POPULATION HEALTH ALLIANCE

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Build Back Better Act
Key Healthcare Provisions

The current framework of the Build Back Better Act contains some significant provisions relating to healthcare. These are all the subject of ongoing negotiations, but the narrative below covers some of the significant policy changes that are understood to be included as of November 15, 2021.

ACA Marketplace Subsidies: The BBBA expands who is eligible for Affordable Care Act (ACA) premium tax credits (PTCs) and makes those PTCs more generous. This provision would increase the number of insured individuals by 2.2 million in 2022, increasing to 3.9 million in 2025 relative to current law, and would cost $272 billion over those four years. The coverage provisions would need to be reauthorized in 2026.

Enhanced Individual Market Premium Tax Credits: Under the ACA, an individual or family's PTC for individual market insurance coverage is adjusted based on their household income and the cost of the second-lowest cost Silver plan in their rating area. The BBBA proposal would extend these policies three years, through 2025. The American Rescue Plan Act (ARP) changed these percentages to increase the size of the premium subsidy for 2021 and 2022. The BBBA proposal would extend these policies three years, through 2025.

Medicare Part D Benefit Redesign: Currently, under the Medicare Part D program, which covers retail prescription drugs, Medicare contracts with private plan sponsors to provide a prescription drug benefit. The law that established the Part D benefit includes a provision known as the "noninterference" clause, which stipulates that the HHS Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP [prescription drug plan] sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." This is the subject of heated negotiations between drug manufacturers, PDPs, and Congress. The following is a summary of provisions believed to be on the table as of this writing:

> **Negotiation:** Beginning in 2025, the Secretary of HHS would be authorized to "negotiate" the prices of up to 10 "negotiation-eligible drugs." In 2026 and 2027, the cap increases to 15 drugs annually, and rises to 20 drugs in 2028 and beyond. Part B drugs would be exempt until 2027. All insulin products would be able to be negotiated in addition to the stated yearly caps. The BBBA would set a ceiling for negotiated price of between 40-75 percent of the non-federal average manufacturer price (AMP), scaling down depending on how far the drug is past its initial exclusivity period. The BBBA would also aim to prevent drug manufacturers from increasing their prices faster than the rate of inflation.

880 M Street, SE ■ Suite #100 ■ Washington, DC 20003
tel: (202) 737-5476 ■ staff@populationhealthalliance.orgn ■ www.populationhealthalliance.org ■ @PHAVoice

Limited Cost Sharing for Insulin: Under Medicare Part D, the BBBA would limit cost-sharing for insulin to $35 per month. Starting in 2023, health insurers offering group or individual health insurance coverage would be required to provide coverage for at least one of each insulin dosage form of each type of insulin. Plans would be required to limit patient costs for insulin to no more than either $35 for a 30-day supply, or an amount equal to 25 percent of the negotiated price of the insulin product for a 30-day supply—net all price concessions—whichever is lower. Beginning in 2024, this would realign PDP plan and manufacturer incentives to constrain drug prices and to limit beneficiaries' OOP costs.

Out of Pocket (OOP) Cost Reductions: The BBBA amends the design of the Part D benefit by adding a hard cap on out-of-pocket spending, set at $2,000 in 2024, and increasing each year based on the rate of increase in per capita Part D costs. Under the BBBA, brand-name and biosimilar drug manufacturers would become liable for 10 percent of costs in the initial coverage phase and 20 percent in the catastrophic phase. Government reinsurance would fall to 20 percent for brand-name drugs and biosimilars and to 40 percent for generic drugs. Insurer liability in the catastrophic phase would increase to 60 percent for all drugs. The catastrophic phase would cap beneficiary costs at $2,000 in OOP costs. The BBBA would allow for beneficiaries' OOP costs to be "smoothed" over the course of the year, rather than potentially having to pay as much as $2,000 in a single month. The BBBA would reduce beneficiaries' coinsurance liability to 23 percent in the initial coverage phase (from 25 percent currently) and their premium liability to 23.5 percent (from 25.5 percent currently). Consequently, the federal premium subsidy rate would rise to 76.5 percent (from 74.5 percent) and insurer liability in the initial coverage phase will be 77 percent for generic drugs and 67 percent for brand-names and biosimilars.

Permanent Repeal of the Trump Part D Rebate Rule: The BBBA permanently repeals a controversial Medicare Part D rebate rule (the "Part D Rebate Rule") until 2026. This Trump-era regulation, originally set to go into effect in 2022, eliminates the safe harbor for Part D rebates and replaces it with a far narrower safe harbor for point-of-sale discounts which are designed to directly benefit patients with high out-of-pocket costs. in January 2021, the Biden Administration successfully sought to delay the Part D Rebate Rule from taking effect until 2023 via a court order. The Infrastructure Bill further delays it for an additional three years.

Medicaid Coverage Gap: The BBBA would provide $10 billion in annual reinsurance funding to the 50 states and the District of Columbia to be used either to establish a state reinsurance program or to provide financial assistance to reduce out-of-pocket (OOP) costs. States would be automatically approved for funds unless the Department of Health and Human Services (HHS) otherwise intervenes, and approval would last for five years unless revoked by HHS for unapproved use. If a state does not apply, HHS would operate a reinsurance program in the state. Non-Medicaid expansion states would not be able to apply for this funding, but HHS would operate reinsurance programs during those plan years.

Maternal Care and Postpartum Coverage and Care: The BBBA would require states to extend Medicaid postpartum coverage from 60 days to 12 months, ensuring continuity of Medicaid coverage for postpartum individuals in all states. The BBBA would also provide federal grants to bolster other aspects of maternal health care. The funds would be used to address a wide range of

issues, such as addressing social determinants of maternal health, diversifying the perinatal nursing workforce, expanding care for maternal mental health and substance use, and supporting research and programs that promote maternal health equity.

Continuous Coverage for Children in Medicaid / CHIP: The BBBA would require states to extend 12-month continuous coverage for children on Medicaid and CHIP. Under current law, states have the option to provide 12-months of continuous coverage for children. Under this option, states allow a child to remain enrolled for a full year unless the child ages out of coverage, moves out of state, voluntarily withdraws, or does not make premium payments. As such, 12-month continuous eligibility eliminates coverage gaps due to fluctuations in income over the course of the year.

Permanent Extension of the Children's Health Insurance Program (CHIP): The BBBA would permanently extend the CHIP program. Currently, Medicaid is the base of coverage for low-income children. CHIP complements Medicaid by covering uninsured children in families with incomes above Medicaid eligibility levels. Unlike Medicaid, federal funding for CHIP is capped and provided as annual allotments to states. CHIP funding is authorized through September 30, 2027. While CHIP generally has bipartisan support, during the last reauthorization effort funding lapsed before Congress reauthorized funding.

Medicaid Home and Community Based Services and the Direct Care Workforce: The BBBA would make the Money Follows the Person (MFP) program and the ACA HCBS spousal impoverishment protections permanent. Medicaid is currently the primary payer for long-term services and supports (LTSS), including home and community-based services (HCBS), that help seniors and people with disabilities with daily self-care and independent living needs. There is currently a great deal of state variation as most HCBS eligibility pathways and benefits are optional for states. Sections 30711-30715 of the BBBA would create the HCBS Improvement Program, which would provide a permanent 7 percentage point increase in federal Medicaid matching funds for HCBS. To qualify for the enhanced funds, states would have to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan to expand HCBS access, strengthen the direct care workforce, and monitor HCBS quality. The bill includes some provisions to support family caregivers. In addition, the Act would include funding ($130 million) for state planning grants and enhanced funding for administrative costs for certain activities (80% instead of 50%).

Paid Family and Medical Leave? This provision was removed from the latest version of the BBBA but it is still the subject of negations. The original framework of the BBBA would guarantee 12 weeks per year of paid family and medical leave annually to all workers in the U.S. who need time off work to welcome a new child, recover from a serious illness, care for a seriously ill family member, or for certain military-related reasons. Also included is three days of paid bereavement leave. The progressive benefits formula means that that the amount of pay replaced while on qualified leave is higher for workers with lower wages, with 85% wage replacement for individuals earning about $15,080/year. While all workers taking qualified leave would be eligible for at least some wage replacement, earnings above $250,000/year are not included in the benefit formula.