

# Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

April 27, 2021

## Reconciliation Rhapsody: Opportunities for Health Reform

As spring flowers bloom, stimulus checks are spent, and vaccines find their way into arms, people are understandably eager to get outside and walk off their quarantine 15. However, while congressional leaders might yearn to stroll among Washington D.C.'s own [blossoms](#), much of their attention must be focused on negotiating and crafting the next piece of legislation aimed at helping the nation recover from the pandemic.

On March 11, President Biden signed into law the [American Rescue Plan Act](#), passed by a slim congressional majority using the budget reconciliation process. Much [attention](#) has been paid to this special legislative process. In a nutshell, budget reconciliation allows congressional leaders to bypass minority votes stalling progress by filibuster and pass legislation with a simple majority. However, this process comes with important limits: *budget* reconciliation is only meant to affect the budget; reconciliation bills can functionally only change tax provisions and spending on government programs.

Further, under a special procedure known as the Byrd rule, Senators can block parts of the bill that have budget impacts considered to be “merely incidental” to the provision in question. In practice, this means that attempts to pass broad policy reform without significant budget impact will be swiftly derailed and removed from the bill. Despite these obstacles, congressional leaders have already been able to achieve some of the most [significant expansions](#) to health care programs since the Affordable Care Act (ACA) within this framework.

How often Congress can pass a reconciliation bill is up for debate due to a [recent ruling](#) from the Senate’s rule-keeper. At a minimum, we can expect at [least](#) one more package to be passed using the reconciliation process before the end of the year. Health care advocates are understandably eager to shape the contours of this next bill. While the exact content is still being debated, all signs point to the bill being focused broadly on improving the nation’s infrastructure. Whether or not this will include health care provisions is yet to be hammered out, with some favoring a [narrower definition](#) of infrastructure that does not include health care.

Given the political situation and the rules surrounding budget reconciliation, what types of health care reform could survive to become law in this next round? While the full calculus is too expansive to cover here, below are a few areas that are both promising candidates for reconciliation and potentially viable in Congress.

## Filling the Medicaid Gap

Recent years have seen an acceleration in the [trend](#) toward nationwide Medicaid expansion. The American Rescue Plan Act moves another step in the right direction to fill the gap in coverage left by the remaining [12 holdout states](#) that continue to refuse to expand their Medicaid programs. In these states, [4 million](#) individuals fall into the [coverage gap](#) where their incomes are too high for Medicaid coverage, but too little to meet the Affordable Care Act's threshold for coverage subsidies. The American Rescue Plan Act temporarily increases federal funding to a state's base Medicaid program by 5% for after they choose to expand, with 90% of the cost of the expansion group still covered by the federal government. This generous financial incentive encourages non-expansion states to expand their programs; if all 12 states expanded, they would collectively reap [\\$16.4](#) billion in federal funding over two years that was previously unavailable to them.

While this new opportunity has [changed](#) the conversation in some states, and even picked up enough steam for the beginnings of a [ballot initiative](#) in Mississippi, others remain unfortunately steadfast in their [opposition](#) to expansion. In the next reconciliation bill, Congress could think creatively to fill the holes left in coverage by these patchwork decisions. Many options available under the Byrd Rule fit the bill with varying degrees of political, economic, and practical effects.

One option would simply be to cover these individuals through a [public option](#), something President Biden proposed during his campaign. This would present both technical and political [challenges](#) under the current framework, putting its future in doubt. Congress could also choose to fully fund the cost of the Medicaid expansion population for three years as was the case when the ACA was first implemented in 2014. However, some might argue that while this would benefit many low-income individuals who currently lack health insurance, it would disadvantage states that already opted into Medicaid expansion. Their Medicaid expansion would be effectively punished, as the same deal would not be available to them. A third option thinks outside the Medicaid box. Congress could turn to the private insurance marketplaces created by the ACA and temporarily allow those with incomes below 100% of the federal poverty level to receive subsidized coverage if their state refuses to extend Medicaid coverage to them. While this too would get people covered, it would likely be much more expensive and less cost-effective than serving these individuals through Medicaid, as private coverage often costs more money for fewer services than Medicaid offers.

Whatever they choose, it is imperative that Congress find a way to ensure that everyone can access coverage regardless of their state's decision on Medicaid expansion. A robust body of research continues to demonstrate how expanding coverage [reduces](#) racial and ethnic disparities in coverage and [improves](#) overall access and affordability of care.

## Addressing Health Care Discrimination and Disparities

Both President Biden and congressional leaders have signaled that rooting out discrimination and addressing disparities in health care are key priorities for their agendas. Legislation that expressly targets discrimination may be particularly vulnerable to the Byrd rule's "merely incidental" test. The weaker the link between a provision's non-budgetary components and its fiscal effects, the less likely the provision is to pass the Byrd rule's test. As a result, wide-reaching anti-discrimination provisions whose budgetary effects largely depend on private entities, such as the [Equality Act's](#) extension of sex-based antidiscrimination protections to public accommodations, could run afoul of the Byrd rule. Grant-based legislation, however, operate through direct budgetary mechanisms and are therefore less likely to be deemed "incidental." This makes grant-based proposals good candidates for budget reconciliation.

One issue ripe for grant-based health care proposals in the antidiscrimination and racial equity space is the maternal health crisis. The United States has the [highest](#) maternal mortality rate in the developed world, and that rate has been increasing since 2000. Racial minorities are particularly affected: Black, American Indian, and Alaska Native mothers die from pregnancy-related causes at about [three times](#) the rate of their White counterparts. These disparities stem from multiple factors: Increased

prevalence of chronic diseases, systemic inequality in access to care, and implicit bias in medicine. More broadly, structural racism in the distribution of social determinants of health -- such as housing and education -- exerts a [cumulative](#) negative effect on the physical and mental health of mothers of color.

To address this crisis, advocates and policymakers have crafted the Black Maternal Health Momnibus [Act](#) of 2021, a comprehensive package of bills intended to address the drivers of the maternal health crisis and combat racial disparities in outcomes. The Act builds off of [research](#) suggesting that community-based perinatal care models improve maternal health outcomes, while also lowering health care costs. It would establish a [plethora](#) of grant programs, including: (1) funding to health departments addressing the social determinants of health for pregnant and postpartum women; (2) investments in community-based organizations working to promote equity; and (3) funding to programs supporting the growth and diversification of the perinatal workforce.

Congress can fund these programs through a number of mechanisms. The annual appropriations process is one option that policymakers appear to be considering; last month the House Appropriations Committee held a subcommittee [hearing](#) on the subject of the maternal health crisis. Alternatively, Congress can establish grant programs through budget reconciliation. Although budget reconciliation is limited to mandatory spending, Congress can easily restructure a discretionary spending bill - - such as the appropriations proposals recently discussed in the House -- to satisfy the requirements of budget reconciliation. But even if Congress does choose to pursue the appropriations route for maternal health, many more equity-driven programs could feasibly receive grant funding through budget reconciliation, such as community-and hospital-based strategies to combat [violence](#) from a public health perspective or an expansion of the oral health infrastructure and [workforce](#).

## Prescription Drug Pricing and Access

Prescription drug pricing, and drug access more generally, have been the subject of heightened concern during the COVID-19 pandemic. The clear need for a national vaccine program has made its implementation a priority for lawmakers utilizing the budget reconciliation process. Even prior to the pandemic, advocates on both sides of the political aisle have called for legislation that would expand access to prescription drugs, including by reducing prescription drug prices. Notably, there is bipartisan agreement that prescription drugs cost too much: [Two-thirds of Americans](#) believe that the Biden administration should highly prioritize lowering drug costs.

The American Rescue Plan Act allocated funds to the Department of Health and Human Services (HHS) to evaluate, promote, administer, and monitor COVID-19 vaccines, therapeutics, and diagnostics. The bill also requires mandatory coverage of COVID-19 vaccines and treatment in Medicaid. Aside from these COVID-19-specific measures, however, the reconciliation bill failed to address the significant barriers to prescription drug access that two-thirds of Americans agree should be highly prioritized.

For the next reconciliation bill, lawmakers are considering a provision proposed previously in [H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act](#) and re-introduced [last week](#), that would require HHS to negotiate prices for certain drugs covered under the Medicare prescription drug benefit. To satisfy the Byrd Rule for inclusion in the reconciliation package, lawmakers will need to show that the provision is primarily budget-focused legislation that would not increase the federal budget deficit.

Allowing Medicare drug negotiation proposal in H.R. 3 may satisfy the Byrd Rule if specific tools are provided to ensure that negotiations would have a substantial budgetary impact. In 2019, the Congressional Budget Office (CBO) found that negotiating drug prices alone, without a source of pressure on drug manufacturers to secure price concessions, would have only a [negligible effect on federal savings](#). However, savings would increase significantly with the implementation of [fallback](#) drug plans, minimum discounts or rebates, preferred drug lists, or other formulary requirements. For example, the CBO found that a provision requiring the HHS secretary to negotiate prices for certain drugs so that they do not exceed 120 percent of the average price from selected countries would [save \\$448 billion for Medicare](#)—a clear budgetary impact. Notably, such a budgetary

impact would not only enable the Medicare drug negotiation proposal itself to be included in the next reconciliation bill, but would also allow for resulting savings to be allocated to other provisions or entitlement programs.

The new drug pricing [bill](#) also includes a provision mandating that the drug prices negotiated for Medicare be made available to purchasers in the private insurance marketplaces. Expanding the reach of the negotiation provisions beyond governmental expenditures and federal payers would raise a more difficult Byrd Rule question. On the one hand, the federal budgetary effects of the provision affecting private marketplace prices would be less direct. On the other hand, the interaction of Medicare and the private insurance marketplace (e.g., through ACA subsidies of private insurance premium prices) are linked enough to find the requisite budgetary impact. Moreover, [the CBO's analysis of H.R. 3](#) took the private market provision into account in its finding of savings of almost half a trillion dollars, weighing in favor of the private market provision satisfying the Byrd Rule.

## What to Watch Going Forward

No significant federal policy has ever come into law without significant jockeying within the halls of Congress. The window on what is possible in the current constellation of federal lawmakers is already beginning to close. Budget reconciliation has come to define the boundaries of what can be done. Health care access must compete with a vast array of other areas of reform whose backers want to see them included in the reconciliation process. While nobody can say with certainty what will happen in the months to come, we can expect continued debate on what Congress will use the budget reconciliation to accomplish before the end of the year. Health care advocates should continue to educate their members of Congress about why health care is important to include in any package moving forward as the nation continues to recover.

## Subscribe to all Health Care in Motion Updates

*Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Clinical Fellow; Maryanne Tomazic, Clinical Fellow; and Rachel Landauer, Clinical Fellow. This issue was also authored by Ray Lefco, Jessica Zhao, and Brian Brooks, students of the Health Law and Policy Clinic of Harvard Law School.*

For further questions or inquiries please contact us at [chlpi@law.harvard.edu](mailto:chlpi@law.harvard.edu).