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SUMMARY

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Build Back Better Act (BBBA) Health Coverage Provisions: House-Passed and Senate-Released Language

This report provides information about House-passed and Senate-released Build Back Better Act (BBBA) provisions related to private health insurance, Medicaid, the State Children's Health Insurance Program (CHIP), and Medicare. The BBBA, considered under the congressional reconciliation process, addresses numerous issues, such as taxes, child care, health care, education, the environment, and immigration, among others.

Per the reconciliation instructions in the budget resolution for fiscal year (FY) 2022 (S.Con.Res. 14), the House passed its reconciliation bill, H.R. 5376—the BBBA—with amendments on November 19, 2021. Since then, two Senate committees, the Senate Finance Committee and the Senate Committee on Health, Education, Labor, and Pensions (HELP), have released draft bill language described as being intended for the BBBA. These releases, referred to as *Senate-released BBBA provisions* or *language* for purposes of this report, include provisions affecting the topics covered in this report.

Many of the private health insurance, Medicaid, CHIP, and Medicare provisions are identical or similar in the House-passed bill and in the Senate-released BBBA language. For example, provisions in both would provide subsidies for private health insurance offered through the health insurance exchanges for individuals with incomes below the poverty level in certain states; would create a new program requiring price negotiation of certain Medicare drugs, mandatory rebates on Medicare drugs, and a redesign of the Medicare Part D outpatient drug benefit; and would implement a Medicaid home and community-based services (HCBS) improvement program.

There are some variations in the language of the House-passed and Senate-released versions. Examples of such variations include technical edits; shifts in funding amounts and/or duration; and policy changes, including to the scope and/or timing of a provision.

Some provisions are included in only the House-passed language or only the Senate-released language. The House-passed language that would reduce Medicaid disproportionate share hospital (DSH) allotments by 12.5% for states that have not implemented the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion was not included in the Senate-released language. The Senate-released language includes provisions that were not included in the House-passed language related to federally certified nursing facilities regarding improvements to the Special Focus Facility Program and grants to improve staffing and infection control in long-term care institutional settings.

This report contains seven tables that together provide high-level comparisons of relevant House-passed and Senate-released provisions. The summary of the House-passed language is baselined against current law, and the summary of the Senate-released language is compared with the House-passed language. **Table 1** includes provisions related to private health insurance. **Table 2** includes provisions related to tax credits associated with private health insurance. **Table 3** includes provisions related to prescription drugs. **Table 4** includes provisions related to Medicaid. **Table 5** includes provisions related to CHIP. **Table 6** includes provisions related to Medicare. **Table 7** includes additional provisions that affect the Medicaid and Medicare programs with respect to HCBS and long-term care facilities (LTCFs).

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Introduction

The Build Back Better Act (BBBA) includes provisions addressing numerous issues, such as taxes, child care, health care, education, the environment, and immigration, among others. This report provides information about the House-passed and Senate-released BBBA provisions related to private health insurance, Medicaid, the State Children's Health Insurance Program (CHIP), and Medicare.

Per the reconciliation instructions in the budget resolution for fiscal year (FY) 2022 (S.Con.Res. 14), the House passed its reconciliation bill, H.R. 5376—the BBBA—with amendments on November 19, 2021.[1] Since then, two Senate committees, the Senate Finance Committee and the Senate Committee on Health, Education, Labor, and Pensions (HELP), have released draft bill language described as being intended for the BBBA. These releases, referred to as *Senate-released BBBA provisions* or *language* for purposes of this report, include provisions that would affect the topics covered in this report.[2]

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) released a summary cost estimate for the text of H.R. 5376, as amended by H.Res. 774 on November 18, 2021.[3] (After release of the CBO score and prior to House passage, the text of H.R. 5376, as amended by H.Res. 774, was further modified upon adoption of H.Res. 803 by the text of the amendment printed in H.Rept. 117-175.) According to the CBO estimate, H.R. 5376, as amended by H.Res. 774, would increase federal deficits by $367 billion over the FY2022-FY2031 period.[4] As of this report's publication date, CBO and JCT had not released a cost estimate for the Senate-released BBBA language.

The report begins with a summary of the reconciliation process for the BBBA. The report includes seven tables that together provide high-level comparisons of relevant House-passed and Senate-released BBBA provisions. The summary of the House-passed language is baselined against current law, and the summary of the Senate-released language is compared with the House-passed language. **Table 1** includes provisions related to private health insurance. **Table 2** includes provisions related to tax credits associated with private health insurance. **Table 3** includes provisions related to prescription drugs. **Table 4** includes provisions related to Medicaid. **Table 5** includes provisions related to CHIP. **Table 6** includes provisions related to Medicare. **Table 7** includes additional provisions that affect the Medicaid and Medicare programs with respect to home and community-based services (HCBS) and long-term care facilities (LTCFs). **Appendix A** includes a table with a list of the abbreviations used in this report, and **Appendix B** contains a list of relevant CRS experts.

[1] "Build Back Better Act," Text of the Bill, *Congressional Record*, daily edition, vol. 167, no. 201 (November 18, 2021), pp. H6375-H6576.

[2] Senate Finance Committee-released Build Back Better Act (BBBA) language can be found at U.S. Senate Committee on Finance, "Finance Committee Releases Updated Build Back Better Text," press release, December 11, 2021, at https://www.finance.senate.gov/chairmans-news/finance-committee-releases-updated-build-back-better-text. Senate Health, Education, Labor, and Pensions (HELP) Committee-released BBBA language can be found at U.S. Senate HELP Committee, "HELP Committee Posts Updated Build Back Better Text Ahead of Bipartisan Parliamentary Discussions," press release, December 11, 2021, at https://www.help.senate.gov/chair/newsroom/press/help-committee-posts-updated-build-back-better-text-ahead-of-bipartisan-parliamentary-discussions.

[3] Congressional Budget Office (CBO), *Summary of Cost Estimate for H.R. 5376, the Build Back Better Act*, November 18, 2021, at https://www.cbo.gov/publication/57627.

[4] This estimate does not account for any revenue that may be generated by additional funding for tax enforcement.

Budget Reconciliation Process

In August 2021, the House and the Senate adopted S.Con.Res. 14, a budget resolution for FY2022.[5] The budget resolution generally represents an agreement between the House and the Senate on a budgetary plan for the upcoming fiscal year and allows Congress to employ the budget reconciliation process.

S.Con.Res. 14 triggered the reconciliation process by including reconciliation directives to 13 House committees and 12 Senate committees, instructing each committee to develop and report legislation within its jurisdiction that would increase or decrease the deficit by a specified amount.[6] Committees were directed to transmit such legislation to their respective Budget Committees by September 15, 2021. Under reconciliation procedures, once instructed committees transmit such legislation to their respective Budget Committees, the appropriate Budget Committee must package the responses together into an omnibus budget-reconciliation bill and report the bill without "any substantive revision."[7] The resulting reconciliation bill is then eligible to be considered under special expedited procedures. These procedures are especially important in the Senate, as they exempt the reconciliation bill from the general requirement that legislation garner the support of at least three-fifths of Senators to bring debate to a close.[8]

In responding to reconciliation instructions, three House committees developed legislation affecting private health insurance, Medicaid, CHIP, and Medicare, as described in later sections of this report:

- In response to a reconciliation instruction to increase the deficit by no more than $779.5 billion over the period FY2022-FY2031, the House Committee on Education and Labor held a markup on September 9 -10, 2021,[9] and voted to transmit the legislation to the House Budget Committee.[10]
- In response to a reconciliation instruction to increase the deficit by no more than $486.5 billion over the period FY2022-FY2031, the House Committee on Energy

[5] For more information on S.Con.Res. 14, see CRS Report R46893, *S.Con.Res. 14: The Budget Resolution for FY2022*.

[6] Compliance with reconciliation instructions is measured on a net basis. This means that a committee's response might include both deficit increases and deficit decreases so long as, taken as a whole, the legislative text complies with the instruction.

[7] Pursuant to §310(b)(2) of the Congressional Budget Act of 1974, as amended (P.L. 93-344). In fulfilling this requirement, the Budget Committee typically will hold a business meeting before voting to report to the chamber. Although amendments are not in order during the markup, members of the Budget Committee still may communicate support or concern related to the underlying legislation.

[8] For more information on the reconciliation process, see CRS Report R44058, *The Budget Reconciliation Process: Stages of Consideration*.

[9] U.S. Congress, House Committee on Education and Labor, *Committee Print to Comply with the Reconciliation Directive Included in Section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2022, S.Con.Res. 14*, 117th Cong.,2nd sess., September 9, 2021, at https://edlabor.house.gov/hearings/committee-print-to-comply-with-the-reconciliation-directive-included-in-section-2002-of-the-concurrent-resolution-on-the-budget-for-fiscal-year-2022-s-con-res-14.

[10] U.S. Congress, House Committee on the Budget, *Build Back Better Act*, report to accompany H.R. 5376, 117th Cong., 1st sess., H.Rept. 117-130, September 27, 2021, p. 54 (hereinafter, H.Rept. 117-130). The letter of transmission to the Budget Committee is dated September 14, 2021.

and Commerce held a markup on September 13-15, 2021,[11] and voted to transmit the legislation to the House Budget Committee.[12]

- In response to a reconciliation instruction to reduce the deficit by at least $1 billion over the period FY2022-FY2031, the House Committee on Ways and Means held a markup on September 9-10 and September 14-15, 2021,[13] and voted to transmit the legislation to the House Budget Committee.[14]

As required, the House Budget Committee packaged together the reconciliation responses transmitted by each of the 13 instructed House committees. On September, 25, 2021, the House Budget Committee voted to report the resulting reconciliation bill, titled the Build Back Better Act (H.R. 5376).[15]

On November 6, 2021, the House adopted H.Res. 774, a special rule reported from the House Committee on Rules that brought H.R. 5376 to the House floor for consideration.[16] Upon adoption of H.Res. 774, the text of H.R. 5376 as reported from the House Budget Committee was automatically replaced with the text of Rules Committee Print 117-18, modified by Rules Committee Print 117-19.[17]

On November 18, 2021, after CBO released a summary cost estimate for the text of H.R. 5376, as amended by H.Res. 774,[18] the House adopted H.Res. 803, a special rule reported from the House Committee on Rules that provided for further consideration of H.R. 5376. Upon adoption of H.Res. 803, the text of H.R. 5376 was further modified by the text of the amendment printed in H.Rept. 117-175. On November 19, the House passed H.R. 5376, as amended.[19]

The Senate committees that were instructed to submit reconciliation legislation to the Senate Budget Committee did not formally respond to their instruction; however, many of the committees released legislative text described as being intended for the BBBA.[20] Two Senate committees released legislation affecting private health insurance, Medicaid, CHIP, and Medicare, as described in later sections of this report:

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[11] U.S. Congress, House Committee on Energy and Commerce, *Markup of the Build Back Better Act*, 117th Cong., 1st sess., at https://energycommerce.house.gov/committee-activity/markups/markup-of-the-build-back-better-act-full-committee-september-13-2021.

[12] H.Rept. 117-130, p. 151. The letter of transmission to the Budget Committee is dated September 12, 2021.

[13] U.S. Congress, House Committee on Ways and Means, *Markup of the Build Back Better Act*, 117th Cong., 1st sess., at https://waysandmeans.house.gov/legislation/markups/markup-build-back-better-act.

[14] H.Rept. 117-130, p. 785. The letter of transmission to the Budget Committee is dated September 17, 2021.

[15] H.Rept. 117-130, p. 1493.

[16] H.Res. 744 was considered by the House on November 5, 2021, and was adopted in the early morning hours of November 6, 2021, by a vote of 221-213. During consideration of H.Res. 744, a point of order was raised against the resolution under Section 426(a) of the Congressional Budget Act of 1974, which prohibits the consideration of a special rule that waives the application of requirements included in the Unfunded Mandates Reform Act of 1995. Because such a point of order is required to be disposed of by the question of consideration, the House proceeded with 20 minutes of debate, after which the House voted to consider the resolution (in light of the point of order), by a vote of 215-212.

[17] Rules Committee Prints 117-18 and 117-19 are available at U.S. Congress, House Committee on Rules, "H.R. 5376—Build Back Better Act," at https://rules.house.gov/bill/117/hr-5376.

[18] CBO, *Summary of Cost Estimate for H.R. 5376, the Build Back Better Act*, November 18, 2021, at https://www.cbo.gov/publication/57627.

[19] H.R. 5376 was considered by the House on November 18-19, 2021, and passed by a vote of 220-213.

[20] See, for example, committees' legislative text and associated CBO estimates at Senate Democrats, "Senate Committee CBO Scores for Build Back Better," January 7, 2022, at https://www.democrats.senate.gov/senate-committee-cbo-scores-for-build-back-better.

- The Senate Committee on Finance, which received a reconciliation instruction to reduce the deficit by at least $1 billion over the period FY2022-FY2031, released legislative text on its website on December 11, 2021.[21]
- The Senate HELP Committee, which received a reconciliation instruction to increase the deficit by no more than $726.38 billion, released legislative text on its website on December 11, 2021.[22]

As of the date of this report, no further formal congressional action had occurred on H.R. 5376.

Comparison Tables

Following are seven tables that together provide high-level summaries of the BBBA provisions as passed by the House and the Senate provisions described as being intended for the BBBA. The summary of the House-passed language is baselined against current law, and the summary of the Senate-released language is compared with the House-passed language. Four of the tables focus on provisions generally related to private health insurance, Medicaid, CHIP, and Medicare, respectively. Three of the tables address additional and/or crosscutting topics: private health insurance-related tax credits, prescription drugs, and provisions that affect the Medicaid and Medicare programs with respect to HCBS and LTCFs.

The tables are organized in this way to facilitate readers' review of provisions that address a common topic. Each table does not necessarily align with a single title of the House-passed BBBA or with one of the Senate committee versions. However, within a table, the provisions are generally listed in the order in which they appear in H.R. 5376 as passed, with each row generally representing one section of the House-passed bill and its corresponding section of the language released by either the Senate Finance Committee or the Senate HELP Committee. There are two exceptions:

- A few provisions appeared in more than one place in the House and/or Senate legislation (e.g., a provision related to cost sharing for insulin, which would amend three existing statutes). In such cases, the several sections are discussed in the same row, which appears in the table according to the earliest such appearance in the House bill.
- Where necessary due to complexity or for other reasons, a few provisions are broken out into multiple rows (e.g., with each subsection in a row).

Many of the private health insurance, Medicaid, CHIP, and Medicare provisions are identical or similar in the House-passed bill and the Senate-released BBBA language. For example, both the House bill and the Senate language contain provisions that would provide subsidies for private health insurance offered through the health insurance exchanges for individuals with incomes below the poverty level in certain states; would create a new program requiring price negotiation of certain Medicare drugs, mandatory rebates on Medicare drugs, and a redesign of the Medicare Part D outpatient drug benefit; and would implement a Medicaid HCBS improvement program.

[21] U.S. Congress, Senate Committee on Finance, *Finance Committee Build Back Better Text*, 117th Cong., 1st sess., December 11, 2021, at https://www.finance.senate.gov/download/finance-committee-build-back-better-text-.

[22] U.S. Congress, Senate Committee on Health, Education, Labor, and Pensions, "HELP Committee Posts Updated Build Back Better Text Ahead of Bipartisan Parliamentary Discussions," press release, December 11, 2021, at https://www.help.senate.gov/chair/newsroom/press/help-committee-posts-updated-build-back-better-text-ahead-of-bipartisan-parliamentary-discussions.

There are some variations in the language of the House-passed and Senate-released versions. Examples of such variations include technical edits; shifts in funding amount and/or duration; and policy changes, including to the scope and/or timing of the provision.

Some provisions are included in only the House-passed language or only the Senate-released language. The House-passed language includes a provision that would reduce Medicaid disproportionate share hospital (DSH) allotments by 12.5% for states that have not implemented the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion. This provision was not included in the Senate-released language. The Senate-released language includes provisions that were not included in the House-passed language related to federally certified nursing facilities regarding improvements to the Special Focus Facility Program and grants to improve staffing and infection control in long-term care institutional settings.

Table 1. Private Health Insurance Provisions in the Build Back Better Act (BBBA)

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Civil Monetary Penalties for Parity Violations	Federal mental health parity (MHP) requirements prohibit group health plans and group (and individual) health insurance issuers that provide coverage for mental health/substance use disorder (MH/SUD) benefits from imposing terms for such coverage that are more restrictive than terms for the coverage of medical and surgical benefits. Under the Employee Retirement Income Security Act of 1974 (ERISA; P.L. 93-406), group plan participants and other persons may bring civil actions relating to alleged MHP violations. These persons may file an action against a group health plan or a group health insurance issuer to recover benefits under the plan's terms or to enforce or clarify the plaintiff's rights under the plan's terms. The Secretary of Labor also has limited authority to bring civil actions against group health plan sponsors—but not against group health insurance issuers—to enforce MHP requirements. Although the Secretary of Labor has authority to impose civil monetary penalties (CMPs) on group health plan sponsors and group health insurance issuers to enforce certain other requirements (e.g., regarding the use of genetic information), CMPs are not authorized for enforcement of MHP requirements.	**Section 21005** would extend the Secretary of Labor's authority to impose CMPs against any group health plan (including plan sponsors or plan administrators) or any group health insurance issuer for violations of MHP requirements. This authority would apply with respect to group plans or group health insurance issuers for plan years (PYs) beginning one year after the enactment of the act. The provision also would allow the Secretary of Labor to bring civil actions against group health insurance issuers to enforce MHP requirements.	**Section 21005** is nearly identical to the House provision, except for one technical change: the Senate-released language would amend ERISA at 29 U.S.C. §1132(c)(10), whereas House-passed Section 21005 would amend ERISA at 29 U.S.C. §1132(c)(10)(A).
Ensuring Affordability of Coverage for Certain Low-Income Populations	The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required government-run health insurance exchanges to be established in every state. Through exchanges, consumers can purchase qualified health plans (QHPs; private health insurance plans certified to be sold in the exchanges), and can receive financial subsidies for coverage, if eligible (based on income and other factors).	**Section 30601** would provide for access to coverage through the health insurance exchanges for certain low-income individuals. It would address cost sharing, benefits, enrollment periods, and consumer outreach. See discussions of subsections (a)–(e) in sub-rows below for more information. Note that terminology regarding eligible low-income individuals varies slightly across the subsections.	**Section 27001** is similar to the House provision, except for changes related to retroactive cost-sharing reductions in subsection (a) and new language in subsections (d) and (e) that references these changes. See sub-rows below.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Reducing Cost Sharing Under Qualified Health Plans	Individuals may receive cost-sharing reductions (CSRs) that decrease cost-sharing requirements for certain QHPs. To be eligible for CSRs, individuals must qualify for the premium tax credit, be enrolled in a silver QHP, and have annual household incomes between 100% and 250% of the federal poverty level (FPL). A silver QHP is a plan with an actuarial value (AV) of 70%; AV measures a plan's generosity, expressed as the percentage of estimated medical expenses paid by a health insurance issuer for a standard population and set of allowed charges. CSR-eligible individuals receive two types of CSRs: one reduces the annual cost-sharing limit, and the other directly reduces cost-sharing requirements (e.g., co-payments). Greater cost-sharing assistance is provided to individuals with lower incomes. For example, CSR-eligible individuals with incomes between 100% and 150% of FPL receive cost-sharing assistance that increases the AV of their coverage to 94%; by contrast, eligible individuals with incomes between 200% and 250% of FPL receive assistance that increases their coverage's AV to 73%.	***Section 30601(a)*** would temporarily change the CSR income eligibility criteria and would provide special access for a limited time to individuals with incomes not exceeding 138% of FPL. Over the period PY2023-PY2025, this provision would require only that incomes do not exceed 400% of FPL to be income eligible for CSRs. For PY2022, individuals with incomes not exceeding 138% of FPL would be treated as having income at 100% of FPL. This provision would deem such individuals to have met the CSR income eligibility criteria and would allow them to receive the highest level of cost-sharing assistance currently available (as long as they also met CSR non-income-eligibility criteria). Over the period PY2023-PY2025, the provision would temporarily provide greater cost-sharing assistance to individuals with incomes not exceeding 138% of FPL who would be eligible for CSRs (i.e., "specified enrollees"). The provision would reduce cost-sharing requirements to increase the AV of the exchange QHP in which a specified enrollee is enrolled to 99%. To effect this provision, the Secretary of Health and Human Services (HHS) would establish procedures under which applicable QHPs would reduce cost-sharing requirements. The provision would require such plans to notify the HHS Secretary of the cost-sharing assistance provided to specified enrollees, and it would require the Secretary to make periodic and timely payments to the plans. The provision would provide appropriations of such sums as may be necessary to finance these payments.	***Section 27001(a)*** is similar to the House provision, except it would require the exchange QHPs in which specified enrollees are enrolled during PY2025 to provide payments to health care providers or specified enrollees to cover items or services provided to the enrollees during the retroactive coverage period, as specified in the provision. The provision would require plans providing retroactive payments to notify the HHS Secretary of any retroactive payments. It also would require the Secretary to make periodic and timely payments to the plans. The provision would provide appropriations of such funds as may be necessary to finance these payments.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Open Enrollments Applicable to Certain Lower-Income Populations	Outside of annual open enrollment periods (OEPs), consumers may enroll in a QHP in an individual exchange only if they qualify for a special enrollment period (SEP). An SEP is generally a certain amount of time (e.g., 60 days) after a *triggering event,* such as a change in marital status or a loss of *qualifying coverage*, which generally means the types of coverage considered to be *minimum essential coverage* (MEC). Most types of comprehensive coverage are considered MEC, including *government sponsored programs* (e.g., full-benefit Medicaid coverage, Medicare), private health insurance, and other types of coverage as recognized by the HHS Secretary in coordination with the Secretary of the Treasury. Per regulation, certain types of limited-benefit Medicaid coverage options (e.g., family planning, tuberculosis services, COVID-19 testing) are not included in the definition of *government sponsored program MEC*.	***Section 30601(b)*** would create a new federal SEP to allow "individuals described" to enroll in a silver QHP for which CSRs are applicable, through their state's individual exchange. The individuals eligible for this SEP would be those with household income that does not exceed 138% of FPL who are not otherwise eligible for certain types of government sponsored program MEC (other than the types exempt from the definition of MEC, such as certain types of limited-benefit Medicaid coverage). In general, these would be individuals who otherwise would be eligible for coverage through the ACA Medicaid expansion but are in states that have not taken up the ACA Medicaid expansion (currently, 12 states). Overall, the SEP would be "for months occurring during" calendar years 2022-2025 (CY2022-CY2025). For an individual described, the SEP would be for "the continuous period beginning on the first day that such individual is so described."	***Section 27001(b)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Additional Benefits for Certain Low-Income Individuals for Plan Years 2024 and 2025	The ACA requires certain plans, including those sold on the exchanges (i.e., QHPs), to cover 10 broad categories of essential health benefits (EHB). The specific benefits that comprise the EHB are not defined in federal law but rather are generally defined by states. Cost-sharing requirements may apply to services covered as EHB, and coverage details may vary for EHB services furnished by out-of-network providers, subject to applicable federal and state requirements. The ACA also requires most plans, including those sold on the exchanges, to cover specified preventive services without cost sharing. These services include contraceptive services and supplies (for women but not for men), as recommended by the Health Resources and Services Administration. By regulation, plans generally are not required to cover the specified preventive services furnished out of network. Also by regulation, the requirement to cover specified preventive services without cost sharing is incorporated into EHB requirements. There is no federal requirement regarding QHP or other private health insurance coverage of non-emergency medical transportation.	***Section 30601(c)*** would require QHP issuers to provide certain benefits to eligible individuals, via silver QHPs for which CSRs are applicable, in PY2024-PY2025. The individuals eligible for the additional benefits would be those with household income that does not exceed 138% of FPL and who are eligible for CSRs. In general, these would be individuals who otherwise would be eligible for coverage through the ACA Medicaid expansion but are in states that have not taken up the ACA Medicaid expansion. For such individuals and plans, the provision would require coverage of the following, where not already provided as EHB: (1) non-emergency medical transportation services and (2) family planning services and supplies.[a] The provision would require such coverage without consumer cost sharing and "without any restriction on the choice of a qualified provider from whom an individual may receive such benefits." The provision would require applicable QHP issuers to notify the HHS Secretary of covering the additional benefits as specified, and it would require the Secretary to make "periodic and timely payments to the issuer equal to payments for such services so furnished." The provision would appropriate such sums as may be necessary to the Secretary to make these payments to issuers.	***Section 27001(c)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Education and Outreach Activities	Federal statute and regulations require exchanges to carry out certain consumer outreach and assistance functions. Requirements include having Navigator programs, for which grants are provided to entities to perform consumer outreach and assistance functions. Exchanges also provide consumer information and outreach via mail, radio, or television advertisements, and/or other methods. Navigator grants and other exchange consumer education and outreach activities are federally funded for federally facilitated exchanges (FFEs). There is no specific appropriation or statutorily required program spending level for such activities. To raise funds for these and certain other exchange functions, HHS assesses a monthly fee on each health insurance issuer that offers plans through an FFE. States with state-based exchanges and state-based exchanges on the federal platform fund their own Navigator grants and other consumer outreach and education activities. These states may assess their own user fees on issuers participating in their exchanges.	***Section 30601(d)(1)*** would require the HHS Secretary to conduct consumer outreach and education activities focused on informing specified individuals, in states with FFEs, about the availability of QHPs and of financial assistance for such coverage in each applicable state's exchange. The specified individuals would be those who otherwise would be eligible for coverage through the ACA Medicaid expansion but are in states that have not taken up the ACA Medicaid expansion. No funds appropriated for these activities could be used to promote "non-ACA compliant health insurance coverage," including, as specified, an association health plan or short-term, limited-duration insurance. For purposes of conducting these outreach activities, $105 million would be appropriated for FY2022 and would remain available until expended. Of that amount, $15 million would be specified for use in FY2022 and $30 million would be specified for use in each of FY2023-FY2025. ***Section 30601(d)(2)*** would require the HHS Secretary to obligate not less than $10 million for FY2022 and not less than $20 million for each of FY2023-FY2025 for the purpose of awarding grants to Navigator entities in FFEs. These funds would be obligated from exchange issuer user fee amounts collected and would remain available until expended.	***Section 27001(d)*** is largely identical to the House provision, except it would further specify that the provision's funded activities must include informing individuals "on the availability of payment and reimbursement for services during the retroactive coverage period, as defined in section 1402(c)(6)(D)(vii)" (see discussion of ***Section 27001(a)***, above). This provision would apply to the outreach and education activities and to the Navigator grants.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Funding	Not applicable.	***Section 30601(e)*** would appropriate $65 million to the HHS Secretary for FY2022, to remain available until expended, for purposes of "carrying out the provisions of, and the amendments made by" **Sections 30601-30603**.	***Section 27001(e)*** is largely identical to the House provision in reference to funding for the corresponding provisions in the Senate language, other than the following difference: ***Section 27001(e)*** would appropriate an additional $5 million for FY2022, to remain available until expended, "for purposes of carrying out section 1402(c)(6)(D) of the [ACA] (as added by this section)."
Establishing a Health Insurance Affordability Fund	There is currently no federal reinsurance program, but 15 states have established state-based reinsurance programs using the Section 1332 waiver process.	**Section 30602** would establish a fund to provide reinsurance payments to individual health insurance issuers with high-cost enrollees or to provide other types of assistance to reduce specified out-of-pocket costs. (See sub-rows below.)	**Section 27002(a)** is similar to the House provision, with differences highlighted in sub-rows below.

In General

The ACA established the Transitional Reinsurance Program, which was a temporary federal reinsurance program that operated from PY2014 through PY2016 and provided reimbursement to most individual health insurance issuers that enrolled high-cost enrollees.

Section 1332 of the ACA provides states with the option to waive specified requirements of the ACA in order to implement their own plans to provide health insurance coverage to state residents, as long as the plan meets the ACA's terms. Currently, 15 of the 16 approved waivers include a variant of a statewide individual market reinsurance program.

The ACA Medicaid expansion provides Medicaid eligibility to most non-elderly adults up to 133% of FPL. Currently, 12 states are *non-expansion states* (i.e., have not implemented the Medicaid expansion).

The Basic Health Program (BHP) is an optional program for states to make affordable health benefits coverage available to a specific group of individuals in lieu of offering coverage through an exchange. Through the BHP, states can make coverage available to individuals under the age of 65 with household incomes between 133% and 200% of FPL who are not otherwise eligible for Medicaid or other minimum essential coverage specified in the ACA. Minnesota and New York are the only states that have implemented the BHP.

Section 30602(a) would establish the Improve Health Insurance Affordability Fund to allocate funding to states to either (1) provide reinsurance payments to issuers with respect to their individual health insurance coverage enrollees or (2) provide other types of assistance to reduce out-of-pocket costs for individuals enrolled in QHPs offered through an individual market health insurance exchange and individuals enrolled in plans offered through a BHP. The fund would provide funding beginning January 1, 2023.

To be eligible for a fund allocation, ***Section 30602(a)*** would require states to submit to the Administrator of the Centers for Medicare & Medicaid Services (CMS) an application that describes how the funds would be used. Any application submitted would be approved, unless the CMS Administrator notified the applying state that its application had been denied for not complying with specified requirements.

The HHS Secretary would determine state allocation amounts using a formula based on an assumption that all funding would go to reinsurance payments. Total state allocations would equal the amount of appropriated funds for a given year.

For 2023, the provision would require the HHS Secretary to allocate funding to states not later than 90 days after enactment of this section. For 2024-2025, the provision would require the HHS Secretary to allocate funding to states not later than January 1 of the respective year. Any funds allocated to a state in a given year would be available to the state through the end of the subsequent year.

Section 30602(a) would apply different fund rules to non-expansion states in 2023-2025. Instead of these states applying and managing their own allocations, the CMS Administrator, in consultation with applicable state authorities, would provide reinsurance payments to issuers in such states with

Section 27002(a) would establish the Improve Health Insurance Affordability Fund, similar to the House provision. However, Section 27002(a) also would apply rules to non-expansion Medicaid states in 2022 that are different from, and in addition to, the rules applicable to non-expansion states in 2023-2025. Additionally, Section 27002(a) would appropriate $1 billion for FY2022 for the CMS Administrator to provide reinsurance payments to issuers in non-expansion states in 2022. These funds would remain available until expended.

Instead of appropriating $10 billion for 2023 and each subsequent year through 2025 for the HHS Secretary to allocate funding to states and to make payments for non-expansion states, Section 27002(a) would appropriate $30 billion in FY2022. Of this amount, $10 billion would be used for each of FY2023-FY2025 to allocate funding to states and to make payments for non-expansion states. Each year's allocation would remain available until September 30, 2026.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		respect to their individual health insurance coverage enrollees. The total amount available for these reinsurance payments would be based on the summation of all non-expansion-state allocations. Non-expansion-state allocations would be based on a formula that is similar, but not identical, to the formula used to determine expansion states' allocations. ***Section 30602(a)*** would appropriate $10 billion for 2023 and each subsequent year through 2025 for the HHS Secretary to allocate funding to states and to make payments for non-expansion states.	
Basic Health Program Funding Adjustments	States with an optional BHP receive federal payments that equal 95% of the value of premium tax credits (PTCs) and CSRs that BHP enrollees would have been provided, had they enrolled in QHPs through an exchange. The HHS Secretary determines this amount on a per enrollee basis, taking into account all relevant factors necessary to determine the value of the PTCs and CSRs. Minnesota and New York are the only states that have implemented the BHP.	***Section 30602(b)*** would require states, as a condition of establishing a BHP, to report to the HHS Secretary the premium that would have applied to each QHP that receives reinsurance payments from the Improve Health Insurance Affordability Fund, had the reinsurance payments not applied. This requirement would apply for plan years beginning on or after January 1, 2023. The HHS Secretary would use this information from states to calculate the BHP payments to states.	***Section 27002(b)*** is identical to the House provision.
Implementation Authority	Not applicable.	***Section 30602(c)*** would allow the HHS Secretary to implement the provisions and amendments made by Section 30602 by sub-regulatory guidance or otherwise.	***Section 27002(c)*** is identical to the House provision.
Funding for the Provision of Health Insurance Consumer Information	The ACA required the Secretary to award grants to states to provide for offices of health insurance consumer assistance or health insurance ombudsman programs. Per that requirement, $30 million were appropriated "for the first fiscal year for which this section applies to carry out this section" (i.e., FY2010). Such sums as necessary were authorized to be appropriated for subsequent FYs.	**Section 30603** would provide for new funding for these grants. It would appropriate $100 million for 2022, which would remain available until expended. Of that amount, it would specify $25 million for use in each of 2022-2025.	**Section 27003** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Cost-Sharing Reductions for Individuals Receiving Unemployment Compensation	The ACA established CSRs and the applicable income and other eligibility criteria. The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) provided special access to individuals who received unemployment compensation (UC). The ARPA deemed individuals who received UC for any week in CY2021 to have met the CSR income eligibility criteria for PY2021. The ARPA also disregarded any household income above 133% of FPL in 2021, which provided UC beneficiaries with the greatest level of cost-sharing assistance.	**Section 30605** would extend the ARPA's CSR provision one more year, through PY2022. The provision would deem individuals who receive UC for any week during a given year to have met the CSR income eligibility criteria. It also would change the income disregard to income in excess of 150% of FPL.	**Section 27005** is identical to the House provision.
Funding to Support State Applications for Section 1332 Waivers and Administration	Section 1332 of the ACA allows states to apply for waivers of specified ACA provisions for up to five years. Under a state innovation waiver (or Section 1332 wavier), a state is expected to implement a plan (in place of the waived provisions) that meets certain minimum requirements. The HHS Secretary and the Secretary of the Treasury review and approve state innovation waiver applications pertaining to provisions under their respective jurisdictions.	**Section 30607** would require the HHS Secretary to award grants to states for purposes of developing a new waiver application, preparing an application for a waiver extension or amendment, or implementing a state plan. **Section 30607** would appropriate $50 million to the HHS Secretary for FY2022 for purposes of implementing the grant program and awarding grants. These funds would remain available until expended. The grant amount to a state would not exceed $5 million and would remain available to the state until expended.	**Section 127308** is identical to the House provision.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, the language released by the Senate Committee on Health, Education, Labor, and Pensions (HELP) and the Senate Finance Committee described as being intended for the BBBA, and relevant current law. See report introduction for links to legislative language.

Notes: This table includes provisions generally relevant to private health insurance. Also see **Table 2** and **Table 3** for additional provisions related to private health insurance and tax credits and to private health insurance and prescription drugs, respectively. See **Appendix A** for all abbreviations used in table.

a. The provision points to the Medicaid statute as a baseline for defining this coverage requirement. The non-emergency medical transportation services benefits would include coverage "as described in section 1902(a)(4) of the Social Security Act (SSA) for which Federal payments would have been available under title XIX of the SSA had such services been furnished to an individual under a State plan (or waiver of such plan) under such title." The family planning services benefits would include those "described in subsection (a)(4)(C) of section 1905 of [the SSA] for which Federal payments would have been so available."

Table 2. Private Health Insurance-Related Tax Credit Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers	Individuals who meet income eligibility criteria, are not eligible for subsidized health coverage (e.g., Medicaid), and meet other requirements may receive a PTC, which reduces the cost of QHPs offered through exchanges. As authorized under the ACA, the PTC was available to individuals whose annual household incomes were between 100% and 400% of FPL. The ARPA made temporary changes to the PTC. For tax year (TY) 2021 and TY2022, the ARPA eliminated the income eligibility phaseout at 400% of FPL, requiring individuals to meet only the minimum threshold to be income eligible for the PTC (such individuals must still meet the applicable non-income eligibility criteria to receive the credit). PTC-eligible individuals still may be required to pay an amount toward the premium. Under the ACA, the required premium contribution is capped at a dollar amount that is equivalent to a percentage of annual household income, with income measured relative to the FPL. The cap requires lower-income individuals to contribute a smaller share of income toward the premium compared with the contribution requirement for higher-income individuals, with applicable percentages adjusted on an annual basis. Prior to enactment of the ARPA, the 2021 percentages varied from 2.07% to 9.83% for incomes within the original range of 100%-400% of FPL. The ARPA temporarily reduced the percentage of income used in the credit formula. For TY2021-TY2022, applicable percentages range from 0.0% to 8.5% of income, effectively reducing the amounts eligible individuals pay to enroll in exchange QHPs.	**Section 137301** would extend the ARPA PTC provisions through TY2025 by continuing to eliminate the eligibility phaseout for households with annual incomes above 400% of FPL and would use the ARPA-specified percentages (0.0% to 8.5% of income) to calculate the credit amount. Similar to the ARPA, this provision would continue full subsidies to cover standard QHP premiums for PTC-eligible individuals with incomes at or below 150% of the FPL. In addition, the provision would disallow the annual adjustment to applicable income percentages used in the PTC formula through TY2026.	**Section 127301** is nearly identical to the House provision, except it would permanently disallow the annual adjustment to applicable income percentages used in the PTC formula.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit	Individuals who are offered health benefits through an employer generally are not eligible for the PTC. An exception exists for individuals whose employer-provided health benefits are unaffordable or inadequate. An applicable employer plan is considered unaffordable if the premium for self-only coverage exceeds a certain percentage of household income, with such percentage adjusted on an annual basis. In 2022, employer coverage is considered unaffordable if the premium for self-only coverage exceeds 9.83% of household income; the ACA initially established the percentage at 9.5%.	**Section 137302** would temporarily lower the percentage of household income used to determine affordability of employer coverage for PTC-eligibility purposes. For the period TY2022-TY2025, the affordability test applied to applicable employer plans would be set at 8.5% of household income, allowing more households to be eligible for the PTC compared with those eligible under current law. In addition, the provision would disallow the annual adjustment to the affordability test percentage from TY2022 through TY2026.	**Section 127302** is nearly identical to the House provision, except it would permanently disallow the annual adjustment to the affordability test percentage.
Treatment of Lump-Sum Social Security Benefits In Determining Household Income	Social Security provides monthly cash benefits to qualified workers and certain family members in the event of a worker's retirement, disability, or death. Each year, many Americans become newly entitled to Social Security benefits. Whereas applications for retirement or survivor benefits are processed relatively quickly, applications and appeals for disability benefits may take many months or years. Sometimes, a claimant may be determined to have been entitled to benefits for months before the benefit determination is made. In such cases, the individual receives a lump-sum payment for months of past-due benefit entitlement, which may include months in past taxable years. Because calculation of the PTC is based on household income for a given year, a multiyear award added to income in one year may affect an individual's eligibility for the PTC or may substantively reduce the credit amount.	**Section 137303** would exclude certain income from the determination of PTC eligibility and calculation of the credit amount. Beginning in TY2022, the provision would exclude from household income any lump-sum Social Security benefit payment attributable to a prior year. Beginning in TY2026, this provision would allow taxpayers to elect to include the excludable amount as part of their income.	**Section 127303** is identical to the House provision.

Temporary Expansion of Health Insurance Premium Tax Credits for Certain Low-Income Populations	Individuals with household incomes less than 100% of FPL generally are ineligible for the PTC. Likewise, individuals who are eligible for subsidized health coverage (e.g., Medicaid, employer-provided health benefits) generally are ineligible for the PTC. However, current law provides exceptions applicable to certain subsidized coverage. Eligible individuals may receive the PTC in advance to coincide with payment of monthly premiums or wait to claim the credit when filing income taxes. Calculation of the advance premium tax credit (APTC) is based on an estimate of household income for the year in which subsidized exchange coverage is sought. Individuals who receive the APTC are required to reconcile that estimated amount with the credit amount they should have received (based on actual income as determined on the tax return). If an individual's income increased during the year and he or she received excess APTC, the excess amount generally will be recaptured as a tax payment. The amount subject to recapture is capped for individuals with annual household incomes less than 400% of FPL, with greater tax relief provided to individuals with lower incomes. The employer shared responsibility provisions (ESRP) generally incentivize large employers to offer adequate and affordable health insurance coverage to their full-time employees (and their employees' dependents). If an applicable large employer fails to offer health insurance or offers substandard coverage, the employer may be subject to a penalty if at least one full-time employee enrolls in an exchange plan and is eligible for a PTC or a CSR. For applicable large employers subject to an ESRP penalty, the penalty amount is determined according to a formula that varies depending on whether the employer offered health benefits to at least 95% of its full-time employees. In situations where an employer does meet this threshold, the formula for calculating the penalty incorporates the number of	**Section 137304** would expand PTC eligibility to certain lower-income households and would make other changes for the period TY2022-TY2025. The provision would expand PTC eligibility by disregarding income criteria and disallowing the affordability test applicable to employer health coverage for households with incomes not exceeding 138% of FPL. The provision would reduce household tax liability by decreasing the amount households with excess APTC would have to pay back, for households with incomes less than 200% of FPL, and by disallowing the requirement to pay back excess APTC if an exchange projected a household's income would not exceed 138% of FPL, for households that would not be required to file a tax return except to reconcile APTC payments. The provision would prevent employees with household incomes projected to not (or that do not) exceed 138% of FPL from triggering the ESRP penalty or from being factored into any penalty amount calculations (where applicable).	**Section 127304** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
	full-time employees (of such an employer) who received a PTC or a CSR.		
Special Rule for Individuals Receiving Unemployment Compensation	Under the ARPA, individuals who received UC for any week in CY2021 were deemed to have met the PTC income eligibility criteria for TY2021. In addition, the calculation of the credit for such individuals disregarded any household income above 133% of FPL.	**Section 137305** would extend the UC PTC provision one more year, through TY2022. The provision would deem individuals who receive UC for any week during a given year to have met the PTC income eligibility criteria. The provision also would disregard any household income above 150% of FPL for credit calculation purposes in TY2022.	**Section 127305** is identical to the House provision.
Permanent Credit for Health Insurance Costs	Certain workers who have experienced job loss and retirees whose private pension plans were taken over by the Pension Benefit Guaranty Corporation may have been eligible for the Health Coverage Tax Credit (HCTC). The HCTC covered 72.5% of the premium for qualified health insurance, as specified in statute. It had a sunset date of January 1, 2022.	**Section 137306** would authorize the HCTC on a permanent basis by striking the sunset date. The provision also would increase the HCTC's subsidy rate to 80% of the premium for qualified health insurance for coverage months beginning after December 31, 2021.	**Section 127306** is identical to the House provision.
Exclusion of Certain Dependent Income for Purposes of Premium Tax Credit	For purposes of determining eligibility for and the amount of the PTC and CSRs, household income consists of a given taxpayer's modified adjusted gross income (MAGI) and the aggregate MAGI of all persons for whom the taxpayer claims a deduction for a personal exemption. Given this definition, the household may include the taxpayer, the taxpayer's spouse, and other tax dependents.	**Section 137307** would temporarily exclude dependent income for specified purposes. For the period TY2023-TY2026, the provision would exclude income of a dependent younger than 24 years of age from the calculation of the PTC and determination of eligibility for CSRs. An exception to this exclusion would apply to aggregate income from all dependents younger than the age of 24 in a given household that exceeds $3,500; the dollar level would be adjusted annually beginning in TY2024. Beginning in TY2026, this provision would allow taxpayers to elect to include the excludable amount as part of their income.	**Section 127307** is identical to the House provision.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, language released by the Senate Finance Committee described as being intended for the BBBA, and relevant current law. (The Senate HELP Committee language did not include provisions relevant to this table.) See report introduction for links to legislative language.

Notes: This table includes provisions relevant to private health insurance and tax credits. Also see **Table 1** for provisions related to private health insurance generally. See **Appendix A** for all abbreviations used in table.

Table 3. Prescription Drug Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Requirements with Respect to Cost Sharing for Certain Insulin Products	Private health insurance prescription drug coverage for insulin products can vary by plan, subject to federal and state requirements. Differences in coverage include which insulin products are included in a plan's formulary and the associated cost-sharing requirements. Non-grandfathered plans in the individual and small-group markets (on and off the exchanges) must cover 10 categories of EHBs. One category is prescription drugs. Although states, rather than the federal government, generally specify the coverage to be provided within these 10 categories, certain HHS regulations effectively require EHB insulin coverage. Cost sharing is possible for EHB, and there are no specific limits on consumer cost sharing for insulin products. There are no federal requirements mandating the coverage of insulin by large-group market and self-insured group plans. Catastrophic plans cover the EHB but generally may not provide benefits for any plan year until after the annual limitation on cost sharing has been reached. One exception is that catastrophic plans must cover at least three primary care visits per year pre-deductible. Enrollment eligibility requirements apply.	**Section 27001** would amend ERISA, **Section 30604** would amend the Public Health Service Act (PHSA; P.L. 78-410), and **Section 137308** would amend the *Internal Revenue Code* (IRC) to establish standards for coverage and cost sharing for certain insulin products. These requirements would apply for PYs beginning on or after January 1, 2023. The provisions would require individual market, small- and large-group market, and self-insured group plans to select and provide coverage for at least one type of each dosage form (e.g., vial, pump, inhaler) of each different type of insulin (e.g., rapid to ultra-long acting, premixed), when available. The insulin products would need to be licensed, or deemed to be licensed, and would continue to be marketed pursuant to the license. The provisions would cap cost sharing for 30-day supplies at the lesser of a $35 co-payment or 25% of the negotiated price of the selected insulin product net of all price concessions received by or on behalf of the plan, including payments to third parties such as pharmacy benefit managers (PBMs). This coverage would be required pre-deductible, and other cost-sharing limits would apply. This cost-sharing cap requirement would not apply to insulin products delivered by out-of-network providers. The PHSA provision would require catastrophic plans to provide coverage for the selected insulin products for a PY before an enrolled individual has incurred cost-sharing expenses in an amount equal to the annual limitation on cost sharing.	**Section 26001** would amend ERISA and the IRC, and **Section 27004** would amend the PHSA, with language identical to the House provisions in H.R. 5376 Sections 27001, 137308, and 30604, respectively.

Oversight of Pharmacy Benefit Manager Services	Group health plans and health insurance issuers offering group and individual health insurance coverage commonly contract with third-party entities referred to as pharmacy benefit managers (PBMs) to manage the prescription drug benefits offered under a plan, including developing prescription drug formularies and contracting with networks of pharmacies that agree to dispense drugs for set reimbursement. On behalf of the health plan or issuer, the PBM also negotiates with pharmaceutical manufacturers to obtain discounts, rebates, and other concessions. Group health plans or health insurance issuers offering group or individual health insurance coverage are required to report certain information on pharmacy benefits and drug costs to the Secretaries of Labor, HHS, and the Treasury. The information includes total spending on prescription drugs; the 50 most costly prescription drugs and the 50 drugs with the greatest increase in expenditures; any impact on premiums by rebates, fees, and other remuneration paid by drug manufacturers to the plan; and any premium and out-of-pocket cost reductions associated with such rebates, fees, or other remuneration paid by manufacturers. Currently, there are no federal requirements on PBMs to share certain information, such as drug pricing data, with group health plan sponsors (e.g., employers) with whom they are contracted to manage prescription drug coverage. There are requirements on PBMs to share such information, as specified, with QHP issuers with whom they are contracted. Currently, there are no federal prohibitions on PBMs entering into contracts with drug manufacturers or other entities in the prescription drug supply chain, nor are there prohibitions on PBMs sharing certain information	**Section 27002** would amend ERISA, **Section 30606** would amend PHSA, and **Section 137309** would amend the IRC to require the following entities to report specified drug pricing data to group health plan sponsors: (1) a health insurance issuer offering group health insurance coverage and (2) an entity providing PBM services on behalf of a group health plan or a group health insurance issuer. The provisions would require reports at least once every six months for PYs beginning on or after January 1, 2023, and would require that certain reports also be submitted to the Comptroller General, as specified. The provisions would require reports to include specified information, such as co-payment assistance amounts paid or funded by manufacturers; details on drugs dispensed, such as number of prescriptions filled (as specified); wholesale acquisition cost, consumer out-of-pocket spending, and additional data by drug category and class; total gross spending, price reductions, and net spending on prescription drugs by the plan; and remuneration for third-party referrals. Existing Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and other requirements would apply to plans' use and disclosure of the reports. The provisions would bar group health plans, group health insurance issuers, and entities or subsidiaries providing PBM services on behalf of such plans or issuers from entering into drug manufacturer or other specified contracts that would limit the disclosure of information in a way that would prevent the making of the required reports. These provisions would apply for PYs beginning on or after January 1, 2023. The Secretaries of Labor, HHS, and the Treasury would enforce the reporting requirements and the specified ban on contracting. Reporting entities would be subject to a CMP of $10,000 for each day	**Section 26002** would amend ERISA and the IRC, and **Section 27006** would amend PHSA, with language identical to the House provisions in H.R. 5376 Sections 27002, 137309, and 30606, respectively, other than the following differences. The Senate and House versions differ in the language regarding the "limited form" reports. In the House versions of the provisions, the Secretaries of Labor, HHS, and the Treasury would issue rules defining a limited form of the report required "of" plan sponsors who are "drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior." In the Senate versions of this language, the Secretaries would issue rules defining a limited form of the report required "to be submitted to" such plan sponsors, for the same reasons. In addition, **Section 26002(c)** would appropriate $43.75 million for the Department of Labor for FY2022, for purposes of carrying out the amendments made by the section.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
	with group health plans or health insurance issuers.	they violated the ban or failed to report the required information, or up to $100,000 per item of false information knowingly provided, in addition to other penalties prescribed by law. The Secretaries could waive penalties or extend the compliance period for entities that are in violation of the provisions but made a good-faith effort to comply. The procedures for enforcing CMPs under SSA Section 1128A would apply to the enforcement of these CMPs. **Section 30603** also would require the Comptroller General to issue a report to Congress that would include information on pharmacy network topics as specified, no later than three years after enactment of this provision.	

Providing for Lower Prices for Certain High-Priced Single-Source Drugs

Medicare Part A covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Part A typically pays providers for drugs as part of a predetermined per episode payment, and hospitals can receive add-on payments for certain new innovator drugs.

Medicare Part B covers physician services, outpatient services, and some home health and preventive services. Providers that administer prescription drugs under Part B are paid based on a list price formula defined in statute (the average sales price [ASP]), plus a specified add-on payment. Part B beneficiaries pay 20% coinsurance.

The voluntary Medicare Part D prescription drug benefit provides coverage of outpatient prescription drugs through stand-alone prescription drug plans or Medicare Part C managed care plans with a Part D component (Medicare Advantage prescription drug plans, or MA-PDs). The Part D noninterference provision bars the HHS Secretary from negotiating Part D drug prices and from requiring a set formulary or pricing structure. Part D plan sponsors (insurers), working with PBMs, negotiate prescription drug price discounts and rebates with drug manufacturers and dispensing pharmacies. Sponsors must offer enrollees their "negotiated price," as defined in regulations, for covered drugs. Under the HHS definition of negotiated prices, sponsors have latitude to decide whether to pass on rebates and certain other price concessions at the pharmacy at the point of sale or to use the rebates to reduce overall plan premiums.

Section 139001 would establish a Drug Price Negotiation Program covering selected qualifying single-source drugs dispensed to certain Medicare enrollees, including drugs and biological products with the highest expenditures in Medicare Parts B and D, as well as insulin products. The negotiated prices would take effect in 2025.

Identification of selected drugs and negotiation and application of drug maximum fair prices (MFPs) for the drugs would occur annually. In general, negotiations would take place yearly for newly identified selected drugs. However, an MFP resulting from a negotiation would apply during price applicability periods that would begin with the initial price applicability year for that selected drug—the first year for which the negotiated MFP would become effective—and would end with the last year during which the drug was a selected drug.

Drugs included on the list of selected drugs for a price applicability year would be considered selected drugs until the HHS Secretary determined there was at least one Food and Drug Administration (FDA)-approved drug (generic) or biological product (biosimilar).

The provision would require the HHS Secretary and manufacturers to renegotiate the MFP for a selected drug if a specified change in circumstances occurred.

Although qualifying drugs would be eligible for negotiation at 7 and 11 years, the HHS Secretary could not apply an MFP until 9 years had elapsed since FDA approval (for drugs) or 13 years had elapsed since licensure (for biological products).

There would be a ceiling on the MFP, based on a specified applicable percentage of the nonfederal average manufacturer price (AMP) for a selected drug. There also would be a temporary floor for MFP for drugs manufactured by small biotech firms.

Section 129001 contains most of the House Drug Price Negotiation Program provisions but would make a number of changes to the House bill, including in the following areas: (1) definition of a negotiation-eligible drug, (2) criteria for excepted drugs, (3) calculation of an MFP ceiling price, and (4) certain timelines.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		MFPs would be adjusted annually to account for inflation. Manufacturers would be subject to an excise tax for noncompliance, including failure to enter into an agreement to negotiate an MFP.	
		Negotiation-Eligible Drugs Under **Section 139001**, for each initial price applicability year, the HHS Secretary would create a list of negotiation-eligible drugs ranked in order of total expenditures under Medicare Parts B and D for the most recent 12-month period prior to the selected drug publication date for which expenditure data were available. The combined list would include the 50 qualifying single-source drugs with the highest total expenditures under Medicare Part D and the 50 qualifying single-source drugs with the highest total expenditures under Medicare Part B (with the exception of initial price applicability years 2025 and 2026, when only Medicare Part D drugs would be on the list). Part D *total expenditures* would be defined as "ingredient costs, dispensing fees, sales tax, and if applicable, vaccine administration fees." From the list of selected drugs, the HHS Secretary would select no more than 10 non-insulin, negotiation-eligible drugs for PY2025. The number of non-insulin, negotiation-eligible single-source drugs would increase in subsequent years. For 2026 and 2027, the HHS Secretary would select and publish a list of not more than 15 non-insulin qualifying single-source drugs. For 2028 and subsequent years, the HHS Secretary would select not more than 20 non-insulin qualifying single-source drugs. All insulin products that were considered qualifying single-source drugs would be considered negotiation-eligible drugs.	***Negotiation-Eligible Drugs*** **Section 129001** would not change the number of drugs selected as negotiation eligible but would change the criteria used to select the highest spending drugs in Part D. It would base selection on a broader definition of Part D *total gross covered prescription drug costs,* as defined in SSA 1860D–15(b)(3)), rather than Part D *total expenditures*, as in the House provision. (The SSA 1860D–15(b)(3) definition of *total gross prescription drug costs* is yearly costs for an enrollee incurred under a Part D plan, not including administrative costs but including costs directly related to the dispensing of covered Part D drugs and costs relating to the deductible. Costs count whether paid by the individual or paid under the plan and regardless of whether the plan coverage exceeds basic Part D drug coverage.)

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		Exempt Low-Spend Drugs **Section 139001** would exempt certain drugs from the Drug Price Negotiation Program, including certain orphan drugs and *low-spend Medicare drugs*, defined as drugs or biological products (other than insulin products) that had total Medicare Parts B and D expenditures during the most recent period for which data were available for at least 12 months prior to the selected drug publication date of less than $200 million in 2021. For subsequent years, the expenditure cap would be $200 million, increased by the annual increase in Consumer Price Index For All Urban Consumers (CPI-U) as of December of the previous year.	***Exempt Low-Spend Drugs*** Under **Section 129001**, the $200 million cap for 2021 would be increased in subsequent years by the annual increase in the CPI-U for the 12-month period *ending with September* of a previous year. The section would exempt plasma-derived products from the definition of *negotiation-eligible drugs*.
		Termination of Selected Drug Status Under **Section 139001**, negotiation-eligible drugs included on the published list of selected drugs for a price applicability year would be considered selected drugs for that year. They would continue to be considered selected drugs for each subsequent plan year until the first plan year beginning after the date the HHS Secretary determined there was at least one drug (generic) or biological product (biosimilar) that was FDA-approved or licensed using the selected drug as the list drug or reference product and was marketed pursuant to the approval or licensure.	***Termination of Selected Drug Status*** Under **Section 129001**, a drug would cease being a selected drug in the first year that begins at *least 9 months* after the date on which the HHS Secretary determines there is a generic or biosimilar drug for the selected drug on the market.
		Judicial Review **Section 139001** would deem certain actions in regard to the Drug Price Negotiation Program as not subject to administrative or judicial review, including the selection of drugs for publication as selected drugs, the determination of whether a drug is a negotiation-eligible drug, the determination of the MFP for a selected drug, and the determination of units of a drug or biological.	***Judicial Review*** **Section 129001** also would bar administrative and judicial review of the determination of qualifying single-source drugs.

MFP Ceiling

Section 139001 would make negotiated MFPs subject to price ceilings for the first year of a price applicability period. The MFP ceilings would be set as a percentage of an inflation-adjusted nonfederal AMP for each drug and would vary depending on drug type.

Under the section, the MFP ceiling would be calculated as follows.

For a drug with an initial price applicability year of 2025: The MFP ceiling would be based on the average of the nonfederal AMP for the selected drug for the first three calendar quarters of 2021, increased by the percentage increase in the CPI-U from September 2021 to the year prior to the drug's publication as a selected drug. If a selected drug did not have a nonfederal AMP for any of the first three calendar quarters of 2021, then the applicable measure would be the nonfederal AMP for the first full year following the drug's market entry, increased by the percentage increase in the CPI-U for the first full year following market entry.

For initial price applicability in 2026 and subsequent years: The MFP ceiling would be based on the lower of

- the average of the nonfederal AMP for a selected drug for the first three calendar quarters of 2021 (or, if no nonfederal AMP were available for such drug for any of the first three calendar quarters of 2021, then for the first full year following the drug's market entry), increased by the percentage increase in the CPI-U from September 2021 (or the first full year following market entry), as applicable, to the year prior to the selected drug publication date for the applicability year; or
- the nonfederal AMP for the selected drug for the year prior to the drug's publication as a

MFP Ceiling

Section 129001 would differ from the House bill because it would set the MFP ceiling by (1) basing the ceiling price on *the lower of* a modified nonfederal inflation-adjusted AMP or changes in Part D and Part B prices and (2) applying a ceiling to low-cost insulin. It also would differ from House-provision definitions relating to the different MFP ceilings that are based on the time a drug has been on the market.

For a drug with an initial price applicability year of 2025: The MFP ceiling calculation would be based on the average of the nonfederal AMP for the selected drug for the first three calendar quarters of 2021, increased by the percentage increase in the CPI-U from September 2021 *(or December of such first full year following the market entry*), as applicable, to *September* of the year prior to the drug's publication as a selected drug. If no nonfederal AMP were available for such drug for any of such first three calendar quarters of 2021, then for the first full year following the drug's market entry.

The December and September timeline changes also would apply to the MFP ceiling for 2026 and subsequent years, as well as to an MFP price floor for small biotech firms.

For a drug other than a low-cost insulin product, with respect to the first year of the price applicability period, the MFP ceiling could not exceed the lower of the annual AMP formula or

- For a covered Part D drug, the average *net price* (defined as the

selected drug, with respect to an initial price applicability year.

Section 139001 would set different MFP ceilings for drugs based on how long the drugs had been on the market.

The allowable ceiling for a *short-monopoly drug* (i.e., any drug that was not a post-exclusivity or long-monopoly drug, as defined in the bill) would be 75% of the inflation-adjusted nonfederal AMP.

The ceiling for a *post-exclusivity drug* would be 65% of the inflation-adjusted nonfederal AMP. A selected drug would be considered a post-exclusivity drug if it were a drug or biological product that had been FDA-approved or licensed for at least 12 years but less than 16 years prior to the initial price-applicability year.

The MFP ceiling for a *long-monopoly drug* would be 40%. Long-monopoly drugs would be defined as selected drugs or biological products that had been FDA-approved or licensed for at least 16 years.

negotiated price under Part D plans net of all price concessions received by such plans or PBMs on behalf of such plans) for the drug under part D for the most recent year for which data are available; and

- For a Part B drug, the ASP for the year prior to the year of the selected drug publication date with respect to the initial price applicability year for the drug or biological.

MFP Ceiling for Insulin

Section 129001 would set an MFP ceiling for certain low-cost insulin products. Under the provision, the MFP for a selected insulin product for the first year of its price applicability period could not exceed the average of the nonfederal AMP for the drug for the first three calendar quarters of 2021 (or, if there were not an available nonfederal average AMP for any of such first three calendar quarters of 2021, for the first full year following the market entry for such drug), increased by the percentage increase in the CPI-U from September 2021 (or December of such first full year following the market entry), as applicable, to the year prior to the selected drug publication date with respect to such initial price applicability year.

An insulin product subject to negotiation would be considered a *low-cost product* if its nonfederal AMP did not exceed 110% of the sum of (1) the costs and expenses per unit of the drug and (2) the sales, general, and administration expenses per unit of the drug.

Section 129001 refers to short-monopoly drugs and vaccines.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
			A drug defined as a *post-exclusivity drug* in Section 139001 of the House bill would be defined as an *extended monopoly* drug in Section 12900l. A drug would be considered an extended monopoly drug if it were a drug or biological product that, *as of the selected drug publication date,* had been FDA-approved or licensed for at least 12 years but less than 16 years prior to the initial price applicability year. **Section 129001** would change the House-passed legislation's definition of a *long-monopoly drug* to specify that long-monopoly drugs would be selected drugs for which, *as of the selected drug publication date* with respect to an initial price applicability year, at least 16 years had elapsed since approval or licensure.
		MFP Annual Inflation Update **Section 139001** would provide an annual inflation-based price increase for drugs with a negotiated MFP. For a year after the first initial price applicability year, the updated MFP for selected drugs would be the MFP for the selected drug for the previous year, increased by the annual percentage increase in the CPI-U, as of September of the previous year.	***MFP Annual Inflation Update*** **Section 129001** would provide an annual inflation-based price update based on the percentage increase in the CPI-U, as of *the 12-month period ending with* September of the previous year.
		MFP Factors in Negotiation **Section 139001** states that for purposes of negotiating the MFP of a selected drug with the manufacturer, the HHS Secretary would have to consider a list of factors.	***MFP Factors in Negotiation*** **Section 129001** would expand criteria for purposes of negotiating an MFP so that the HHS Secretary would consider certain factors about specific drugs and *therapeutic alternatives* of such drugs.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
			340B MFP Prohibition **Section 129001** would add a new provision to prohibit 340B-covered entities from purchasing covered outpatient drugs at the negotiated MFP if the drugs were subject to a Medicaid rebate. (Under the 340B program, manufacturers participating in Medicaid provide outpatient drugs to covered entities at reduced prices. Covered entities include certain health centers, Ryan White clinics and state AIDS Drug Assistance programs, children's hospitals, Medicare/Medicaid disproportionate share hospitals [DSHs], and other safety net providers.)

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		Part D Noninterference	***Part D Noninterference***
		Under current law, the noninterference provision at SSA §1860D-11(i) states, "(i) Noninterference.—In order to promote competition under this part and in carrying out this part, the Secretary— (1) may not interfere with the negotiations between drug manufacturers and pharmacies and prescription drug plan sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." **Section 139001** would amend the noninterference provision by striking in (2) "or institute a price structure for the reimbursement of covered part D drugs" and instead inserting "for covered part D drugs." The section also would add a new (3): "may not institute a price structure for the reimbursement of covered part D drugs, except as provided under part E of title XI." (Part E is the new section created by this provision.)	**Section 129001** differs from the House bill because it would eliminate the period at the end of (2) of the noninterference provision and adding "except as provided under section 1860D–4(b)(3)(l)," which is a new section created by this provision pertaining to the required inclusion of Part D drugs as selected drugs.
		Part D Formulary Placement	***Part D Formulary Placement***
		Section 139001 contains a provision stating that covered Part D drugs that are selected drugs with MFPs are to be carried on Part D plan formularies.	**Section 129001** differs from the House bill because it would alter the formulary requirement to clarify that a Part D plan sponsor could remove a selected drug from a plan formulary if an equivalent generic came to the market.

Selected Drug Manufacturer Excise Tax Imposed During Noncompliance Periods	Chapter 32 of the IRC imposes excise taxes on manufacturers of automobiles and related items, coal, certain vaccines, recreational equipment, and medical devices. The taxable event is typically the sale of a covered item. Depending upon the provision, the amount of the tax may be a fixed amount per sale or per quantity of the item sold, or a percentage of the price for which the item is sold. When an excise tax is based on the sale price, it may be charged separately by the seller; otherwise, the tax is assumed to be included in the total amount paid by the purchaser. Certain transactions may be exempted from these excise taxes. For example, excise taxes under Chapter 32 are not generally applied to items purchased for use by the purchaser in further manufacturing or purchased for export.	**Section 139002** would amend Chapter 32 of the IRC to add new Section 4192, which would impose an excise tax on selected drug sales by manufacturers, producers, or importers during the following noncompliance periods with the Drug Price Negotiation Program in Section 139001: • The period beginning on the March 1 immediately following the selected drug publication date and ending on the first date during which the selected drug manufacturer enters into an agreement with the HHS Secretary to negotiate a drug's MFP. • The period beginning on the November 2 immediately following the March 1 referenced in the first noncompliance period above and ending on the first date during which the manufacturer and the HHS Secretary agree on an MFP. • In the case of a selected drug for which the HHS Secretary had specified a renegotiation period under an agreement, the period beginning on the first date after the last date of the renegotiation period and ending on the first date during which the manufacturer agreed to a renegotiated MFP. • With respect to information that was required to be submitted to the HHS Secretary, the period beginning on the date on which the HHS Secretary certified the required information was overdue and ending when the information was submitted. The amount of the excise tax imposed on the sale of a selected drug would be a percentage of the sum of the sales price and the tax imposed under this section (this differs from some other excise taxes in which the amount of the tax is a percentage of the sales price alone). The House Budget Committee report accompanying H.R. 5376 provides the following	**Section 129002** is identical to the House bill except for a technical correction to a citation for the definition of a selected drug.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		illustration of how this new excise would operate: "Assume that, prior to imposition of the excise tax, Manufacturer A charged $100 for drug A. If, after imposition of the excise tax, Manufacturer A charges $100 and does not separately state a tax, the price is deemed to be $35, and Manufacturer A owes $65 in tax. Alternatively, manufacturer A could separately state a price of $100 and a tax of $186, in which case it would owe $186 in tax." H. Rept. 117-130 at 441 (internal citations omitted). The applicable percentage for the excise tax would increase the longer noncompliance continues, with an applicable percentage of 65% during the first 90 days, 75% during the 91st day through the 180th day, 85% during the 181st day through the 270th day, and 95% for sales subsequent to the 270th day of the noncompliance period. For sales that were timed to avoid the excise tax, the Secretary of the Treasury would treat the sale as occurring during a day in a noncompliance period. Manufacturers would be prohibited from deducting excise tax payments from their federal income taxes.	
Funding	Not applicable.	**Section 139003** would appropriate for FY2022, to remain available until expended, $300 million, available each FY between FY2022 and FY2031 to carry out Sections 139001 and 139002.	**Section 129003** would provide to CMS $3 billion for FY2022, to remain available until expended, to carry out Sections 129001 and 129002.

Medicare Part B Rebate by Manufacturers	Medicare Part B covers selected outpatient drugs and biologic products (hereinafter for Section 139101, drugs), which generally are administered by health professionals. Biological products are medical products derived from living organisms, whereas conventional drugs are manufactured from chemicals. Health providers purchase Part B drugs and bill Medicare for the cost of the drug and the administration of the product, although payment for some Part B drugs can be included in the payment for a procedure or treatment. For most Part B services, after meeting an annual deductible, Medicare beneficiaries are responsible for coinsurance of 20% of the cost of the item or service. For Part B drugs, the 20% coinsurance is based on a drug's ASP plus a 6% add-on payment. Drug manufacturers are not required to pay rebates to Medicare as a condition for having their drugs covered under Part B.	**Section 139101** would require drug manufacturers, beginning July 1, 2023, to pay a quarterly rebate to Medicare when the price of most single-source Medicare Part B drugs (*rebatable drugs*) exceeded the product's quarterly inflation-adjusted price. Drugs with annual average total Part B allowed charges per individual of less than $100 and Part B-covered vaccines would not be considered rebateable drugs. The inflation rebate would be waived for drugs that were listed on the Federal Food, Drug, and Cosmetic Act (P.L. 75-717) shortage list, as well as for biosimilar products if the HHS Secretary determines there were severe supply chain disruptions. There would be special provisions for drugs approved or licensed by the FDA after March 1, 2021. Drug manufacturers' Part B rebateable drug quarterly inflation rebate would be the difference between the Part B drug's price and the drug's inflation-adjusted price. The rebate would apply to all units of the drug sold, except Medicaid sales, for each quarter. The Part B rebateable drug rebate paid by drug manufacturers would be deposited into the Medicare Supplementary Insurance Trust Fund. The Part B rebateable drug inflation-adjusted price would be based on the greater of either the benchmark period CPI-U (September 2021) or the CPI-U for the first month of the calendar quarter that is two calendar quarters prior to the rebate period calendar quarter. Medicare beneficiary coinsurance for Part B rebatable drugs would be 20% of the inflation-adjusted Part B drug payment amount. Part B inflation determinations made by the HHS Secretary would not be subject to administrative and judicial review. The HHS Secretary would be required by the provision to provide information to drug	**Section 129101** is similar to the House provision but includes the following differences. **Section 129101** would require drug manufacturers to begin paying a quarterly inflation rebate on Medicare Part B rebateable drugs on January 1, 2023, rather than July 1, 2023. The Section 129101 benchmark period CPI-U would be January 2021 rather than September 2021. Section 129101 would change the definition for a *subsequently approved drug* to apply to a Part B rebatable drug first approved or licensed by the FDA after December 1, 2020 (in contrast to March 1, 2021, in the House version). **Section 129101** would add a transition provision allowing the HHS Secretary to delay the timeframe for providing drug manufacturers with rebate information for calendar quarters beginning in 2023 and 2024 until not later than September 30, 2025. **Section 129101** would authorize CMS to receive the same appropriation as the House version to carry out this section, but the FY2022 appropriation would be for $80 million, with $12.5 million designated for FY2022 and $7.5 million for each of FY2023-FY2031.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		manufacturers within six months after the end of the calendar quarter; this information would include the amount of the Part B inflation rebate owed for the period. Drug manufacturers would have 30 days after receiving the information to pay the inflation rebate. If drug manufacturers failed to pay the Part B inflation rebate on time, they would be subject to a CMP of at least 125% of the rebate amount for that calendar quarter, in addition to other CMP procedural enforcement provisions. CMS would receive an appropriation that would remain available until expended of $12.5 million for FY2022 and $7.5 million for each of FY2023-FY2031.	

Medicare Part D Rebate by Manufacturers	No current provision. Manufacturers that choose to participate in Part D must pay a 70% discount on the negotiated price of certain drugs sold to enrollees in the benefit coverage gap, or *doughnut hole*. However, discounts at the point of sale are different than after-sale rebates. Further, the current manufacturer discounts are not tied to inflation.	**Section 139102** would create a mandatory rebate program, effective in 2023, for manufacturers of most Medicare Part D-covered drugs that had price increases above the rate of consumer inflation (CPI-U) since September 2021. HHS would calculate an annual price for Part D-covered drugs, based on the AMP, which reflects drug sales to retail community pharmacies, directly or via wholesalers. The inflation-adjusted payment amount would be defined as the AMP for each dosage form and strength of the drug in the payment amount benchmark year (the year ending in the month immediately prior to October 1, 2021), increased by the percentage by which the applicable year CPI-U (CPI-U in January of an applicable year) exceeded the benchmark period CPI-U (CPI-U for the month immediately prior to October 2021). **Section 139102** would define an *applicable year* as a calendar year beginning with 2023. If the price of a Part D-covered drug grew faster than allowable inflation for a year, the manufacturer would pay HHS a rebate amount equal to the excess price times the total billing units of the drug to all payers (excluding units with rebates paid under Medicaid or Medicare Part B). No later than nine months after the end of an applicable year, the HHS Secretary would be required to report the following to the manufacturer of a Part D rebatable drug: (1) information on the amount, if any, of the excess annual manufacturer price increase for each dosage form and strength for such drug and such year and (2) the rebate amount for each dosage form and strength of such drug for the year. Should a manufacturer not pay the mandated rebate, the manufacturer would be subject to a CMP of at least 125% of the rebate amount for such year.	**Section 129102** would create a mandatory rebate program following most of the provisions in the House bill. However, the Senate language has numerous differences from the House bill, including changes in the timeframes used to implement the provision and to calculate and report rebates. In general, the House bill would base rebate calculation and payment on annual changes in inflation and prices. The Senate language instead would use defined time periods to calculate inflation and prices. **Section 129102** would create an applicable period, which would be the 12-month period beginning with July 1 of a year (beginning with July 1, 2022). **Section 129102** would create a payment benchmark period that would begin on January 1, 2021, and would end in the month immediately prior to October 1, 2021. **Section 129102** would define a benchmark period CPI–U, which would be the CPI-U for January 2021. *Applicable period* CPI-U would be defined as the CPI-U for the first month of such an applicable period. In **Section 129102**, no later than nine months after the end of an applicable period, the HHS Secretary would be required to report to the manufacturer (1) information on the amount, if any, of the excess manufacturer price increase for each dosage form and strength for such drug and such period and (2) the rebate amount for each dosage form and strength of such drug for the period.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		There would be some exceptions to the Part D rebate requirements, including for a Part D drug that was on an FDA shortage list or, in the case of a generic drug, when the Secretary determined there were severe supply chain disruptions. The bill would appropriate to CMS $12.5 million for FY2022 and $7.5 million for each of FY2023-FY2031, to remain available until expended, to carry out the provisions of the section.	**Section 129102** would expand the list of possible exemptions from the rebate requirement compared with the House bill. The section would allow an exemption for generics and biosimilars that met the definition of Part D rebatable drugs, in situations where the HHS Secretary determined there were severe supply chain disruptions. The section also would allow an additional exemption for a generic in a case where the HHS Secretary determined that access to the drug could be severely reduced if a rebate were imposed. The HHS Secretary would be required to review the possible exemption annually. **Section 129102** includes definitions of drugs or biologicals that could be subject to a rebate. In general, the definitions refer to new chemical drugs approved under Federal Food, Drug, and Cosmetic Act (P.L. 75-717) 505(c); generic drugs that lack competition (i.e., the brand-name drug that the generic is a copy of is not being marketed, and there are no other generic versions being marketed) and that are not covered by the specified 180-day generic drug-exclusivity periods; and biologic drugs licensed under Section 351 of the PHSA. The Senate bill would provide to CMS $80 million for FY2022, including $12.5 million for FY2022 and $7.5 million for each of FY2023-FY2031, to carry out provisions of the section. The funds would remain available until expended.

Medicare Part D Benefit Redesign

Medicare Part D provides a voluntary, outpatient prescription drug benefit for Medicare beneficiaries and is the primary source of drug coverage for dual-eligible individuals (low-income subsidy, or LIS) covered by both Medicare and the state-federal Medicaid program. Part D coverage is provided by private insurers, or plan sponsors. At a minimum, Part D sponsors must offer plans with *standard* benefits, as defined in law. Plan sponsors also may offer alternative or enhanced coverage that is at least actuarially equivalent to a standard plan.

Under the Part D standard benefit, an enrollee pays a deductible. After the deductible has been met, the enrollee is responsible for 25% of the cost of prescription drugs up to the initial coverage limit. After the initial coverage threshold has been reached, a beneficiary enters the coverage gap, or doughnut hole. Manufacturers that choose to sell their drugs through the Part D program are required to participate in the coverage gap discount program, which provides a 70% discount for brand-name, biologic, and biosimilar drugs purchased by non-LIS enrollees in the doughnut hole. Enrollees exit the doughnut hole if they have sufficient spending to reach the catastrophic threshold. Enrollees above the catastrophic threshold have a maximum 5% coinsurance, and CMS provides sponsors with 80% reinsurance payments for these high-cost enrollees.

The dollar levels of the deductible, initial coverage, and catastrophic thresholds are adjusted annually for the standard benefit based on changes in average per capita spending for covered Part D drugs during the 12-month period ending in July of the previous year.

In addition, Part D enrollees pay monthly premiums, which are based on a rate equal to

Section 139201 would change the Part D standard benefit, beginning in 2024, by

- Capping annual enrollee out-of-pocket spending at the catastrophic threshold, which would be set at $2,000 in out-of-pocket spending in 2024 and adjusted in subsequent years based on Part D drug inflation (current law formula).
- Reducing the 80% reinsurance subsidy to Part D sponsors to the sum of two amounts: an amount equal to 20% of the cost of applicable drugs (biologics and brand-name drugs) above the catastrophic threshold, plus an amount equal to 40% of the cost of non-applicable drugs (generics) above the catastrophic threshold.
- Reducing cost sharing for non-LIS enrollees to 23% coinsurance from the current 25%. (There would be no initial coverage limit or coverage gap in the redesigned benefit. LIS beneficiaries would continue to have low, set cost sharing.)
- Reducing the Part D base premium to 23.5% of the average bid of plan sponsors, down from the current 25.5% level, starting in 2024.
- Raising the Medicare subsidy to plans for standard coverage to 76.5% of the average of plan bids, an increase from the current 74.5%.
- Creating a new manufacturer discount program, effective in PY2024. The existing coverage gap discount program would sunset after 2023.

In the new program, manufacturers would provide a 10% discount from a Part D plan's negotiated price for applicable drugs purchased by enrollees who had exceeded the annual Part D deductible but had not reached the catastrophic threshold. Manufacturers would provide a 20% discount off the negotiated price on applicable drugs purchased

Section 129201 largely tracks the House bill but differs from H.R. 5376 throughout.

Supplemental Coverage

Section 129201 adds language that would allow enrollees to count supplemental coverage through a group health plan or certain other third-party payment arrangements as their own out-of-pocket spending.

Reinsurance

Section 129201 refines the House language on reinsurance to specify that reinsurance payments would apply to *covered* Part D drug costs, not just Part D drug costs.

Premium Stabilization

Section 129201 would add a premium stabilization program for 2023-2027. (The premium stabilization program would be in addition to provisions of the House bill that would change the formula for calculating the base premium from the current 25.5% of the average bid to 23.5% of the average bid starting in 2024.)

Under the premium stabilization program, the base beneficiary premium for 2023-2025 would be equal to the *lesser* of (1) the base premium for the previous year (i.e., 2022 for 2023), increased by 4%, *or* (2) the base beneficiary premium for the applicable year (in this case, 2023) as computed under the underlying statutory language that otherwise would have applied.

For 2026, the base premium would be equal to the lesser of (1) the base premium computed for 2025 increased by 4% *plus* 25% of the difference between (a)

25.5% of the annual nationwide average of plan bids for standard benefits; however, actual premiums vary widely by the plan selected.

by enrollees who had reached the catastrophic threshold. The discounted prices would be provided to enrollees at the pharmacy or through mail order at the point of sale, and enrollees would not be allowed to count the manufacturer discount as their own out-of-pocket spending. There would be special provisions for smaller manufacturers and for drugs primarily sold to LIS enrollees.

The legislation would appropriate to CMS $44 million for FY2022, $38 million for FY2023, and $32 million for each of FY2024-FY2031 to carry out the provisions on this section.

the base premium for 2025 (as increased by 4%) and (b) the base premium calculated under statute that otherwise would have applied for 2026; *or* (2) the base premium calculated for 2026 under the statutory formula (23.5% of the average bid) that otherwise would have applied.

For 2027, the base premium would be equal to the lesser of (1) the base premium computed for 2026 increased by 4% *plus* 50% of the difference between (a) the base premium for 2026 (as increased by 4%) and (b) the base premium that would have applied for 2027 *or* (2) the base beneficiary premium calculated for 2027 under the permanent statutory formula (23.5% of the average bid) that otherwise would have applied.

For 2028 and following years, the base premium calculation would revert back to the underlying formula (23.5% of the average bid).

Manufacturer Discount Program

Section 129201 would specify that a manufacturer would have to sign an agreement by March 1, 2023, to participate in 2024. The Senate provision does not include language in the House bill that specified the HHS Secretary would have to develop a model agreement by January 1, 2023, and the manufacturer would have to sign 30 days after the model agreement had been established. The Senate provision also would specify that a manufacturer discount agreement would take effect at the start of a calendar quarter or another date specified by the HHS Secretary.

Section 129201 does not include language in the House bill requiring the HHS Secretary to enter into third-party contracts to administer the manufacturer discount program. The House bill, among other things, would require the third parties to receive and transmit information; receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities to meet manufacturers' obligations under agreements under this section; and provide adequate and timely information to manufacturers, as necessary for the manufacturers to fulfill their obligations.

Section 129201 would change the definition of Part D *total expenditures* to total gross covered prescription drug costs as defined in SSA 1860D–15(b)(3).

Section 129201 would not include House language requiring Part D plan sponsors to count the value of manufacturer discounts in their annual plan bids. Instead, the bill would amend SSA 1860D–16(b)(1), governing payments from the managing trustee into the Federal Supplementary Medical Insurance Trust Fund, to include payments pertaining to the Senate bill's new Section 1860D–14D. Under 1860D–14D, in cases where Part D applicable enrollees who had not reached the catastrophic threshold were prescribed brand-name or biologic drugs that would have been applicable drugs, had they not been covered by an HHS negotiated price agreement under the new Price Negotiation Program in Section 129001, the HHS Secretary would provide a 10% discount to a Part D plan.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
			The bill would appropriate $341 million for FY2022 to carry out the provisions, which would remain available until expended. The total would include $47 million and $38 million in FY2022 and FY2023, respectively, and $32 million in each of FY2024-FY2031.
Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans and MA-PD Plans	No provision.	**Section 139202** would amend Part D prescription cost-sharing requirements to allow any enrollee in a Part D plan, including an LIS enrollee, to elect to make prescription cost-sharing payments in monthly, capped installments up to the annual out-of-pocket threshold, beginning in 2025. An enrollee could opt for capped cost sharing at any time prior to or during a plan year. Enrollees who did not make required monthly payments would lose the right to participate in the capped payment option and would have to pay the cost sharing otherwise applicable for any Part D drug up to the annual out-of-pocket threshold. The section would appropriate $1 million for each of FY2022-FY2031 to carry out the provisions.	**Section 129202** largely tracks the House language but would increase the penalty for enrollees who fail to pay the amount billed. Under the Senate provision, if an enrollee failed to pay the amount billed for a month, the enrollee would lose the right to participate in the capped option and would be required to pay the remaining cost sharing. In addition, the Part D sponsor would be allowed to preclude the enrollee from making an election for capped cost sharing in a subsequent year. The section would appropriate $10 million for each of FY2022-FY2031 to carry out the provisions.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Prohibiting Implementation of Rule Relating to Eliminating the Anti-Kickback Statute Safe Harbor Protection for Prescription Drug Rebates	The federal anti-kickback statute makes it a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value in return for a referral or to induce generation of business reimbursable under a federal health care program. There are certain statutory exceptions to the anti-kickback statute. In addition, the HHS Office of Inspector General (OIG) has promulgated regulations that contain several *safe harbors* to prevent common business arrangements from being considered kickbacks. In November 2020, the HHS OIG published a final rule that would alter an anti-kickback regulatory safe harbor to restrict the use of manufacturer drug rebates to Part D plans. Implementation of the rule was delayed until 2026 as part of the Infrastructure Investment and Jobs Act (P.L. 117-158).	**Section 139301** would bar the HHS Secretary, beginning on January 1, 2026, from implementing, administering, or enforcing the final anti-kickback rebate rule published by the HHS OIG in November 2020.	**Section 129301** is identical to the House version.
Appropriate Cost Sharing for Certain Insulin Products Under Medicare Part D	Cost sharing for insulin varies among Part D plans and according to the specific brand of insulin prescribed to an enrollee. Beginning with PY2021, CMS offered a pilot program (for non-LIS beneficiaries) that reduced cost sharing for insulin. Under the pilot, participating Part D plan sponsors could charge no more than a $35 co-payment for a 30-day supply of insulin from the plan deductible through the coverage gap.	**Section 139401** would cap insulin cost sharing for Part D enrollees. Starting with 2023, Part D deductibles would no longer apply to insulin products. During PY2023, the provision would require a Part D plan sponsor to provide insulin at a co-payment of $35, (referred to as the *applicable co-payment*). The applicable co-payment would apply regardless of whether an enrollee had reached the initial coverage limit or the out-of-pocket threshold. For PY2024 and subsequent PYs, the provision would require Part D plans to provide coverage for insulin products at the applicable co-payment amount up to the annual catastrophic threshold. The maximum $35 co-payment would apply to both LIS and non-LIS enrollees. The section would appropriate $12.5 million for FY2022 and $7.5 million for each of FY2023-FY2031 to carry out the provisions of this section.	**Section 129401** would alter the formula for setting the insulin co-payment. The provision would set the applicable co-payment amount at $35 for PY2023 and PY2024. Starting in 2025, the co-payment amount would be the lesser of (1) $35 or (2) an amount equal to 25% of the negotiated price of the covered insulin product net of all price concessions received or expected to be received by the plan or a PBM on behalf of the plan for such product. The language would provide that the co-payment could not exceed the co-payment level set in the bill. The section would appropriate $1.5 million for FY2022 to carry out the provisions of this section.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D	The Advisory Committee on Immunization Practices (ACIP) provides guidance to HHS and the Centers for Disease Control on the use of vaccines, including recommending immunization schedules for the U.S. population, with certain vaccine dosages based on age. Medicare coverage for vaccines is divided between Part B and Part D. Part B covers vaccines for influenza, pneumonia, Hepatitis B, beneficiaries at increased risk, and COVID-19. Part B also covers vaccines administered directly in relation to treatment of an injury or direct exposure to a disease or condition, such as tetanus shots. Medicare Part D covers all commercially available vaccines, except for vaccines covered under Part B, or in cases where the vaccine manufacturer has chosen not to participate in the Part D coverage gap discount program. For example, the shingles vaccine, which the ACIP recommends for adults aged 50 and older, is covered under Part D. Medicare Part B beneficiaries have no cost sharing (co-payment and annual deductible) for covered vaccines, except when the vaccine is administered for the treatment of an injury or direct exposure to a disease or condition, in which case beneficiaries would be responsible for 20% of the Medicare-approved amount for the vaccine and its administration. By comparison, Medicare Part D enrollees may face substantial cost sharing for vaccines, especially if beneficiaries are in the deductible phase of the benefit or if a vaccine has been placed on a formulary tier with high cost sharing.	**Section 139402** would specify that, beginning in 2024, Part D plans could no longer set a deductible, coinsurance, or other cost-sharing requirement for adult vaccinations recommended by the ACIP.	**Section 129402** largely tracks the House bill, with some technical differences. It would give the HHS Secretary authority to implement the provision by program instruction and other forms of program guidance (rather than by program instruction or otherwise).

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Payment for Biosimilar Biological Products During Initial Period	Biological products are medical products derived from living organisms, whereas conventional drugs are manufactured from chemicals. Medicare reimburses Part B providers and suppliers for prescription drugs and biologicals after the provider has purchased the drug or biological product and administered it to a patient. Medicare generally reimburses providers and suppliers for Part B drugs and biologicals at the rate of the product's ASP plus a 6% add-on payment. To encourage development of lower-priced biosimilar biological products, Medicare statute requires that biosimilar biologics are paid 100% of their ASP plus an add-on payment equal to 6% of the reference biological product's ASP. Medicare statute does not specify the payment rate for biosimilar biological products during the initial product introduction period (first full calendar quarter in which the drug is marketed), when pricing data may be insufficient to calculate the product's ASP. Generally, when prescription drug and biological sales data are insufficient to calculate a product's ASP, such as during the initial period the drug or biological product is marketed, the HHS Secretary sets the Part B reimbursement rate at the wholesale acquisition cost, a published price, which usually exceeds the ASP, plus a 3% add-on payment.	**Section 139403** would establish an initial period payment rate for Medicare Part B biosimilar products furnished on or after July 1, 2023. The biosimilar payment rate during the statutory initial period would be the lesser of the following: (1) the biosimilar product's wholesale acquisition cost plus a 3% add-on payment or (2) 100% of the reference biological product's ASP plus a 6% add-on payment based on the reference biological product's ASP.	**Section 129403** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Temporary Increase in Medicare Part B Payment for Certain Biosimilar Biological Products	Biosimilar biological products are based on an original biological (reference) product, similar to a generic drug being an exact copy of the active ingredients in a brand-name prescription drug. Medicare reimburses Part B providers and suppliers for prescription drugs and biologicals after the provider has purchased the drug or biological product and administered it to the patient. With exceptions, Medicare generally reimburses providers and suppliers for most Part B drugs and biologicals at the rate of the product's ASP plus a 6% add-on payment. To encourage development of lower-priced biosimilar biological products, Medicare statute requires that biosimilar biologics are paid 100% of their ASP plus an add-on payment equal to 6% of the reference biological product's ASP.	**Section 139404** would increase the Medicare Part B add-on payment temporarily (for five years) for qualifying biosimilar biological products from 6% to 8% of the reference biological product's ASP. The temporary increase in Medicare Part B payments for biosimilar products would begin April 1, 2022, and end March 31, 2027.	**Section 129404** is identical to the House provision.
Improving Access to Adult Vaccines Under Medicaid and CHIP	See sub-rows below.	See sub-rows below regarding **Section 139405**.	See sub-rows below regarding **Section 129405**.

Medicaid	Federal law provides two primary benefit packages with unique federal requirements for state Medicaid programs: traditional and alternative benefit plan coverage. For certain subgroups, states may offer a targeted benefit package. Under traditional Medicaid, coverage of ACIP-recommended adult vaccines is generally available at state option. However, states may cover vaccines and vaccine administration under certain traditional state plan mandatory service categories (e.g., physicians' services), depending on how the state defines such coverage; such coverage would be required for 19- and 20-year-olds under Medicaid's Early and Periodic Screening Diagnostic and Treatment Program. Adult vaccines and vaccine administration also may be covered via an optional state plan benefit category (e.g., preventive services). In addition, for medically needy subgroups, states may offer a more restrictive benefit package than is available to other enrollees, which could include such coverage. States are permitted to impose enrollee cost sharing on adult vaccines and vaccine administration, when otherwise permitted. States may receive a 1-percentage-point increase in the state federal medical assistance percentage (FMAP) rate for providing coverage of adult vaccines (and vaccine administration), as well as other preventive services, if states meet certain specified requirements (e.g., they must cover, without enrollee cost sharing, any clinical preventive services that are assigned a grade of A or B by the U.S. Preventive Services Task Force and all ACIP-recommended vaccines and their administration for adult beneficiaries).	***Section 139405(a)*** would add ACIP-recommended adult vaccines and vaccine administration, without beneficiary cost sharing, to the list of mandatory services under traditional Medicaid. For states that offer services in institutions for mental diseases or in intermediate-care facilities for the mentally retarded (or both) to their medically needy subgroups, the provision would require such coverage, without beneficiary cost sharing. The FMAP rate associated with adult vaccine coverage under traditional Medicaid would be increased by 1 percentage point during the first eight fiscal quarters on or after the date of enactment.	***Section 129405(a)*** is almost identical to the House provision, except it would clarify that the 1-percentage-point FMAP increase also would apply to vaccine administration.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
	Under ABPs, coverage of ACIP-recommended vaccines and vaccine administration, without enrollee cost sharing, is mandatory.		
CHIP	The State Children's Health Insurance Program (CHIP) provides health insurance coverage to low-income, uninsured children (through the age of 18) in families with incomes above applicable Medicaid income standards, as well as to certain pregnant women. There are circumstances in which CHIP coverage may be available to an adult aged 19 and older, as when states provide CHIP coverage to pregnant individuals by extending coverage to unborn children as permitted through federal regulation. Vaccines are not required to be covered for pregnant individuals covered through a separate CHIP program, although all states that cover pregnant individuals through a separate CHIP program currently cover vaccines and their administration without cost sharing for this population.	***Section 139405(b)*** would mandate coverage of ACIP-recommended adult vaccines and vaccine administration, without beneficiary cost sharing, for CHIP enrollees who are 19 years of age or older.	***Section 129405(b)*** is identical to the House provision.
Effective Date	Not applicable.	***Section 139405(c)*** would define the effective date as the first day of the first fiscal quarter on or after one year after enactment.	***Section 129405(c)*** is identical to the House provision.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, the language released by the Senate HELP Committee and the Senate Finance Committee described as being intended for the BBBA, and relevant current law. See report introduction for links to legislative language.

Notes: This table includes provisions relevant to prescription drugs for private health insurance, Medicare, Medicaid, and CHIP. Also see **Table 1** for provisions related to private health insurance generally, **Table 4** for provisions related to Medicaid generally, **Table 5** for provisions related to CHIP generally, and **Table 6** for provisions related to Medicare generally. See **Appendix A** for all abbreviations used in table.

a. For purposes of this report, *MFP* or *MFP*s refers to *maximum fair prices* in regard to prescription drug pricing; this is distinct from *Medicaid MFP,* which refers to the Money Follows the Person Program, in **Table 7**.

Table 4. Medicaid Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Adjustments to Uncompensated Care Pools and Disproportionate Share Hospital Payments	Medicaid statute requires that states make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. In addition, some states have uncompensated care pools that make Medicaid payments to providers to defray the cost of uncompensated care. The ACA Medicaid expansion provides Medicaid eligibility to most non-elderly adults up to 133% of FPL. Currently, 12 states are non-expansion states (i.e., have not implemented the Medicaid expansion).	**Section 30608(a)** would exclude from the determination of uncompensated care pool payments expenditures for the Medicaid expansion population in non-expansion states beginning in FY2023. **Section 30608(b)** would reduce the Medicaid DSH allotment by 12.5% for states that do not provide Medicaid coverage to the expansion population for FY2023 and subsequent years.	**Section 122232** is almost identical to Section 30608(a) in the House bill regarding uncompensated care pools. **Section 122232** does not include the language from Section 30608(b) in the House bill regarding DSH.
Further Increase in FMAP for Medical Assistance for Newly Eligible Mandatory Individuals	States received 100% federal reimbursement rate (i.e., full federal financing) for the cost of providing Medicaid coverage to newly eligible individuals under the ACA Medicaid expansion, from CY2014 through CY2016. The rate for newly eligible individuals phased down to 95% in CY2017, 94% in CY2018, 93% in CY2019, and 90% for CY2020 and subsequent years.	**Section 30609** would increase the newly eligible reimbursement rate to 93% for CY2023-CY2025. For CY2026 and subsequent years, the newly eligible Medicaid reimbursement rate would be 90%.	**Section 122233** is identical to the House provision.
Extending Continuous Coverage for Pregnant and Postpartum Individuals	See sub-rows below.	See sub-rows below regarding **Section 30721**.	See sub-rows below regarding **Section 122211**.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Medicaid	Medicaid benefits and duration of coverage for pregnant individuals can differ by eligibility pathway, both across and within states. Depending on the individual's eligibility pathway, coverage may include full Medicaid benefit coverage or states may limit services to those related to pregnancy. The ARPA establishes a state plan option to extend full Medicaid benefit coverage (in addition to any available pregnancy-related services and 60-day postpartum care that an individual might be entitled to) during pregnancy and throughout the 12-month postpartum period to any individual who received Medicaid coverage while pregnant, during the five-year period beginning April 1, 2022, and ending March 31, 2027.	***Section 30721(a)*** would require states to provide 12 months of full Medicaid benefit coverage to postpartum individuals under Medicaid and would modify the pregnancy and postpartum coverage that is available to lawfully residing pregnant women and children. Services provided to individuals enrolled in the ACA Medicaid expansion and who become pregnant would be reimbursed at the "newly eligible" increased federal reimbursement rate for the timeframe beginning at the conclusion of 60 days postpartum through 12 months after the last day of the individual's pregnancy. In general, the provision would apply to medical assistance provided starting the first day of the first FY quarter that begins one year after the date of enactment of this act, with exceptions for the ARPA state plan option conforming amendments and for states that require approval from the state legislature.	***Section 122211(a)*** is almost identical to the House provision but includes technical amendments.
CHIP	Eligibility criteria, benefit coverage, and duration of coverage for pregnant individuals under separate CHIP plans can differ by eligibility pathway, both across and within states. The ARPA requires states that elect to provide full Medicaid coverage during pregnancy and throughout the 12-month postpartum period under Medicaid during the five-year period beginning April 1, 2022, and ending March 31, 2027, to provide all items or services available to a targeted low-income child or a targeted low-income pregnant woman under the CHIP state plan (or waiver) to individuals during pregnancy and throughout the 12-month postpartum period under CHIP.	***Section 30721(b)*** would require states to provide all items or services available to a targeted low-income child or a targeted low-income pregnant individual under the CHIP state plan (or waiver) to individuals during pregnancy and throughout the 12-month postpartum period. In general, the provision would apply to CHIP pregnancy-related assistance provided starting with the first FY quarter that begins one year after the date of enactment, with exceptions for the ARPA state plan option conforming amendments and for states that require approval from the state legislature.	***Section 122211(b)*** is almost identical to the House provision but includes technical corrections (e.g., to clarify the current law sections that are being amended).

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
State Option to Provide Coordinated Care Through a Maternal Health Home for Pregnant and Postpartum Individuals	States may establish a Medicaid health home to integrate services and coordinate care for targeted groups of Medicaid enrollees with complex or chronic physical or behavioral health needs, beginning January 1, 2011. Target populations may include enrollees with (1) two or more chronic conditions, (2) one chronic condition who are at risk for a second, or (3) a serious and persistent mental health condition. States receive a 90% federal reimbursement rate for health home services that meet certain specified standards for the first eight fiscal quarters that the health home is in effect (or for a total of 10 fiscal quarters for substance use disorder-focused health homes approved after October 1, 2018). Thereafter, the state's regular FMAP rate applies.	**Section 30722** would establish a state option to provide coordinated care through a maternal health home for targeted individuals during pregnancy through 12 months postpartum, beginning two years after the date of enactment. The provision would specify what qualifies as a maternal health home, the types of providers that may participate on the care team, provider payment methodologies, care coordination, and provider and state data collection and reporting requirements, among other criteria. During the first eight fiscal quarters that a maternal health home is in effect, the federal reimbursement rate for allowable expenditures would be increased by 15 percentage points, not to exceed 90%. For FY2022, the provision would appropriate $5 million for awarding planning grants that would remain available until expended. States would receive their regular federal reimbursement rate for planning grant expenditures.	**Section 122212** is similar to the House provision but would eliminate specified provider and state data collection and reporting requirements. The provision also would eliminate specified coordination, education, and enrollee confidentiality requirements, among other changes.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Increasing Medicaid Cap Amounts and the FMAP for the Territories	The territories operate Medicaid programs under rules different from those that apply to the states. The permanent source of federal Medicaid funding for the territories is the annual federal capped funding, which was significantly increased for FY2020 and FY2021. The FMAP rate for American Samoa, Commonwealth of the Northern Mariana Islands (CNMI), Guam, and the U.S. Virgin Islands (USVI) was increased from 55% to 83% for FY2020 and FY2021. For Puerto Rico, the FMAP rate was increased from 55% to 76% for FY2020 and FY2021; Puerto Rico also received $200 million in additional funding for establishing a physician payment rate that was 70% of Medicare's rates.	**Section 30731(a)** would provide increased federal annual capped funding for Medicaid to the territories for FY2022 and subsequent years. For FY2022, the federal annual capped funding would be $3.6 billion for Puerto Rico, $135 million for USVI, $140 million for Guam, $70 million for CNMI, and $90 million for American Samoa. For FY2023 and subsequent years, the federal annual capped funding for Medicaid would be the sum of the amount provided in the preceding FY increased by the percentage increase, if any, in Medicaid spending during the preceding FY. **Section 30731(b)(1)-(3)** would keep the FMAP rate at 83% for USVI, Guam, CNMI, and American Samoa for FY2022 and subsequent years. It would keep the FMAP rate for Puerto Rico at 76% in FY2022 and 83% in FY2023 and subsequent years. **Section 30731(b)(4)** would establish a requirement for Puerto Rico to have physician payment rates that are 70% of Medicare's rates. Failure to meet this requirement would result in a reduction to the FMAP rate. This provision would be effective the first fiscal quarter after the date of enactment.	**Section 122221** is almost identical to the House provision. However, it would increase the aggregate federal annual capped funding for CNMI from $70 million to $73 million.
Investments to Ensure Continued Access to Health Care for Children and Other Individuals	See sub-rows below.	See sub-rows below regarding **Section 30741**.	See sub-rows below regarding **Section 122231**.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Providing for One Year of Continuous Eligibility for Children	Under Medicaid, eligibility for MAGI-based eligibility groups must be renewed at least annually. Program regulations generally require enrollees to report changes in circumstances that may affect eligibility between regularly scheduled redeterminations. States are permitted to extend 12 months of continuous eligibility to children under an age specified by the state (not to exceed 19 years of age), regardless of changes in family income or composition that may affect that child's eligibility. Under CHIP, eligibility redeterminations must occur at least annually. Although a number of states extend 12 months of continuous eligibility to some subpopulations of CHIP program enrollees, statutory authority for this policy does not exist for separate CHIP programs.	***Section 30741(a)*** would permit the state plan option to continue through the period that is one year after the date of enactment. Beginning one year after the date of enactment (with an exception for state legislation), the provision would require states to provide continuous eligibility to Medicaid and CHIP enrollees under the age of 19 until the earlier of (1) 12 months after such individual is determined eligible for Medicaid or CHIP, (2) the time that such individual reaches 19 years of age, or (3) the date that such individual is no longer a state resident.	***Section 122231(a)*** is identical to the House provision.
Revisions to Temporary Increase of Medicaid FMAP Under the Families First Coronavirus Response Act	The Families First Coronavirus Response Act (FFCRA; P.L. 116-127), Section 6008, provided an increase to the regular FMAP rate of 6.2 percentage points, beginning on the first day of the calendar quarter in which the COVID-19 public health emergency period began (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the COVID-19 public health emergency period ends. To receive the FFCRA FMAP increase, states must provide continuous coverage of Medicaid enrollees during the COVID-19 public health emergency period, among other requirements.	***Section 30741(b)*** would end the FFCRA FMAP increase on September 30, 2022, and the provision would phase down the 6.2-percentage-point FFCRA FMAP increase to 3.0 percentage points from April 1, 2022, until June 30, 2022, and to 1.5 percentage points from July 1, 2022, through September 30, 2022. The provision also would amend the continuous coverage requirement that is tied to receipt of the FFCRA FMAP increase. For the period April 1, 2022, through September 30, 2022, states would be permitted to terminate Medicaid coverage for individuals who were enrolled for 12 consecutive months and who are no longer eligible, when certain conditions are met (e.g., states would be prohibited from initiating redeterminations of more than one-twelfth of program enrollees in any month during the specified period).	***Section 122231(b)*** is identical to the House provision for the phasedown of the FFCRA FMAP increase. The modifications to the FFCRA FMAP increase continuous coverage requirement are almost identical to those in the House bill, but the Senate provision would prohibit states from initiating redeterminations for more than one-ninth of program enrollees (instead of one-twelfth of program enrollees) in any month during the specified period, among other changes.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Medical Assistance Under Medicaid for Inmates During 30-Day Period Preceding Release	Under Medicaid, an individual detained in a setting that is organized for the primary purpose of involuntary confinement (e.g., local jail, state or federal prison) is considered an "inmate of a public institution." Medicaid statute prohibits the use of federal funds to pay for the health care of an "inmate of a public institution," except when the individual is a "patient in a medical institution." Beginning on or after October 24, 2019, the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) prohibits states from terminating Medicaid eligibility for eligible juveniles (i.e., individuals under the age of 21 and former foster youth up to the age of 26 who become incarcerated while enrolled in Medicaid or who are determined eligible for Medicaid while incarcerated). The SUPPORT Act also requires states to process Medicaid applications and make an eligibility determination for such individuals "upon release" from a public institution. Eligibility may be suspended while the individual is an inmate. Different eligibility criteria apply to inmates of a public institution under CHIP. The CHIP statute explicitly excludes children who are inmates of a public institution from the definition of *targeted low-income child*.	***Section 30741(c)*** would change certain Medicaid and CHIP coverage criteria for inmates of public institutions, including eligible juveniles. Specifically, the provision would lift the prohibition on Medicaid federal matching payments to inmates of a public institution, including eligible juveniles, for the 30-day period preceding the date of release from a public institution. For eligible juveniles, the provision would (1) prohibit states from suspending Medicaid coverage during the 30-day period preceding the date of release and (2) require that eligibility determinations for new Medicaid applications be completed 30 days prior to release. The provision also would allow otherwise eligible inmates of a public institution to be eligible for CHIP during the 30-day period preceding the date of release of such a child from such public institution. These modifications would take effect on the first day of the first FY quarter that begins two years after the date of the enactment.	***Section 122231(c)*** is similar to the House provision but includes technical corrections to separate a grouping within the existing list of individuals who are excluded from the definition of *targeted low-income child*.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
[Extension of] Express Lane Eligibility Option	States are permitted to rely on a finding from specified Express Lane agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program) to assess whether a child has met one or more of the eligibility requirements necessary for a Medicaid or CHIP initial eligibility determination, eligibility redetermination, or renewal of eligibility coverage through FY2027. For children who do not satisfy a Medicaid or CHIP eligibility requirement under an Express Lane eligibility determination, states must use regular Medicaid or CHIP eligibility determination procedures.	***Section 30741(d)(1)*** would strike the requirement for states to use regular eligibility determination procedures for children who did not satisfy a Medicaid or CHIP eligibility requirement under an Express Lane eligibility determination.	***Section 122231(d)(1)*** is identical to the House provision.
[Extension of] Conforming Amendments for Assurance of Affordability Standards for Children and Families	The ACA extended and expanded the maintenance of effort (MOE) provisions in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). Under the ACA MOE provisions, states were required to maintain their Medicaid programs with the same eligibility standards, methodologies, and procedures in place on the date of the ACA's enactment of the ACA through September 30, 2019, for children up to the age of 19. The penalty to states for not complying with this Medicaid MOE requirement for children is the loss of all federal Medicaid matching funds. Multiple laws have extended and amended this MOE. Currently, the MOE is in place through FY2027 and, beginning in FY2020, states are permitted to roll back Medicaid eligibility for children in families with annual income that exceeds 300% of FPL.	***Section 30741(d)(2)*** would make permanent the Medicaid MOE requirements for children in families with annual income up to 300% of FPL. The provision would permit states to roll back Medicaid eligibility for children in families with annual income that exceeds 300% of FPL without the loss of all federal Medicaid matching funds.[a]	***Section 122231(d)(2)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Expansion of Community Mental Health Services Demonstration Program	The Protecting Access to Medicare Act of 2014 (P.L. 113-93), Section 223, authorized a demonstration program for eight states to improve community-based behavioral health services through establishing Certified Community Behavioral Health Clinics (CCBHCs). Currently, this demonstration program is authorized through September 30, 2023. Two states were added to the demonstration program in 2020.	***Section 30741(e)*** would require the HHS Secretary to award planning grants to additional states. The provision also would require the HHS Secretary to select new CCBHC demonstration states, which may be any states that were previously or newly awarded planning grants and that submit applications meeting certain requirements. These states would have a two-year demonstration period. For FY2022, the provision would appropriate $40 million for planning grants and $5 million for updating the criteria, drafting annual reports, and providing technical assistance.	***Section 122231(e)*** is similar to the House provision. However, the Senate language would extend the demonstration period for the two states added in 2020 and the new states from two years to four years.
Making Permanent a State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services	The ARPA Section 9813 added a state option to provide Medicaid coverage of qualifying community-based mobile crisis intervention services during the five-year period beginning April 1, 2022, and ending March 27, 2027.	***Section 30741(f)*** would make permanent this state option.	***Section 122231(f)*** is identical to the House provision.
Extension of 100% FMAP for Urban Indian Health Organizations and Native Hawaiian Health Care Systems	States receive 100% federal reimbursement (i.e., fully federally funded) for Medicaid services provided through an Indian Health Service (IHS) facility. This exception applies to (1) IHS-operated facilities and (2) facilities operated by Indian tribes or tribal organizations. The ARPA provided eight fiscal quarters beginning April 1, 2021, through March 31, 2023, of 100% federal reimbursement (i.e., full federal funding) for Medicaid services received through (1) Urban Indian Organizations (UIOs) that have a grant or contract with IHS and (2) Native Hawaiian Health Centers or qualified entities that have a grant or contract with the Papa Ola Lokahi.	***Section 30741(g)*** would extend 100% federal reimbursement for the UIOs and Native Hawaiian Health Centers for eight fiscal quarters. With this extension, the FMAP exception would be in place for 16 quarters (four years), until March 31, 2025.	***Section 122231(g)*** is almost identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Ensuring Accurate Payments to Pharmacies Under Medicaid	Subject to CMS approval, state Medicaid programs determine the amount to reimburse retail community pharmacies (RCPs) for covered outpatient drugs dispensed to Medicaid beneficiaries. The amount state Medicaid programs receive in federal matching payments for the ingredient costs of multiple-source covered outpatient drugs is subject to an aggregate federal upper limit. State Medicaid-covered outpatient drug payment rates include two components: ingredient cost and dispensing fee. Medicaid regulations require states to base multiple-source drugs' ingredient cost on each product's actual acquisition cost. State Medicaid programs have discretion in determining actual acquisition costs for covered outpatient drugs and may use resources such as state-administered pharmacy surveys or the results of a statutory national RCP survey of prices paid to acquire covered outpatient drugs. To implement the statutory RCP survey requirement, CMS established the National Average Drug Acquisition Cost (NADAC) survey, a voluntary, monthly survey of RCP acquisition costs for most covered outpatient drugs.	***Section 30741(h)*** would require the HHS Secretary to continue conducting the NADAC survey of Medicaid-covered outpatient drug prices available at RCPs. To receive federal matching funds for prescription drugs, state Medicaid programs would have to require that randomly selected RCPs receiving Medicaid or CHIP funds participate in the NADAC survey by submitting drug cost and payment information. RCPs that knowingly failed to provide timely or accurate NADAC data could be subject to CMPs up to $10,000 for each day such information was not provided. ***Section 30741(h)*** would require the HHS Secretary to publicly report NADAC survey results. The HHS Secretary would receive a $7 million appropriation in FY2023 and each year thereafter to conduct the NADAC survey. ***Section 13941(h)*** would be effective on the first day of the first quarter beginning 18 months after the enactment date.	***Section 122231(h)*** is identical to the House provision, except it would reduce the CMPs to up to $750 per day for small business pharmacies (as determined by the HHS Secretary) for RCPs that knowingly failed to provide timely NADAC survey data. In comparison to the House provision, funding availability would be addressed in ***Section 122231(i).***
Funding for Implementation and Administration	Not applicable.	***Section 30741(i)*** would appropriate $20 million to the HHS Secretary for FY2022 (available until expended) to provide technical assistance and guidance and to cover administrative costs associated with implementing Part 4 (i.e., ***Section 30741(a)-(h)***) and Part 2 (***Sections 30721 and 30722***).	***Section 122231(i)*** is almost identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Encouraging Continued Access After the End of the Public Health Emergency	FFCRA Section 6008 provided an increase to the regular FMAP rate of 6.2 percentage points during the COVID-19 public health emergency period. To receive the FFCRA FMAP increase, states must provide continuous coverage of Medicaid enrollees during the COVID-19 public health emergency period, among other requirements.	**Section 30751** would encourage states to maintain Medicaid eligibility standards after the end of the public health emergency period. Between October 1, 2022, and December 31, 2025, if in any calendar quarter a state puts into effect Medicaid "eligibility standards, methodologies, and procedures" that are more restrictive than those that were in effect on October 1, 2021, the regular FMAP rate for that state would be reduced by 3.1 percentage points for such calendar quarter, with an exception for states that modify eligibility for nonpregnant, nondisabled adults with annual income greater than 133% of FPL and certify with the HHS Secretary the existence of a budget deficit or projected budget deficit during this period.	**Section 122241** is similar to the House provision. However, it would add that in applying this provision, the eligibility standards, methodologies, or procedures that were in effect October 1, 2021, should be determined without regard to those established during the COVID-19 public health emergency period under a COVID-19-related emergency authority.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, the language released by the Senate Finance Committee described as being intended for the BBBA, and relevant current law. (The Senate HELP Committee language did not include provisions relevant to this table.) See report introduction for links to legislative language.

Notes: Although this table focuses on Medicaid in general, some rows also are relevant to CHIP and some rows are relevant to prescription drugs (in either case, especially where such rows represent subsections of a larger provision). Also see **Table 5** for provisions generally relevant to CHIP, **Table 3** for additional provisions relevant to prescription drugs and Medicaid, and **Table 7** for additional Medicaid provisions regarding Home and Community-Based Services and Long-Term Care Facilities. See **Appendix A** for all abbreviations used in table.

a. Section 30801(b)(2) of H.R. 5376 as passed by the House also would make changes to the CHIP child MOE requirement by removing the end date of the period during which the CHIP MOE requirements would apply for children in families with annual income less than 300% of FPL. In addition, the provision would eliminate the two exceptions to the MOE requirement for separate CHIP programs.

Table 5. The State Children's Health Insurance Program (CHIP) Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Investments to Strengthen CHIP	See sub-rows below.	See sub-rows below regarding **Section 30801**.	See sub-rows below regarding **Section 122301**.
Permanent Extension of CHIP	Multiple laws have funded CHIP since its establishment in the Balanced Budget Act of 1997 (P.L. 105-33). CHIP was funded from FY1998 through FY2023 with appropriated amounts specified in statute. Funding amounts for FY2024-FY2026 were not specified; instead, the appropriation provides such sums as are necessary to fund allotments to states. Funding for FY2027 consists of semiannual appropriations of equal amounts plus a one-time appropriation.	***Section 30801(a)*** would permanently fund CHIP by providing such sums as are necessary to fund allotments to states for FY2027 and each subsequent year.	***Section 122301(a)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Pediatric Quality Measures Program	SSA Section 1139A authorized various activities related to pediatric quality measurement for health care provided under Medicaid or CHIP, including identifying and publishing an initial core set of pediatric quality measures; establishing a Pediatric Quality Measures Program; and requiring states to submit reports to the HHS Secretary annually to include information about state-specific child health quality measures as applied by the state. The Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) originally appropriated funding for SSA Section 1139A in the amount of $45 million for each of FY2009-FY2013. The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) appropriated $20 million for the period FY2016-FY2017, and the HEALTHY KIDS Act (Division C, P.L. 115-120) appropriated funding in the amount of $90 million for the period FY2018-FY2023. The Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-72) appropriated $60 million for the period FY2024-FY2027. The funds are available until expended.	***Section 30801(b)(1)*** would appropriate $15 million for FY2028. It also would appropriate, for each subsequent FY, the amount appropriated for the previous FY, increased by the percentage increase in the CPI-U over such previous FY.	***Section 122301(b)(1)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Assurance of Eligibility Standards for Children	Under the ACA MOE provisions, states were required to maintain their Medicaid and CHIP programs with the same eligibility standards, methodologies, and procedures in place on the date of the ACA's enactment through September 30, 2019, for children up to the age of 19. The penalty to states for not complying with either the Medicaid or the CHIP child MOE requirements would have been the loss of all federal Medicaid funds. Multiple laws have extended and amended this MOE. Currently, the MOE is in place through FY2027, and states have been permitted to make Medicaid and/or CHIP eligibility more restrictive for children in families with annual income that exceeds 300% of FPL since FY2020. CHIP provides health coverage to eligible children (up to the age of 19) without health insurance who do not qualify for Medicaid. States can administer their CHIP programs as part of Medicaid, as a separate program, or as a combination of Medicaid and one or more separate CHIP programs. States with separate CHIP programs receive two exceptions to the child MOE requirement: (1) states may impose waiting lists or enrollment caps to limit CHIP expenditures and (2) after September 1, 2015, states may enroll CHIP-eligible children in qualified health plans in the health insurance exchanges.	***Section 30801(b)(2)*** would make permanent the CHIP MOE by removing the end date of the period during which CHIP MOE requirements would apply for children in families with annual income less than 300% of FPL. The provision also would eliminate the two exceptions to the child MOE requirement for separate CHIP programs.	***Section 122301(b)(2)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Qualifying States Option	Certain states had significantly expanded Medicaid eligibility for children prior to the 1997 enactment of CHIP. These states may use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., FMAP and enhanced federal medical assistance percentage, or E-FMAP, rates, respectively) for the cost of Medicaid-eligible children in families with income above 133% of FPL. This provision is referred to as the *qualifying states option*. FY2027 is the last year in which the qualifying states option is authorized.	***Section 30801(b)(3)*** would permanently extend the qualifying states option.	***Section 122301(b)(3)*** is identical to the House provision.
Outreach and Enrollment Program	CHIPRA Section 201 appropriated (out of funds in the Treasury that were not otherwise appropriated) $100 million in outreach and enrollment grants for FY2009-FY2013 to be used by eligible entities (e.g., states, local governments) to conduct outreach and enrollment efforts that increase the participation of Medicaid- and CHIP-eligible children. The section also provided direction for the use of such funds. Subsequent laws provided additional appropriations and identified set-aside amounts to be directed at specified activities, among other changes. Most recently, BBA 2018 provides $48 million for CHIP outreach and enrollment grants for the period FY2024-FY2027. Currently, the law requires 10% of the funding to be set aside to use for a national campaign to improve the enrollment of underserved child populations and another 10% of the funding to be set aside for evaluations and technical assistance.	***Section 30801(b)(4)*** would appropriate $60 million for CHIP outreach and enrollment grants for the period FY2028-FY2030. For each of three FYs after FY2030, the section specifies that the appropriation for such grants would be the amount appropriated under this subsection for the previous FY, increased by the percentage increase in the CPI-U rounded to the nearest $100,000 over such previous FY. The provision also would extend the authority for such grants, including the requirements that 10% of the funding be used for a national campaign to improve the enrollment of underserved child populations and another 10% of the funding be used for evaluations and technical assistance.	***Section 122301(b)(4)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Child Enrollment Contingency Fund	For FY2009-FY2027, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific target level receive a payment from the Child Enrollment Contingency Fund. This payment is equal to the amount by which the enrollment exceeds the target, multiplied by the product of projected per capita expenditures and the E-FMAP, which is the federal share of CHIP expenditures.	***Section 30801(b)(5)*** would permanently extend the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund.	***Section 122301(b)(5)*** is identical to the House provision.
CHIP Drug Rebates	CHIP covers uninsured children through age 18. States may include CHIP in Medicaid, have a separate program, or combine CHIP and Medicaid. States determine their CHIP benefit coverage and cost sharing following federal rules. All state CHIP programs cover outpatient prescription drugs, regardless of whether the programs are administered as part of Medicaid, separately, or in combination. Drug manufacturers that participate in Medicaid are statutorily required to pay rebates on covered outpatient drugs. Medicaid covers most FDA-approved outpatient prescription drugs and biological products, as well as insulin. Federal Medicaid and CHIP statutes do not specifically require drug manufacturers to pay rebates on drugs purchased by separate CHIP programs.	***Section 30801(c)*** would require drug manufacturers to pay rebates on drugs provided to separate CHIP program beneficiaries beginning January 1, 2024. The HHS Secretary would be required by Section 30801(c) to develop or adapt necessary processes and mechanisms, including to report and collect data to bill and track prescription drug rebates for covered outpatient drugs, including methadone and opioid addiction treatment biologic products, provided as CHIP or pregnancy-related assistance under a child health plan. ***Section 30801(c)*** would prohibit duplicate CHIP rebates and PHSA Section 340B Program discounts.	***Section 122301(c)*** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
State Option to Expand Children's Eligibility for Medicaid and CHIP	States have broad discretion in setting their CHIP income eligibility standards, and eligibility varies across states. The ACA required states to transition to MAGI income counting rules, beginning January 1, 2014. The transition to MAGI effectively limited CHIP upper income eligibility levels for states by eliminating state use of income disregards to expand eligibility. State CHIP allotments are the funds allocated to each state and territory for the federal share of its CHIP expenditures. Federal CHIP allotments are distributed to states based on a statutory formula that differs across even and odd years. In addition, CHIP allotment increases to account for program eligibility or benefit expansions are permitted for states and the District of Columbia (DC) through FY2027.	***Section 30801(d)(1)*** would permit states to extend coverage to children in families at higher income levels by increasing the CHIP upper income eligibility standards beyond those established by the state as a part of the transition to the MAGI income counting rules. ***Section 30801(d)(2)*** would allow the territories to receive an increase to their federal CHIP allotments to account for a program expansion. ***Section 30801(d)(3)*** would remove the expiration date of the provision allowing states and DC to increase their federal CHIP allotments to account for program expansions.	No provision.
Funding for Implementation and Administration	Not applicable.	***Section 30801(e)*** would appropriate $5 million to the HHS Secretary for FY2022 (available until expended) to provide technical assistance and guidance and to cover administrative costs associated with implementing ***Section 30801(a)-(d).***	***Section 122301(d)*** is identical to the House provision.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, language released by the Senate Finance Committee described as being intended for the BBBA, and relevant current law. (The Senate HELP Committee language did not include provisions relevant to this table.) See report introduction for links to legislative language.

Notes: Although this table focuses on CHIP in general, some rows also are relevant to Medicaid and some rows are relevant to prescription drugs (in either case, especially where such rows represent subsections of a larger provision). Also see **Table 3** for provisions relevant to prescription drugs, including in CHIP, and **Table 4** for provisions generally relevant to Medicaid, including some provisions relevant to CHIP. See **Appendix A** for all abbreviations used in table.

Table 6. Medicare Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Providing Coverage for Hearing Care Under the Medicare Program	Medicare Part B covers certain auditory services, such as hearing and balance assessments when furnished by a qualified audiologist. Part B also covers certain prosthetics when they replace the functioning of parts of the ear anatomy. Hearing aids and hearing aid examinations are excluded from Medicare coverage. Physicians, nonphysician practitioners, and other Part B suppliers that provide auditory services may bill Medicare as either participating or nonparticipating providers and receive payment according to a fee schedule. Participating providers accept the Medicare payment as payment in full for all services provided to beneficiaries, whereas nonparticipating providers do not accept the Medicare payment as payment in full and can balance bill. Medicare payments for certain prosthetics may be based on statutorily specified fee schedules or competitive bidding. Medicare covers certain services provided at rural health clinics (RHCs) based on an all-inclusive rate (AIR) for each visit and pays federally qualified health centers (FQHCs) on the basis of a prospective payment system (PPS). The Ethics in Patient Referrals Act, commonly referred to as the *Stark Law* (part of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239), prohibits certain physician self-referrals for designated health services that may be paid for by Medicare.	**Section 30901(a)** would expand coverage of auditory services starting January 1, 2023, to include aural rehabilitation and treatment services and hearing assessments when furnished by a qualified hearing aid professional. A *qualified hearing aid professional* would be defined as one who is licensed or registered by the state in which services are furnished and meets other requirements as determined by the HHS Secretary (including requirements relating to educational certification or accreditation), taking into account any additional requirements established by other payers. Payment for hearing assessment services furnished by a qualified hearing aid professional would be 80% of either the lesser of the actual charge for the service or 85% of the amount for such service determined under the Medicare physician fee schedule. **Section 30901(b-d)** would eliminate the statutory exclusion for hearing aids furnished under the prosthetic benefit starting January 1, 2023. Covered hearing aids would be allowed for beneficiaries diagnosed with moderately severe, severe, or profound hearing loss. The section would limit coverage to not more than once per ear during any five-year period and only with a written order from a physician or practitioner. Hearing aid payments would be made on an assignment-related basis (precluding suppliers from balance billing) and would be subject to competitive bidding. However, hearing aids and services furnished by physicians or other practitioners to their own patients as part of	**Section 122101** would expand coverage of auditory services and hearing aids in the same way as the House version, with the following exceptions: **Section 122101(a)** would clarify that qualified audiologists could perform treatment services (including greater specificity about which activities would be included under treatment) related to hearing and balance in addition to hearing aid examinations; qualified hearing aid professionals could conduct only hearing aid examinations. Additionally, the provision would specify that when audiologists provide hearing and balance assessment services and hearing aid examination and treatment services, these services would not require an order from a physician or practitioner to be covered by Medicare. Hearing aid examinations provided by a qualified hearing aid professional still would require an order from a physician or practitioner, as per Section 30901(a) of the House version. **Section 122101 (b-d)** would modify coverage by deleting the word "diagnosed" with respect to hearing loss that would qualify a beneficiary for hearing aid coverage. The Senate version also would add a definition section that defines (1) a *hearing aid* as the item and related services and (2) a *qualified hearing aid supplier* as a qualified audiologist; physician; physician assistant; nurse practitioner; or clinical nurse specialist, qualified hearing aid professional, or other supplier as determined by the HHS Secretary. Additionally, the Senate version would require the HHS Secretary to begin a competition for

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		their professional services would be exempt from competitive bidding.	competitive bidding of hearing aids not later than January 1, 2028.
		Section 30901(e) would define *audiology services* as qualified physician services at RHCs and FQHCs and would include qualified audiologists and hearing aid professionals as RHC and FQHC practitioners. Temporary payment rates for audiology services furnished at RHCs and FQHCs would be based on the Medicare physician fee schedule until the HHS Secretary determined that sufficient data had been collected to establish rates under the RHC AIR or the FQHC PPS or until January 1, 2029, if no such determination had yet been made in either case. The costs of audiology services furnished to Medicare beneficiaries would not be considered in determining other RHC AIR or FQHC PPS payment rates during the interim.	The Senate version would add an exception to the physician self-referral prohibition in the Stark law for hearing aid examination services and hearing aids.
		Section 30901(f) would appropriate to the HHS Secretary for FY2022 $370 million to implement the provision beginning January 1, 2022, and ending September 30, 2031. The HHS Secretary would be required to implement this section for 2022 and 2023 by program instructions.	
Registered Professional Nurses	Skilled nursing facilities (SNFs) and nursing facilities (NFs) must provide 24-hour licensed nursing services sufficient to meet the nursing needs of their residents. These services must include, at a minimum, services of a registered nurse (RN) at least eight consecutive hours a day, seven days a week.	**Section 132000** would require SNFs and NFs to use the services of an RN for 24 hours a day, seven days a week	**Section 122115** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Permanent Extension of the Independence at Home Medical Practice Demonstration Program	The Medicare Independence at Home (IAH) demonstration is a payment-incentive and service-delivery model that uses home-based primary care teams to reduce expenditures and improve health outcomes in the care of certain chronically ill Medicare beneficiaries. Qualifying IAH medical practices are legal entities comprising an individual physician or nurse practitioner or a group of physicians and nurse practitioners that provide chronic care management services as part of a team. CMS initially selected 15 individual practices and launched the IAH demonstration in 2012. Originally scheduled to end in 2017, the IAH demonstration has been extended twice through legislation and is set to end on December 31, 2023. These laws also raised the limit on the number of IAH demonstration participants (from 10,000 to 20,000) and the related limit on the number of IAH participating practices.	**Section 132001** would make permanent the IAH demonstration program, remove the limit on the number of demonstration participants, and open participation to additional qualified IAH medical practices without limit. The participating beneficiaries newly added due to the expansion would be included in determining the estimated annual spending target for each IAH medical practice and its incentive payment under the demonstration. The sum of $60 million would be appropriated to the CMS Program Management Account for FY2022 to administer the IAH demonstration program; these funds would be available until September 30, 2031.	**Section 122121** would reorder the House provision and would require a transition period during which the limit for the total number of qualified medical practices participating in the program would increase from 25,000 in CY2022 to 200,000 in CY2029. For CY2030 and subsequent years, there would be no limit.
Administrative Funding of the Rural and Underserved Pathway to Practice Training Programs for Post-Baccalaureate Students, Medical Students, and Medical Residents	No current law.	**Section 137401** would appropriate $6 million in FY2022 to administer the Rural and Underserved Pathway to Practice Training Program for Post-Baccalaureate and Medical Students (which would be established by Section 137402, see below) and the Rural and Underserved Pathway to Practice Training Program for Medical Residents (which would be established by Section 137404, see below). The amount appropriated would remain available until expended.	**Section 127401** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Establishing the Rural and Underserved Pathway to Practice Training Program for Post-Baccalaureate Students and Medical Students	Multiple federal programs aim to increase the number of physicians from diverse backgrounds and to increase the number of physicians who practice in rural and underserved communities. Generally, these programs provide scholarships or loan repayment in exchange for practicing in health professional shortage areas or medically underserved areas, generally at outpatient facilities. These programs generally target primary care and behavioral health providers and support health professional education (e.g., medical school). Programs also may target individuals from underserved communities or provide training exposure in such communities. Programs that incur service commitments generally specify repayment penalties for individuals who fail to complete their service requirements. In some cases, health providers may have their Medicare payments withheld for failing to fulfill their service commitments.	**Section 137402** would establish a new program to award scholarship vouchers to individuals from disadvantaged backgrounds, as specified, for post-baccalaureate and medical school tuition and education expenses. Scholarship recipients would be required to practice medicine in a health professional shortage area, in a medically underserved area, at a public hospital, or in a rural area for the number of years of scholarship support received. The section specifies the criteria to be prioritized when selecting participating students and the requirements for schools receiving tuition vouchers. It also specifies the penalties that scholarship recipients would incur if they failed to complete their scholarship requirements. The provision also would add this new program to the list of programs for which the HHS Secretary is required to enter into agreements with the physicians who have breached their contracts to deduct the amount owed from the Medicare payments that the individuals otherwise would receive. The section defines a number of terms, including *qualifying medical school*, for purposes of the program. Among the elements of the definition, qualifying medical schools would be those that are required to provide coursework and training experiences focused on medical issues prevalent in health professional shortage areas, medically underserved areas, and rural areas and in coursework and training in cultural or structural competency.	**Section 127402** would create a new program that would be substantively similar to the program included in the House provision, except that this program would specify "selection criteria" that the HHS Secretary would be required to consider when selecting qualifying students to receive medical scholarship vouchers (as opposed to the "prioritization criteria" contained in the House provision). This section also defines a number of terms, including *qualifying medical school*, for purposes of the program. Specifically, the Senate provision would require a qualifying medical school to provide certain coursework and training focused on "effectively providing care for populations belonging to diverse cultural, social and economic backgrounds," whereas the House provision would focus on medical issues prevalent in "cultural or structural competency."

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Funding for the Rural and Underserved Pathway to Practice Training Programs for Post-Baccalaureate Students and Medical Students	Scholarships received by an educational institution on behalf of a student for educational expenses are included in the institution's revenue and are not tax deductible to the institution under current law. Students, in contrast, may receive a tax benefit from a scholarship. Specifically, students generally do not have to pay tax on a scholarship, as long as the scholarship is not considered compensation for services (e.g., research, student teaching). Scholarship or fellowship income that is considered compensation for services is generally taxable, unless specifically excluded by law—statutory exceptions include amounts received under the National Health Service Corps Scholarship Program and the Armed Forces Health Professions Scholarship and Financial Assistance Program.	**Section 137403** would create a new refundable tax credit for qualifying educational institutions—certain medical schools or providers of a post-baccalaureate medical education and training—to offset amounts "paid or incurred" by the institution for each eligible student who receives a Rural and Underserved Pathway to Practice medical scholarship voucher. This credit would effectively be a financing mechanism to fund these scholarships—qualifying educational institutions would provide these scholarships to students, and the federal government would reimburse these institutions with a tax credit. (Educational institutions with little to no income tax liability, including those that are federally tax exempt, would be able to benefit from this provision because it is a refundable credit.) Under current law, no comparable tax benefit to the one proposed here exists.	**Section 127403** includes punctuation and minor language changes but is otherwise substantively the same as the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Establishing the Rural and Underserved Pathway to Practice Training Program for Medical Residents	Medicare pays hospitals with an approved medical residency program for the direct and indirect costs of a medical residency training program. Medicare's graduate medical education (GME) payments to a hospital in a given year are subject to a hospital-specific full-time equivalent (FTE) limit, or *cap*, for allopathic and osteopathic residents. In some cases, the FTE cap is not absolute—Medicare provides GME funding for new medical residency programs sponsored either by a new hospital or by an existing hospital that develops a new residency program and for certain GME programs that train residents in rural areas. Medicare requires limited tracking of residents' medical specialties and does not require hospitals to report information about former residents' post-residency practice patterns.	**Section 137404** would exclude the Medicare GME FTE medical residents that an applicable hospital trains under the Rural and Underserved Pathway to Practice Medical Residency Training Program during a Medicare cost-reporting year beginning on or after October 1, 2026, from counting toward a hospital's Medicare GME FTE cap. Thus, this section would increase both the aggregate number of FTEs and the number of an applicable hospital's FTEs that are supported by Medicare only for the period during which a hospital or hospitals are training residents under the Rural and Underserved Pathway to Practice Medical Residency Training Program. (The provision would not limit the number of medical residents that a hospital may train under the Rural and Underserved Pathway to Practice Medical Residency Training Program.) The provision would require applicable hospitals to provide information to the HHS Secretary about where qualifying residents practice medicine or participate in fellowships immediately after their residency. It also defines key terms, such as *qualifying resident*, *applicable hospital*, *health professional shortage area*, *medically underserved area*, *qualifying medical school*, *qualifying medical student*, and *rural area*.	**Section 127404** is identical to the House provision, except it would define an *applicable hospital* differently. Specifically, the Senate provision would include the requirement that the hospital have a residency program that includes "training for residents on how to effectively provide care for populations belonging to diverse cultural, social, and economic backgrounds." By contrast, the House bill would include the requirement that the hospital have a residency program that "includes cultural or structural competency as part of the training of residents."

Distribution of Additional Residency Positions	Medicare's GME payments to a hospital in a given year are subject to a hospital-specific FTE cap for allopathic and osteopathic residents. Generally, the FTE cap is determined at the hospital level. However, under Medicare GME rules, groups of hospitals may enter into formal affiliation agreements that permit these hospitals to pool their FTEs. This pooling allows some hospitals within the affiliated group to reduce their FTE caps and others to increase their FTE caps for purposes of Medicare GME payments, as long as the aggregate number of FTEs among the affiliated group remains the same. The FTE cap is not absolute—Medicare will recognize and pay for FTEs of a new medical residency program sponsored by either a new hospital or an existing hospital that develops a new residency program, or certain GME programs that train residents in rural areas. However, a hospital that already has an FTE cap and wishes to grow its medical residency training program to correspond with the growth of the hospital, its service area, or the population served cannot receive additional Medicare GME funding to support additional residents. Since the FTE cap was established, Congress has enacted exceptions to the FTE caps. For example, the Consolidated Appropriations Act, 2021 (CAA 2021; P.L. 116-260), increased the aggregate number of Medicare GME FTEs by 1,000; the HHS Secretary must begin distributing these FTE positions in FY2023. A hospital that receives additional FTEs under the CAA 2021 will have its hospital-specific cap increased by the number of additional FTEs the hospital receives under this law.	**Section 137405** would add a total of 4,000 Medicare-supported GME resident FTE positions to be distributed to qualifying hospitals in FY2025, FY2026, and any succeeding FYs until all FTEs are distributed. The provision would require a hospital to apply for increases, and it would require the HHS Secretary to initiate a separate round of applications for each FY. A hospital that received FTE residency positions through this provision would have its FTE cap increased by such number of FTEs. The aggregate number of FTE residency positions distributed in any FY would not exceed 2,000. No hospital would be eligible to receive more than an additional 25 FTEs under this provision. With regard to medical specialty, not less than 25% of the aggregate FTEs would be for primary care (as defined) or obstetrics and gynecology residents; 15% would be for psychiatry residents (as defined). Any FTEs that remain to be distributed after July 1, 2027, would be distributed without regard to specialty. Hospitals would be permitted to receive additional residents under this provision and under the CAA 2021 during a given FY. With regard to hospital types, 30% of the aggregate FTEs would be distributed to hospitals that are training more residents than the Medicare FTE limit; 20% to hospitals that are located in rural areas or are treated as such under certain Medicare hospital wage index reclassifications, are located in a census tract assigned a rural-urban commuting area code of 4 or greater, or are Medicare sole community hospitals; 20% to hospitals in states with new medical schools or campuses (as defined); 20% to hospitals located in or that serve an area or population designated as a health professional shortage area (HPSA); and 10% to hospitals	**Section 127405** is identical to the House provision.

Medicare does not require that hospitals report data about the practice patterns or other information about former residents as a condition of receiving Medicare GME payments or additional FTEs. However, hospitals must distinguish between primary care and non-primary care FTEs, because Medicare GME payments differ based on whether the residents are training in a primary care specialty or a non-primary care specialty. Medicare defines *primary care* as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

located in states in the lowest quartile for medical resident-to-population ratios. Any FTEs remaining to be distributed after July 1, 2027, would be distributed first based on the aforementioned hospital types that demonstrate a likelihood of filling the residency positions within five years of the effective date of the FTE cap increase made under this provision and that would use a portion of such FTEs for residencies in primary care, obstetrics and gynecology, and psychiatry.

During the five-year period beginning after the effective date of the increase, a hospital receiving an FTE increase under this provision would not be allowed to reduce its number of primary care or psychiatry FTE residents to below the number it was otherwise training in those specialties during the three most recent Medicare cost-reporting periods preceding enactment.

Hospitals receiving an FTE increase under this provision would be required to make a good-faith effort to report to the HHS Secretary information about former residents, including their race and ethnicity, medical specialty of practice, and whether former residents practice in HPSAs or rural areas.

The FTEs distributed to a rural hospital under this provision must be used to expand existing programs, not to establish new programs. This provision also would require the HHS Secretary to reduce the FTE cap of a hospital that received an FTE increase under this provision if the hospital no longer met the requirements for such increase; in that case, the provision would require the HHS Secretary to redistribute those FTEs to other hospitals based on the distribution requirements under this provision.

Hospitals receiving an FTE increase under this provision would be permitted, after five years,

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		to include such FTEs in the pool of FTEs as part of an affiliation agreement among a group of hospitals. The per resident amount for FTEs distributed under this provision would be calculated in the same manner as under current law for primary care and non-primary care Medicare GME residents. Finally, the provision would make conforming amendments to the Medicare Indirect Medical Education (IME) statute so that Medicare could calculate the IME portion of the Medicare GME payment for hospitals with added FTE residency positions allowed by this provision. The section would appropriate $10 million to carry out this provision. The funds would remain available until expended.	

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, the language released by the Senate Finance Committee described as being intended for the BBBA, and relevant current law. (The Senate HELP Committee language did not include provisions relevant to this table.) See report introduction for links to legislative language.

Notes: This table includes provisions generally relevant to Medicare. Also see **Table 3** for additional provisions relevant to prescription drugs and Medicare and **Table 7** for additional Medicare provisions regarding Home and Community-Based Services and Long-Term Care Facilities. See **Appendix A** for all abbreviations used in table.

Table 7. Home and Community-Based Services (HCBS) and Long-Term Care Facility (LCTF) Provisions in the Build Back Better Act

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Medicaid HCBS Improvement Planning Grants	States are required to cover certain Medicaid-covered long-term services and supports (LTSS) for eligible beneficiaries, such as NF care and home health care. States have a range of options that allow LTSS coverage of HCBS, such as case management, personal care, homemaker, respite care, and adult day health care, among other services.	**Section 30711** would appropriate $130 million for FY2022 (available until expended) to carry out grants to states and territories no later than 12 months after enactment. Grants would be awarded for the purposes of developing and implementing states' HCBS improvement plans in order to expand Medicaid-eligible individuals' access to and use of HCBS and to expand the HCBS direct care workforce. The provision would appropriate an additional $5 million for FY2022 (available until expended) for technical assistance and guidance to states intending to apply for, or that are awarded, HCBS improvement planning grants and for other related administrative expenses.	**Section 122201** is similar to the House provision. It would make certain changes to the use of grant funds, HCBS improvement planning grant requirements, and definitions.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Medicaid HCBS Improvement Program	The ARPA Section 9817 increases the FMAP rate of Medicaid expenditures by 10 percentage points for certain HCBS for states that meet the ARPA-specified HCBS program requirements during the program improvement period (i.e., April 1, 2021, through March 31, 2022).	**Section 30712** would provide a few FMAP increases for certain HCBS program improvement states. These states could receive a 6-percentage-point increase to the regular FMAP rate for Medicaid HCBS for each fiscal quarter beginning on or after the date on which the state becomes an HCBS program improvement state, if the state meets the specified requirements. An HCBS program improvement state could receive an additional 2-percentage-point increase (but not to exceed 95%) during the first six fiscal quarters the state has a program to support self-directed models for the delivery of services. HCBS program improvement states also would receive an increase to an 80% federal reimbursement rate before October 1, 2031, for certain administrative costs for expanding and enhancing HCBS.	**Section 122202** is similar to the House provision. However, the Senate provision would change some requirements for a state to be eligible for the FMAP increases.
Funding for Federal Activities Related to Medicaid HCBS	No current law.	**Section 30713** would appropriate $40 million for FY2022 (available until expended) to carry out the HCBS improvement program, including issuing guidance and technical assistance to states; conducting program integrity and oversight efforts; and preparing and submitting reports to Congress.	**Section 122203** is similar to the House provision but excludes preparing and submitting reports to Congress.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Funding for HCBS Quality Measurement and Improvement	Quality measurement activities in the Medicaid and CHIP programs currently are carried out under the authority of two provisions: SSA Section 1139A for pediatric quality measurement and SSA Section 1139B for quality measurement for the adult Medicaid population. These authorities do not encompass HCBS measure-specific activity. Broadly, these sections required the development, updating, and maintenance of core pediatric and adult health quality measure sets; the establishment of quality measurement programs (both pediatric and adult health); support for the development of quality measures to fill identified gaps in these areas; and requirements around state reporting to HHS on quality and quality measures, among other things. Funding for Section 1139B expired in FY2014.	**Section 30714(a)** would provide 80% federal reimbursement for the reporting of information regarding the quality of HCBS, in accordance with the child health quality measures and the adult health quality measures. **Section 30714(b)** would appropriate $22 million to the HHS Secretary for FY2022, to remain available until expended, to carry out the inclusion of HCBS quality measures in the core set of adult health quality measures maintained under Section 1139B. Generally, the provision would amend SSA Sections 1139A and 1139B to include HCBS quality measurement and improvement in some of the activities under these sections, specifically the development of new HCBS quality measures, their incorporation into the existing pediatric and Medicaid adult core quality measure sets, and state reporting of these new measures.	**Section 122204** would appropriate $25 million to the HHS Secretary for FY2022 (available until expended) to develop, in consultation with nongovernmental stakeholders, a recommended set of HCBS quality measures that reflect the full range of HCBS and the recipients of such services.
Permanent Extension of Medicaid Protections Against Spousal Impoverishment for Recipients of Home and Community-Based Services	When determining financial eligibility for Medicaid-covered LTSS, there are specific rules for the treatment of a married couple's assets when one spouse needs long-term care provided in an institution, such as a nursing home. Commonly referred to as *spousal impoverishment rules*, these rules attempt to allocate income and assets equitably to each spouse when determining Medicaid financial eligibility and are intended to prevent the impoverishment of the non-Medicaid spouse. These rules have been temporarily extended to HCBS participants over time and were most recently extended through September 30, 2023.	**Section 30715** would permanently apply spousal impoverishment protections to all married individuals who are eligible for Medicaid HCBS under specified authorities.	**Section 122205** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Permanent Extension of Medicaid Money Follows the Person Rebalancing Demonstration	The Medicaid Money Follows the Person (Medicaid MFP) Rebalancing Demonstration Program authorized CMS to award competitive grants to states to transition Medicaid participants who reside in institutional settings that provide LTSS, such as NFs, into community-based settings.[a] Medicaid MFP has been extended over time. Most recently, Medicaid MFP was appropriated $450 million in federal funding for each of FY2021-FY2023, for a total of $1.35 billion.	**Section 30716** would make permanent the Medicaid MFP program by removing the specific amounts provided for FY2022 and FY2023, respectively, and would appropriate $450 million "for each fiscal year after fiscal year 2022" for competitive grants to states. It would appropriate $5 million to states for FY2022 and for each subsequent three-year period for carrying out quality assurance and improvement, technical assistance, oversight, research and evaluation, and specified reports on best practices.	**Section 122206** is identical to the House provision, except it would appropriate $450 million "for each fiscal year after fiscal year 2021" for competitive grants to states.
Funding to Improve the Accuracy and Reliability of Certain Skilled Nursing Facility Data	Most SNFs are paid by the Medicare program under a PPS. The HHS Secretary has established an SNF Value-Based Purchasing (VBP) program that adjusts PPS payments to SNFs based on the SNFs' performance related to hospital readmissions. SNFs are required to perform assessments of each resident's functional capacity at specified times during the resident's stay and to report the information to the HHS Secretary and relevant state agencies. CMS refers to the submitted resident assessment data as the minimum data set (MDS). In addition to the MDS, SNFs are required to submit direct-care staffing information based on payroll and other auditable data. The CMS system for electronic submission of staffing information is referred to as the Payroll-Based Journal (PBJ).	**Section 30717** would provide $50 million from the Treasury to support VBP validation activities for the period of FY2022-FY2031. During the period of FY2024-FY2031, the section would expand validation activities to include submissions of MDS data and PBJ information. Further, during the period beginning with FY2026 and ending with FY2031, if the HHS Secretary determined through the validation activities that, with respect to each FY, data related to the VBP measures, MDS data, or PBJ information submitted by an SNF was inaccurate, the Medicare SNF PPS payments made to the SNF would be reduced by 2% for the FY.	**Section 122111** is identical to the House provision.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Ensuring Accurate Information on Cost Reports	SNFs, as well as other Medicare providers, are required to submit an annual cost report to CMS. The cost report contains provider information, such as service cost and charges (in total and for Medicare), and financial statement data.	**Section 30718** would provide to the HHS Secretary, out of what is already appropriated, $250 million from the Treasury for purposes of conducting annual audits of cost reports submitted by SNFs, beginning with cost reports submitted for 2023 and ending with 2031. The funds would be available for FY2022 and would remain available through FY2031.	**Section 122112** is identical to the House provision.

Survey Improvements	To participate in Medicare and/or Medicaid, SNFs and/or NFs, respectively, must adhere to a set of federal requirements, known as the Conditions of Participation (CoPs). To determine whether SNFs and/or NFs comply with the CoPs, federal law requires the HHS Secretary to work in collaboration with state survey agencies (SAs) to inspect (*survey*) SNFs and/or NFs. The HHS Secretary may impose enforcement remedies against noncompliant providers. If, after the SA completes a survey, an SNF and/or NF is found to be deficient in one or more standards, the nursing home is provided with a statement that cites these CoP deficiencies. The remedies imposed upon an SNF and/or NF depend on how "serious" the deficient behavior is determined to be.	**Section 30719** would require the HHS Secretary to conduct reviews of • the extent to which current surveys and enforcement actions result in compliance with the SNF CoPs; • the timeliness and thoroughness of SA verification of compliance after a deficiency has been identified in an SNF; • the appropriateness of the scoping and substantiation of cited deficiencies at SNFs; • the accuracy of the identification and appropriateness of the scope and severity of life safety, infection control, and emergency preparedness CoP deficiencies in SNFs; • the timeliness of SA investigations of complaints; facility-reported incidents; and allegations of abuse, neglect, and exploitation in SNFs; • the consistency of SNF reporting of substantiated complaints to law enforcement; • SAs' ability to sufficiently hire, train, and retain individuals who conduct surveys of SNFs; and • any other area related to surveys of SNFs that the HHS Secretary determines to be appropriate. The provision would require the HHS Secretary, based on the required reviews, to identify plans (as appropriate) for improving the areas reviewed and to provide training, tools, technical assistance, and financial support to SAs for the purpose of improving the surveying of SNFs and the related enforcement processes.	**Section 122113** differs from the House version in a number of ways. Most significantly, the Senate language would include of Medicaid facilities (NFs) and would authorize the HHS Secretary to use appropriated funds for general surveying. **Section 122113** would require the HHS Secretary to provide training, tools, technical assistance, and funding to state agencies that perform surveys of SNFs and/or NFs for the purpose of improving • the extent to which the current surveys and enforcement actions result in compliance with the SNF and NF CoPs; • the timeliness and thoroughness of SA verification of compliance after a deficiency has been identified in an SNF and/or NF; • the identification of the scope and severity of CoP deficiencies at SNFs and/or NFs, particularly with respect to identified life safety, infection control, and emergency preparedness CoP deficiencies in SNFs and/or NFs; • the timeliness of SA investigations of complaints and allegations of abuse, neglect, and exploitation in SNFs and/or NFs; • the identification of SNFs and/or NFs that consistently fail to report substantiated complaints to appropriate state and local authorities in accordance with state law; • the hiring, training, and retention of individuals who conduct surveys of SNFs and/or NFs; and

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
		Section 30719 would appropriate $325 million from the Treasury for FY2022, to remain available through FY2031, for the HHS Secretary to implement the activities required by the provision.	• any other area related to surveys of SNFs and/or NFs that the HHS Secretary determines to be appropriate. **Section 122113** would appropriate $325 million from the Treasury for FY2022, to remain available until September 30, 2031, for general surveying of SNFs and/or NFs and for the HHS Secretary to implement the activities required by the provision.
Nurse Staffing Requirements	There are no required staffing ratios (i.e., number of staff to residents) for SNFs.	**Section 30720** would require the HHS Secretary to conduct a study on the appropriateness of establishing minimum staff-to-resident ratios for SNFs and to submit a report to Congress no later than three years after the date of enactment and no less frequently than every five years thereafter. For the first report and subsequent reports, the section would require the HHS Secretary to include recommendations on minimum staffing levels for specified professionals. It would require the HHS Secretary to specify through regulation, no later than one year after each report is submitted to Congress, the appropriate minimum staffing ratios that are consistent with the recommendations made in each submitted report. **Section 30720** would set criteria that would allow the Secretary to waive staffing ratio requirements for certain SNFs located in rural areas. For purposes of carrying out the activities required by **Section 30720**, $50 million would be appropriated from the Treasury for FY2022, to remain available through FY2031.	**Section 122114** is identical to the House provision with two exceptions: • The HHS Secretary would not be required to specify minimum staffing ratios through regulation. • For purposes of carrying out the activities required by **Section 122114**, $50 million would be appropriated from the Treasury for FY2022, to remain available until September 30, 2031.

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
Improvements to the Special Focus Facility Program	The HHS Secretary is required to conduct a special focus facility (SFF) Program, which provides additional oversight to the SNFs and/or NFs that the HHS Secretary has identified as having "substantially failed" to meet the requirements for participating in the Medicare and/or Medicaid program. As currently conducted, the SFF Program has 88 "slots" for SNFs and/or NFs, out of the over 15,000 facilities.	No provision.	**Section 122116** would appropriate $100 million from the Treasury for FY2022, to remain available until September 30, 2026, to expand the SFF Program and conduct on-site consultation and educational programming for SNFs and/or NFs in the SFF Program. **Section 122116** would require, for a period of not less than three years beginning no later than October 1, 2023, that the number of SFF Program participants equal at least 3.5% of all federally certified nursing homes. **Section 122116** would establish, for a period of not less than two years beginning no later than October 1, 2024, mandatory on-site consultation and educational programming for SFF Program participants that would be carried out by quality-improvement organizations or other independent organizations of similar type that are deemed appropriate by the HHS Secretary and have no conflicts of interest.

Grants to Improve Staffing and Infection Control In Long-Term Care Institutional Settings	No current law.	No provision.	**Section 122117** would establish grants for states to carry out at least two of the following three activities in eligible LTCFs: • Provide wage or benefit enhancements for one or more types of eligible workers who care for individuals in LTCFs • Improve and develop training and career development opportunities, including opportunities for training for infection control, for eligible workers who care for individuals in LTCFs; • Expand staffing of one or more types of eligible workers who care for individuals in LTCFs to increase the staffing ratio of workers to individuals. For the aforementioned activities: SNFs, NFs, and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs) would be considered eligible LTCFs; Medicaid recipients and all residents of LTCFs would be considered eligible individuals; RNs, licensed practical nurses, licensed nursing assistants, certified nursing assistants, nursing assistants, infection preventionists, and any other relevant staffers (as determined by the CMS Administrator) who furnish services to individuals in LTCFs, for which payment is available under the state Medicaid program, would be considered eligible workers. Beginning with FY2024, the provision would require the HHS Secretary, acting through the CMS Administrator, to solicit and make four-FY-term grants to each state (including DC and U.S. territories) that submits an application that meets specified requirements. To use grant funds,

Provision	Current Law	H.R. 5376 as Passed by the House	Senate-Released Language
			states would be required to carry out grant-funded activities in ICF/IIDs and in SNFs or NFs. Additionally, states would be prohibited from using grant funds for the nonfederal share of state expenditures under the state Medicaid program. Each state also must agree to continue state spending using nonfederal funds on grant-supported activities at amounts no less than the state previously spent on such activities during a specified four-quarter period that occurred before the enactment of the section. **Section 122117** would appropriate $800 million to the HHS Secretary for FY2022, to remain available through September 30, 2031, for making staffing and infection control improvement grants. The provision would require the CMS Administrator, in determining the amounts awarded to states, to consider the number of individuals in the state and the proposed improvements to staffing and infection control. **Section 122117** would appropriate $3 million to the HHS Secretary for FY2022, to remain available through September 30, 2031, for administrative and technical assistance costs in carrying out this section.

Sources: CRS analysis of the BBBA as passed by the House and included in the *Congressional Record*, the language released by the Senate Finance Committee described as being intended for the BBBA, and relevant current law. (The Senate HELP Committee language did not include provisions relevant to this table.) See report introduction for links to legislative language.

Notes: This table includes provisions that affect the Medicaid and Medicare programs with respect to HCBS and LCTFs. Also see **Table 4** and **Table 6** for provisions generally relevant to Medicaid and Medicare, respectively. See **Appendix A** for all abbreviations used in table.

a. For purposes of this report, *Medicaid MFP* refers to the Money Follows the Person Program, which is distinct from references to *MFP* or *MFPs* (maximum fair prices), in regard to prescription drug pricing, in **Table 3**.

Appendix A. Abbreviations Used in This Report

Table A-1. Abbreviations Used in This Report

Abbreviation	Definition
ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ACIP	Advisory Committee on Immunization Practices
AIR	All-Inclusive Rate
AMP	Average Manufacturer Price
APTC	Advance Premium Tax Credit
ARPA	American Rescue Plan Act of 2021 (P.L. 117-2)
ASP	Average Sales Price
AV	Actuarial Value
BBA 2018	Bipartisan Budget Act of 2018 (P.L. 115-72)
BHP	Basic Health Program
CAA 2021	Consolidated Appropriations Act, 2021 (P.L. 116-260)
CCBHC	Certified Community Behavioral Health Clinic
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act (P.L. 111-3)
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
CoPs	Conditions of Participation
COVID-19	Coronavirus Disease 2019
CPI-U	Consumer Price Index For All Urban Consumers
CSR	Cost-Sharing Reduction
CY	Calendar Year
DC	District of Columbia
DSH	Disproportionate Share Hospital
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHB	Essential Health Benefits
ERISA	Employee Retirement Income Security Act of 1974 (P.L. 93-406)
ESRP	Employer Shared Responsibility Provisions
FDA	Food and Drug Administration
FFCRA	Families First Coronavirus Response Act (P.L. 116-127)
FFE	Federally Facilitated Exchange
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level

Abbreviation	Definition
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FY	Fiscal Year
GME	Graduate Medical Education
HCBS	Home and Community-Based Services
HCTC	Health Coverage Tax Credit
HELP	Health, Education, Labor, and Pensions
HHS	Department of Health and Human Services
HPSA	Health Professional Shortage Area
IAH	Independence at Home Program
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IHS	Indian Health Service
IME	Indirect Medical Education
IRC	*Internal Revenue Code*
LIS	Low-Income Subsidy (for individuals who meet set income and asset tests)
LTCF	Long-Term Care Facility
LTSS	Long Term Services and Supports
MAGI	Modified Adjusted Gross Income
MA-PD	Medicare Advantage Prescription Drug Plan
MDS	Minimum Data Set
MEC	Minimum Essential Coverage
Medicaid MFP	Money Follows the Person
MFP	Maximum Fair Price
MH	Mental Health
MHP	Mental Health Parity
MOE	Maintenance of Effort
NADAC	National Average Drug Acquisition Cost
NF	Nursing Facility
OEP	Open Enrollment Period
OIG	Office of Inspector General
PBJ	Payroll-Based Journal
PBM	Pharmacy Benefit Manager
PHSA	Public Health Service Act (P.L. 78-410)
PPS	Prospective Payment System
PTC	Premium Tax Credit
PY	Plan Year
QHP	Qualified Health Plan

Abbreviation	Definition
RCP	Retail Community Pharmacy
RHC	Rural Health Clinic
RN	Registered Nurse
SA	State Survey Agency
SEP	Special Enrollment Period
SFF	Special Focus Facility
SNF	Skilled Nursing Facility
SSA	Social Security Act
SUD	Substance Use Disorder
SUPPORT Act	Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)
TY	Tax Year
U.S.C.	U.S. Code
UC	Unemployment Compensation
UIO	Urban Indian Organization
USVI	U.S. Virgin Islands
VBP	Value-Based Purchasing

Source: CRS analysis.

Appendix B. Build Back Better Act Health Coverage Provisions: CRS Experts

See author contact information at the end of this report.

Table B-1. Build Back Better Act Health Coverage Provisions: CRS Experts

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title II, Subtitle B, Section 21005	Civil Monetary Penalties for Parity Violations	**Table 1**	Vanessa Forsberg
Title II, Subtitle H, Section 27001	Requirements with Respect to Cost Sharing for Certain Insulin Products	**Table 3**	Katherine Kehres
Title II, Subtitle H, Section 27002	Oversight of Pharmacy Benefit Manager Services	**Table 3**	Vanessa Forsberg
Title III, Subtitle E, Section 30601	Ensuring Affordability of Coverage for Certain Low-Income Populations	**Table 1**	See sub-rows below.
Title III, Subtitle E, Section 30601(a)	Reducing Cost Sharing Under Qualified Health Plans	**Table 1**	Bernadette Fernandez
Title III, Subtitle E, Section 30601(b)	Open Enrollments Applicable to Certain Lower-Income Populations	**Table 1**	Vanessa Forsberg
Title III, Subtitle E, Section 30601(c)	Additional Benefits for Certain Low-Income Individuals for Plan Years 2024 and 2025	**Table 1**	Vanessa Forsberg
Title III, Subtitle E, Section 30601(d)	Education and Outreach Activities	**Table 1**	Vanessa Forsberg
Title III, Subtitle E, Section 30601(e)	Funding	**Table 1**	Vanessa Forsberg
Title III, Subtitle E, Section 30602	Establishing a Health Insurance Affordability Fund	**Table 1**	See sub-rows below.
Title III, Subtitle E, Section 30602(a)	In General	**Table 1**	Ryan Rosso
Title III, Subtitle E, Section 30602(b)	Basic Health Program Funding Adjustments	**Table 1**	Ryan Rosso and Alison Mitchell
Title III, Subtitle E, Section 30602(c)	Implementation Authority	**Table 1**	Ryan Rosso
Title III, Subtitle E, Section 30603	Funding for the Provision of Health Insurance Consumer Information	**Table 1**	Vanessa Forsberg

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title III, Subtitle E, Section 30604	Requirements with Respect to Cost Sharing for Insulin Products	**Table 3**	Katherine Kehres
Title III, Subtitle E, Section 30605	Cost-Sharing Reductions for Individuals Receiving Unemployment Compensation	**Table 1**	Bernadette Fernandez
Title III, Subtitle E, Section 30606	Oversight of Pharmacy Benefit Manager Services	**Table 3**	Katherine Kehres
Title III, Subtitle E, Section 30607	Funding to Support State Applications for Section 1332 Waivers and Administration	**Table 1**	Ryan Rosso
Title III, Subtitle E, Section 30608	Adjustments to Uncompensated Care Pools and Disproportionate Share Hospital Payments	**Table 4**	Alison Mitchell
Title III, Subtitle E, Section 30609	Further Increase in FMAP for Medical Assistance for Newly Eligible Mandatory Individuals	**Table 4**	Alison Mitchell
Title III, Subtitle F, Section 30711	Medicaid HCBS Improvement Planning Grants	**Table 7**	Kirsten Colello
Title III, Subtitle F, Section 30712	Medicaid HCBS Improvement Program	**Table 7**	Kirsten Colello and Alison Mitchell
Title III, Subtitle F, Section 30713	Funding for Federal Activities Related to Medicaid HCBS	**Table 7**	Kirsten Colello
Title III, Subtitle F, Section 30714	Funding for HCBS Quality Measurement and Improvement	**Table 7**	Amanda Sarata and Alison Mitchell
Title III, Subtitle F, Section 30715	Permanent Extension of Medicaid Protections Against Spousal Impoverishment for Recipients of Home and Community-Based Services	**Table 7**	Kirsten Colello
Title III, Subtitle F, Section 30716	Permanent Extension of Medicaid Money Follows the Person Rebalancing Demonstration	**Table 7**	Kirsten Colello
Title III, Subtitle F, Section 30717	Funding to Improve the Accuracy and Reliability of Certain Skilled Nursing Facility Data	**Table 7**	Phoenix Voorhies

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title III, Subtitle F, Section 30718	Ensuring Accurate Information on Cost Reports	**Table 7**	Phoenix Voorhies
Title III, Subtitle F, Section 30719	Survey Improvements	**Table 7**	Phoenix Voorhies
Title III, Subtitle F, Section 30720	Nurse Staffing Requirements	**Table 7**	Phoenix Voorhies
Title III, Subtitle F, Section 30721	Extending Continuous Coverage for Pregnant and Postpartum Individuals	**Table 4**	Evelyne Baumrucker
Title III, Subtitle F, Section 30722	State Option to Provide Coordinated Care Through a Maternal Health Home for Pregnant and Postpartum Individuals	**Table 4**	Evelyne Baumrucker
Title III, Subtitle F, Section 30731	Increasing Medicaid Cap Amounts and the FMAP for the Territories	**Table 4**	Alison Mitchell
Title III, Subtitle F, Section 30741	Investments to Ensure Continued Access to Health Care for Children and Other Individuals	**Table 4**	See sub-rows below.
Title III, Subtitle F, Section 30741(a)	Providing for One Year of Continuous Eligibility for Children	**Table 4**	Evelyne Baumrucker
Title III, Subtitle F, Section 30741(b)	Revisions to Temporary Increase of Medicaid FMAP Under the Families First Coronavirus Response Act	**Table 4**	Alison Mitchell and Evelyne Baumrucker
Title III, Subtitle F, Section 30741(c)	Medical Assistance Under Medicaid for Inmates During 30-Day Period Preceding Release	**Table 4**	Evelyne Baumrucker
Title III, Subtitle F, Section 30741(d)	Extension of Certain Provisions	**Table 4**	Evelyne Baumrucker
Title III, Subtitle F, Section 30741(e)	Expansion of Community Mental Health Services Demonstration Program	**Table 4**	Alison Mitchell
Title III, Subtitle F, Section 30741(f)	Making Permanent a State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services	**Table 4**	Alison Mitchell

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title III, Subtitle F, Section 30741(g)	Extension of 100% FMAP for Urban Indian Health Organizations and Native Hawaiian Health Care Systems	**Table 4**	Alison Mitchell and Elayne Heisler
Title III, Subtitle F, Section 30741(h)	Ensuring Accurate Payments to Pharmacies Under Medicaid	**Table 4**	Cliff Binder
Title III, Subtitle F, Section 30741(i)	Funding for Implementation And Administration	**Table 4**	Alison Mitchell
Title III, Subtitle F, Section 30751	Encouraging Continued Access After the End of the Public Health Emergency	**Table 4**	Evelyne Baumrucker and Alison Mitchell
Title III, Subtitle G, Section 30801	Investments to Strengthen CHIP	**Table 5**	See sub-rows below.
Title III, Subtitle G, Section 30801(a)	Permanent Extension of Children's Health Insurance Program	**Table 5**	Alison Mitchell
Title III, Subtitle G, Section 30801(b)(1)	Pediatric Quality Measures Program	**Table 5**	Amanda Sarata
Title III, Subtitle G, Section 30801(b)(2)	Assurance of Eligibility Standards for Children	**Table 5**	Evelyne Baumrucker
Title III, Subtitle G, Section 30801(b)(3)	Qualifying States Option	**Table 5**	Alison Mitchell
Title III, Subtitle G, Section 30801(b)(4)	Outreach and Enrollment Program	**Table 5**	Evelyne Baumrucker
Title III, Subtitle G, Section 30801(b)(5)	Child Enrollment Contingency Fund	**Table 5**	Alison Mitchell
Title III, Subtitle G, Section 30801(c)	CHIP Drug Rebates	**Table 5**	Cliff Binder
Title III, Subtitle G, Section 30801(d)	State Option to Expand Children's Eligibility for Medicaid and CHIP	**Table 5**	Evelyne Baumrucker
Title III, Subtitle G, Section 30801(e)	Funding for Implementation and Administration	**Table 5**	Alison Mitchell
Title III, Subtitle H, Section 30901	Providing Coverage for Hearing Care Under the Medicare Program	**Table 6**	Paulette Morgan and Jim Hahn
Title XIII, Subtitle B, Section 132000	Registered Professional Nurses	**Table 6**	Phoenix Voorhies
Title XIII, Subtitle B, Section 132001	Permanent Extension of the Independence at Home Medical Practice Demonstration Program	**Table 6**	Jim Hahn

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title XIII, Subtitle G, Section 137301	Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137302	Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137303	Treatment of Lump-Sum Social Security Benefits in Determining Household Income	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137304	Temporary Expansion of Health Insurance Premium Tax Credits for Certain Low-Income Populations	**Table 2**	Bernadette Fernandez and Ryan Rosso
Title XIII, Subtitle G, Section 137305	Special Rule for Individuals Receiving Unemployment Compensation	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137306	Permanent Credit for Health Insurance Costs	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137307	Exclusion of Certain Dependent Income for Purposes of Premium Tax Credit	**Table 2**	Bernadette Fernandez
Title XIII, Subtitle G, Section 137308	Requirements with Respect to Cost Sharing for Certain Insulin Products	**Table 3**	Katherine Kehres
Title XIII, Subtitle G, Section 137309	Oversight of Pharmacy Benefit Manager Services	**Table 3**	Katherine Kehres
Title XIII, Subtitle G, Section 137401	Administrative Funding of the Rural and Underserved Pathway to Practice Training Programs for Post-Baccalaureate Students, Medical Students, and Medical Residents	**Table 6**	Marco Villagrana
Title XIII, Subtitle G, Section 137402	Establishing Rural and Underserved Pathway to Practice Training Program for Post-Baccalaureate Students and Medical Students	**Table 6**	Elayne Heisler

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title XIII, Subtitle G, Section 137403	Funding for the Rural and Underserved Pathway to Practice Training Program for Post-Baccalaureate Students and Medical Students	**Table 6**	Margot Crandall-Hollick
Title XIII, Subtitle G, Section 137404	Establishing Rural and Underserved Pathway to Practice Training Program for Medical Residents	**Table 6**	Marco Villagrana
Title XIII, Subtitle G, Section 137405	Distribution of Additional Residency Positions	**Table 6**	Marco Villagrana
Title XIII, Subtitle I, Section 139001	Providing for Lower Prices for Certain High-Priced Single-Source Drugs	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139002	Selected Drug Manufacturer Excise Tax Imposed During Noncompliance Periods	**Table 3**	Suzanne Kirchhoff and Edward Liu
Title XIII, Subtitle I, Section 139003	Funding	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139101	Medicare Part B Rebate by Manufacturers	**Table 3**	Cliff Binder
Title XIII, Subtitle I, Section 139102	Medicare Part D Rebate by Manufacturers	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139201	Medicare Part D Benefit Redesign	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139202	Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans and MA-PD Plans	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139301	Prohibiting Implementation of Rule Relating to Eliminating the Anti-Kickback Statute Safe Harbor Protection for Prescription Drug Rebates	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139401	Appropriate Cost Sharing for Certain Insulin Products Under Medicare Part D	**Table 3**	Suzanne Kirchhoff
Title XIII, Subtitle I, Section 139402	Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D	**Table 3**	Suzanne Kirchhoff

H.R. 5376 Section Number	H.R. 5376 Section Title	Table in this Report	CRS Contact(s)
Title XIII, Subtitle I, Section 139403	Payment for Biosimilar Biological Products During Initial Period	**Table 3**	Cliff Binder
Title XIII, Subtitle I, Section 139404	Temporary Increase in Medicare Part B Payment for Certain Biosimilar Biological Products	**Table 3**	Cliff Binder
Title XIII, Subtitle I, Section 139405	Improving Access to Adult Vaccines Under Medicaid and CHIP	**Table 3**	Evelyne Baumrucker
Senate-Released BBBA Provisions Not Included in H.R. 5376			
Title XII, Subtitle B, Section 122116	Improvements to the Special Focus Facility Program	**Table 7**	Phoenix Voorhies
Title XII, Subtitle B, Section 122117	Grants to Improve Staffing and Infection Control in Long-Term Care Institutional Settings	**Table 7**	Phoenix Voorhies

Source: Created by CRS.

Notes: For purposes of this table, the Build Back Better Act (BBBA) refers to the H.R. 5376, as passed by the House, and the language released by the Senate Finance Committee and the Senate Committee on Health, Education, Labor, and Pensions described as being intended for the BBBA.

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