid, establish a separate program, or use a combination of the two. CHIP-funded Medicaid expansions are subject to the Medicaid rebate program.) It is likely that separate state CHIP programs obtain far smaller rebates from manufacturers than what manufacturers now pay under the Medicaid rebate program, largely due to their small size.

Starting January 1, 2024, the Build Back Better bill would apply the Medicaid rebate program to all separate state CHIP programs. This would likely result in state CHIP programs receiving much larger rebates than they (or their CHIP managed care plans) receive today, with the federal government and states sharing in these savings. Importantly, this provision would also apply the rebate program's open formulary requirement to separate state CHIP programs, under which Medicaid must cover nearly all FDA-approved drugs. While all separate state CHIP programs cover prescription drugs, most have more restrictive drug formularies than what is provided in Medicaid. As a result, this provision would likely increase CHIP beneficiary access — both for children and pregnant women who are enrolled in CHIP — to needed prescription drugs.

Improvements to Accuracy of Medicaid Drug Pricing Survey of Pharmacies

State Medicaid programs are required to base their pharmacy reimbursement rates on the actual acquisition costs of pharmacies in obtaining the drugs they dispense to Medicaid beneficiaries. In order to determine actual acquisition costs, states are permitted to rely on the National Average Drug Acquisition Cost (NADAC) survey of pharmacies conducted by CMS. But pharmacies are not required to respond to this monthly survey. The Build Back Better bill would require pharmacies to respond to the survey (as well as make improvements to the survey itself), which should improve the accuracy of the survey and better ensure that states' pharmacy reimbursement rates are more in line with pharmacies' actual costs. That, in turn, should produce both federal and state savings over time. This provision is effective the start of the first calendar year quarter that begins 18 months after the date of enactment.

Permanent Prohibition Against Implementation of Rebate Rule

The Build Back Better would permanently block implementation of the rule, finalized by the Trump Administration in November 2020, to eliminate the safe harbor in the federal anti-kickback law for rebates negotiated by pharmacy benefit managers (PBMs) on behalf of Medicare Part D plans. (Court orders blocked implementation until January 2023 and the bipartisan infrastructure law — H.R. 3684 — further blocks implementation for another three years.)

While much of the attention on the rebate rule has focused on how it would significantly increase federal Medicare spending and Medicare beneficiary premiums, the rule would also increase federal and state Medicaid costs. Based on an earlier Congressional Budget Office analysis, the rule, if implemented, would likely increase federal Medicaid spending by $6 billion over 10 years and state spending by nearly $3 billion. That is because if implemented, the rule would effectively replace the current rebates that drug manufacturers provide in Medicare Part D plans with so-called "chargeback" discounts. That would reduce the mandatory rebates that drug manufacturers must provide to Medicaid under the Medicaid rebate program

because such chargebacks in Part D would likely have the effect of lowering the Average Manufacturer Price (AMP) of drugs, which helps determine the amount of mandatory Medicaid rebates. That, in turn, would raise the net cost of prescription drugs for the federal government and the states.[19] As a result, this provision blocking implementation of the safe harbor rebate rule would protect state Medicaid programs from higher drug costs over time.

Requirement for Medicaid and CHIP to Cover Vaccines for Adults

Medicaid requires coverage of vaccines (as recommended by the Advisory Committee on Immunization Practices) without cost-sharing for some adults, such as those covered under alternative benefit plans, but not others. The Build Back Better bill would make vaccines for adults, as well as their administration, a mandatory Medicaid benefit. Adult vaccines would also be exempt from cost-sharing for all Medicaid beneficiaries in order to ensure parity across the program. (Vaccines are already mandatory and exempt from cost-sharing for children in Medicaid.) It would also make adult vaccines and their administration, without cost-sharing, mandatory for CHIP (for anyone who is aged 19 or older). The effective date would be the start of the first fiscal year quarter than begins 1 year after date of enactment, which would be early as January 1, 2023. However, states that provide Medicaid coverage of adult vaccines without cost-sharing as of the date of enactment would receive a one percentage point FMAP increase related to vaccines and their administration for two years.

Private Health Insurance Provisions in the Build Back Better Act

The Build Back Better Act includes a number of policies to build on and improve the Affordable Care Act, including:

- Closing the Medicaid "coverage gap": marketplace subsidies and additional benefits for people with incomes under 138 percent of the federal poverty line in non-expansion states
- Enhanced premium tax credits at all income levels
- Extra financial assistance for people who experience unemployment
- Tax relief for low-income individuals who receive premium tax credits
- Improved access to marketplace subsidies for those with unaffordable employer-based insurance
- Expanded consumer assistance
- Cost-sharing help for insulin products
- A state-level grant program to improve insurance affordability

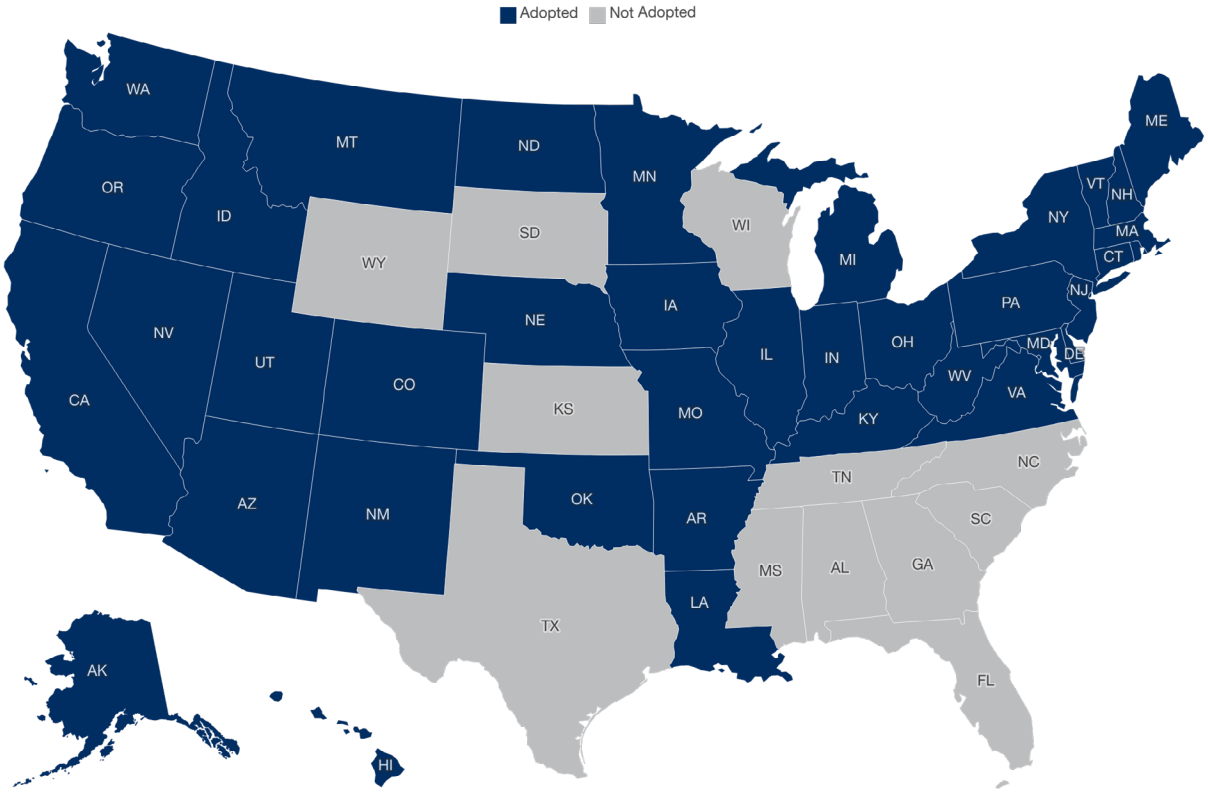
These changes are designed to increase access to affordable private health plans through the Affordable Care Act's marketplaces. Most of the changes, however, would only be temporary and end in 2025, barring further congressional action.

Marketplace Subsidies to Address the Coverage Gap in Non-Expansion States

There are currently 12 states that have still not adopted the Affordable Care Act's Medicaid expansion: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming. **See Figure 1**. According to the Kaiser Family Foundation (KFF), if all of these states expanded Medicaid, about four million uninsured adults would become newly eligible. Of those, 2.2 million low-income people in poverty are stuck in the "coverage gap" with incomes too low to be eligible for marketplace subsidies but who are ineligible for Medicaid.[20]

The Build Back Better bill would temporarily enable these individuals to qualify for premium tax credits to purchase a $0 premium benchmark plan on the marketplaces beginning in 2022 (but only through 2025). These plans would be required to cover 94 percent of an average person's health care costs. In 2023, the plans' generosity would increase to 99 percent. Beginning in 2024, these plans will be required to cover non-emergency transportation and certain family planning services not typically covered in commercial health insurance but covered in Medicaid.

Figure 1. Status of Medicaid Expansion by State



Individuals with incomes under 138 percent of the federal poverty line who do not qualify for Medicaid would have a continuous, year-round opportunity to enroll in a marketplace plan, unlike other applicants who generally must have a qualifying event outside of open enrollment.[21] They would also not be disqualified from premium tax credits if they have an offer of employer coverage; for most of these individuals, the marketplace plan will be a better value. To help raise awareness of these new coverage options, the bill would devote $105 million in funding for culturally and linguistically appropriate outreach and marketing. And the U.S. Health & Human Services Department (HHS) would be required to spend at least $10 million in 2022 to support Navigators in these 12 states to assist people with enrollment, increasing to $20 million each year for 2023, 2024, and 2025. Additionally, because participating insurers were not able to set their 2022 premiums to account for these new enrollees, the bill would create a temporary reinsurance program to provide a financial cushion if they experience excessive claims costs.

To further encourage states to take up the Medicaid expansion, the Build Back Better bill would temporarily increase the expansion FMAP from 90 percent to 93 percent for three years (2023-2025), which would create an additional incentive for states to take up the Medicaid expansion. This would also have the effect of encouraging states that have already adopted the Medicaid expansion to maintain it, despite the temporary availability of this fallback provision extending marketplace subsidies to those with incomes below 138 percent of the federal poverty line not eligible for Medicaid.

In addition, the substantial financial incentives for the twelve non-expansion states to adopt the Medicaid expansion provided through the American Rescue Plan remains in effect.[22] Under that permanent provision, states that newly expand Medicaid receive an additional five percentage point increase in their regular FMAP for two years, no matter when they newly expand. (This increase does not affect the expansion itself but applies to the rest of the Medicaid program covering children, some parents, people with

disabilities and seniors.) KFF has previously estimated that the FMAP increase in the American Rescue Plan is expected to more than offset expansion costs in all of the non-expansion states in a two-year period, assuming expansions are implemented in 2022.[23] And as described above, the Build Back Better Act would increase the expansion FMAP from 90 percent to 93 percent for three years, which would further increase the fiscal benefit to states if states take up the expansion before the end of calendar year 2025.

Finally, the Build Back Better Act would establish some disincentives for states that continue to refuse the expansion. This includes, starting in fiscal year 2023, scaling back certain Medicaid waivers that provide funding to providers for uncompensated care. States with such Section 1115 waivers are Florida, Kansas, Tennessee and Texas. Specifically, federal funding under such waivers would no longer be available for uncompensated care related to individuals who would be otherwise eligible under the Medicaid expansion (if a state had expanded). The bill would also reduce the size of states' federal Medicaid Disproportionate Share Hospital (DSH) allotments, starting in fiscal year 2023, if states do not fully cover expansion individuals. Specifically, the DSH allotment a non-expansion state would otherwise receive would be reduced by 12.5 percent.

Extension of American Rescue Plan Premium Tax Credit Enhancements

The Affordable Care Act provides advance premium tax credits (PTCs) to qualified individuals and families that enroll in coverage through the health insurance marketplaces. Until enactment of the American Rescue Plan, these PTCs were available only to people with modified adjusted gross income between 100 and 400 percent of the federal poverty line (between $26,200 and $104,800 for a family of four), who are lawfully present in the U.S. and do not qualify for other affordable minimum coverage such as Medicaid, Medicare, or an employer plan. The ACA's tax credits effectively cap an individual or family's premium contribution at a percentage of their income. That specified percentage varies, with lower-income families required to pay the lowest percent of income towards premiums. The ACA required these percentages to be adjusted annually for inflation.

The American Rescue Plan Act increased the PTCs available for marketplace enrollees by reducing the percentage of income that individuals and families contribute towards premiums for plan years 2021 and 2022. Under the enhanced premium schedule, families with incomes between 100 and 150 percent of the federal poverty line had their premium contribution reduced to $0. Families with incomes over 400 percent of the federal poverty line became eligible for subsidies for the first time, with their premium contribution capped at 8.5 percent of family income. **See Table 3.**

Table 3. Maximum Income Contribution Percentage by Household Income under the Affordable Care Act and the American Rescue Plan Act

Income Range (Percent of Federal Poverty Level)	Range of Maximum Income Distribution (Percent of Income)		
	Under Affordable Care Act (2014, original schedule)	Under Affordable Care Act (2021, after annual inflation adjustments)	Under American Rescue Plan
100-133	2.0	2.07	0
133-150	3.0-4.0	3.10-4.14	0
150-200	4.0-6.3	4.14.6.52	0-2.0
200-250	6.3-8.05	6.52-8.33	2.0-4.0
250-300	8.05-9.5	8.33-9.83	4.0-6.0
300-400	9.5	9.83	6.0-8.5
400+	–	–	8.5

Under the American Rescue Plan, marketplace enrollment has increased dramatically and enrollees have seen significant reductions in premiums. Over 2.8 million people enrolled in a marketplace health plan during the COVID-19 special enrollment period that ended on August 15, 2021, bringing total marketplace enrollment to its highest ever, at 12.2 million people. On average, enrollees saved $67 per month, with close to half able to find a plan for less than $10 per month. Additionally, because many people were able to take their additional tax credit and "buy up" to a more generous plan, the average deductible for a marketplace plan fell by 90 percent this year.[24]

The Build Back Better Act would extend the American Rescue Plan premium tax credit enhancements through plan year 2025 and would eliminate the annual inflation adjustment through 2026.

Increased Subsidies for Those Experiencing Unemployment

The U.S. economy lost 22 million jobs between February and April 2020.[25] Many individuals lost their employer-based health insurance at the same time. The American Rescue Plan Act increased the amount of premium tax credits and cost-sharing help for individuals who received, or were approved to receive, at least one week of unemployment insurance benefits in 2021. These individuals qualify for a benchmark Silver plan with a $0 premium, with cost-sharing subsidies resulting in the plan paying 94 percent of the cost of care for the average enrollee. This provision of the American Rescue Plan Act extends only through 2021; the Build Back Better Act would provide similarly enhanced subsidies and cost-sharing help for these individuals through the end of 2022.

Tax Time Reconciliation Relief for Low-Income Families

Under the ACA, when an individual enrolls in a marketplace plan with a premium tax credit, the marketplace estimates the amount of premium tax credit to allocate based on that individual's projected income and household size for the coming year. These premium tax credits are then advanced to the enrollee on a monthly basis. If the individual's actual income for the year (as reported in their annual tax filing) is greater than what they projected, they could owe some or all of the excess premium tax credits back to the federal government, in a process called "reconciliation."

The Build Back Better Act recognizes that income often fluctuates for low-income families, placing them at heightened risk of owing the IRS excess premium tax credits at tax time. The bill would cap the amount that individuals under 200 percent of the federal poverty line would have to pay back during reconciliation at $300 for married couples filing jointly and $150 for single individuals. Individuals under 138 percent of the federal poverty line who are not otherwise required to file a tax return would be exempt from repaying any excess premium tax credits, and they could not be denied future premium tax credits if they fail to file a tax return and reconcile their past year's premium tax credits.

Help for People with Expensive Employer-Based Insurance

Under the ACA, only those individuals who are not eligible for "minimum essential coverage" may qualify for marketplace premium tax credits. Minimum essential coverage includes employer-based insurance, so long as that insurance is "affordable" and "adequate." The IRS has defined "affordable" employer-based insurance in 2021 to have a premium for a self-only policy that does not exceed 9.83 percent of the family's income.[26] For 2022-2025, the Build Back Better Act would lower that affordability threshold to 8.5 percent of income, meaning that employees whose premium for their job-based insurance exceeds that amount could opt out and obtain a marketplace plan with subsidies instead.

Expanded Consumer Assistance

Several states have established consumer assistance or ombudsmen programs to help consumers with insurance problems or complaints. Staff of these programs assist consumers with:

- Filing complaints and appeals with insurance companies
- Collecting, tracking, and quantifying consumers' insurance problems
- Educating consumers on their insurance rights and

responsibilities

- Resolving problems with financial assistance programs.[27]

The ACA provided grant funding to help support these consumer assistance programs, but the last federal grants were issued in 2014. Many programs were forced to shut down; others continue to operate with only state or private support. The Build Back Better Act would provide $100 million over four years ($25 million each year from 2022-2025) to support these programs.

Increased Subsidy Eligibility Through "MAGI" Adjustments

Eligibility for marketplace premium tax credits and cost-sharing subsidies is based on a household's "modified adjusted gross income," or MAGI. MAGI includes multiple possible sources of income, including wages, tips, capital gains, investment income, and more. Lump-sum Social Security payments have also been considered part of MAGI. However, these sometimes unexpected payments (such as in the case of a death or retirement) can result in individuals facing reduced premium tax credits or a repayment to the IRS during reconciliation.

The Build Back Better bill would exempt these lump sum Social Security payments from the MAGI calculation. It also would allow individuals to discount income from a dependent under the age of 24, so long as the aggregate amount of dependent income in the household is less than $3,500, indexed for inflation. This latter provision, however, would only be available through 2026.

Reduced Cost-Sharing for Insulin

Over 10 million Americans with diabetes depend on insulin to manage their condition. Since 2012, the price of many newer forms of insulin have risen on average 15 to 17 percent per year, well above the rate of inflation. As many as one in four people report rationing insulin to save money, placing their health — and in some cases their lives — at risk.[28] Beginning in 2025, employer plans and individual market insurers would be required to cover certain insulin products and would be required to exempt them from enrollee deductibles. They would also have to limit cost-sharing to the lesser of $35 or 25 percent of the negotiated price. Any cost-sharing the enrollee faces would have to be applied towards his or her annual out-of-pocket maximum.

The "Improve Health Care Affordability Fund"

The Build Back Better bill would establish a $30 billion fund ($10 billion per year, for 2023-2025) to provide grants to states for either a reinsurance program or to reduce enrollee cost-sharing in marketplace health plans. Although the grant funds would be made available in 2023, states would have just 120 days from the date of enactment to submit applications to HHS. Once HHS has approved a state's proposal, it will be deemed approved for each remaining year of the grant program as well (through 2025). States that have yet to expand Medicaid would not be eligible to submit an application. HHS would instead run a default reinsurance program in their state.

Funding for State Innovation

The ACA includes a provision enabling states to apply to HHS to waive certain provisions of the law in order to implement state-based health reforms. These are often referred to as "Section 1332 waivers." Currently 17 states have 1332 waivers in place, 15 of which are used to support state-level reinsurance programs designed to moderate individual market premiums.[29] The Build Back Better bill would include $50 million in 2022 for grants to states to develop and submit 1332 waiver applications, applications for extensions or amendments and to implement section 1332 waivers. Grants for an individual state are not to exceed $5 million.

Pharmacy Benefit Manager Transparency

Starting with plan years beginning on or after January 1, 2023, the Build Back Better bill would require health insurance issuers, group health plans and pharmacy benefit managers (PBMs) to report certain information to plan sponsors (such as employers) related to prescription drug benefits and pricing. This would include information related to why certain drugs received preferred formulary placement and what rebates, fees, discounts or other remuneration were paid by drug manufacturers for claims incurred or that are related to utilization of drugs. In addition, starting with

plan years beginning on or after January 1, 2023, the bill would prohibit issuers, group health plans, and PBMs from entering into contracts with manufacturers, distributors, wholesalers and other third-party entities that limit the disclosure of the information required to be reported.

This provision would increase drug benefit and pricing transparency in group health plans and likely reduce the prevalence of troubling practices by PBMs. In recent years, for example, some PBMs have received increasing scrutiny for failing to fully pass through rebates and other savings not only to patients at the pharmacy counter but also to employers and other plan sponsors. And some PBMs have placed certain drugs on preferred drug lists or formularies, even though there are alternative drugs in the same therapeutic class that are less costly but are equally, or more, clinically effective. This was because those preferred drugs gleaned greater rebates which then accrued, at least in part, to the PBMs themselves, rather than to patients or plan sponsors.

Expansion of Health Coverage Tax Credit for Workers Losing Jobs due to Trade

In 2002, Congress enacted legislation creating a tax credit to subsidize the health insurance premiums of workers who either lost jobs due to international trade (i.e., when a manufacturer moves its operations overseas) or whose defined-benefit pension plans were taken over by the Pension Benefit Guaranty Corporation because of financial difficulties. Under current law, the Health Coverage Tax Credit (HCTC) covers 72.5 percent of the premium for qualifying health insurance (such as COBRA coverage or an individual market health plan). The HCTC is slated to expire on January 1, 2022. The Build Back Better Act would make the HCTC permanent and increase the amount of premium covered by the credit to 80 percent.

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The Georgetown University Center for Children and Families (CCF) is a nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. The Georgetown University Center on Health Insurance Reforms (CHIR) is a team of nationally recognized experts on private health insurance and health reform, with a mission to improve access to affordable and adequate health insurance by providing balanced, evidence-based research, analysis, and strategic advice. Both are based in the McCourt School of Public Policy's Health Policy Institute.

Appendix Table 1. Current Status of Medicaid and CHIP 12 Months Continuous Eligibility for Children

State	12-Month Continuous in Medicaid	12-Month Continuous in CHIP	12-Month Continuous in Medicaid or CHIP
Alabama	X	X	X
Alaska	X	N/A (M-CHIP)	X
Arizona			
Arkansas		X	X
California	X	N/A (M-CHIP)	X
Colorado	X	X	X
Connecticut			
Delaware		X	X
District of Columbia		N/A (M-CHIP)	
Florida	Only under age 6	X	X
Georgia			
Hawaii		N/A (M-CHIP)	
Idaho	X	X	X
Illinois	X	X	X
Indiana	Only under age 3	Only under age 3	
Iowa	X	X	X
Kansas	X	X	X
Kentucky			
Louisiana	X	X	X
Maine	X	X	X
Maryland		N/A (M-CHIP)	
Massachusetts			
Michigan	X	N/A (M-CHIP)	X
Minnesota		N/A (M-CHIP)	
Mississippi	X	X	X
Missouri			
Montana	X	X	X
Nebraska		N/A (M-CHIP)	
Nevada		X	X
New Hampshire		N/A (M-CHIP)	
New Jersey	X	X	X
New Mexico	X	N/A (M-CHIP)	X
New York	X	X	X
North Carolina	X	X	X
North Dakota	X	N/A (M-CHIP)	X
Ohio	X	N/A (M-CHIP)	X
Oklahoma		N/A (M-CHIP)	
Oregon	X	X	X
Pennsylvania	Only under age 4	X	X
Rhode Island		N/A (M-CHIP)	
South Carolina	X	N/A (M-CHIP)	X
South Dakota			
Tennessee		X	X
Texas		X	X
Utah		X	X
Vermont		N/A (M-CHIP)	
Virginia			
Washington	X	X	X
West Virginia	X	X	X
Wisconsin			
Wyoming	X	X	X

Source: Data from Tricia Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation, March 2020, https://www.kff.org/coronavirus-covid-19/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/ (Data on South Carolina is based on the 2019 survey).

Appendix Table 2. States Expanding Medicaid Postpartum Coverage

State	Status Including Coverage Limits
California	*
Colorado	*
Connecticut	*
District of Columbia	*
Florida	**
Georgia	6 months***
Illinois	***
Indiana	****
Maine	6 months (increases to 12 months by 7/1/23)*
Maryland	*
Massachusetts	**
Michigan	****
Minnesota	*
Missouri	Limited benefits and only for individuals with Substance Use Disorder (SUD)***
New Jersey	***
New York	*****
North Carolina	*****
Ohio	*
Pennsylvania	****
South Carolina	*
Tennessee	*
Texas	6 months*
Virginia	**
Washington	*
West Virginia	*
Wisconsin	90 days*

* Enacted legislation to seek federal approval through SPA or 1115 waiver
** Proposed/pending 1115 waiver
*** Approved 1115 waiver
**** Planning to submit a SPA or 1115 waiver
***** Pending legislation to seek federal approval through SPA or 1115 waiver

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