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Health Care-Related Expiring Provisions of the 117th Congress, First Session

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SUMMARY

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Health Care-Related Expiring Provisions of the 117th Congress, First Session

This report describes selected health care-related provisions that are scheduled to expire during the first session of the 117th Congress (i.e., during calendar year [CY] 2021). For purposes of this report, *expiring provisions* are defined as portions of law that are time-limited and will lapse once a statutory deadline is reached, absent further legislative action. The expiring provisions included in this report are any identified provisions related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance programs and activities. The report also includes any identified expiring provisions among other health care-related provisions enacted or extended in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). In addition, this report describes health care-related provisions within the same scope that expired during the 116th Congress (i.e., during CY2019 or CY2020). Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant provision is included in this report.

This report focuses on two types of health care-related provisions within the scope discussed above. The first, and most common, type of provision provides or controls *mandatory spending*, meaning it provides temporary funding, temporary increases or decreases in funding (e.g., Medicare provider bonus payments), or temporary special protections that may result in changes in funding levels (e.g., Medicare funding provisions that establish a floor). The second type of provision defines *the authority of government agencies or other entities to act*, usually by authorizing a policy, project, or activity. Such provisions also may temporarily delay the implementation of a regulation, requirement, or deadline or establish a moratorium on a particular activity. Expiring health care provisions that are predominantly associated with discretionary spending activities—such as discretionary authorizations of appropriations and authorities for discretionary user fees—are excluded from this report.

Certain types of provisions with expiration dates that otherwise would meet the criteria set forth above are excluded from this report. Some of these provisions are excluded because they are transitional or routine in nature or because they have been superseded by congressional action that modifies their intent. For example, statutorily required Medicare payment rate reductions and payment rate rebasings that are implemented over a specified period are not considered to require legislative attention and are excluded from this report.

The report provides tables listing the relevant provisions scheduled to expire in CY2021 and those that expired in CY2020 or CY2019. The report then describes each listed provision and provides a legislative history of that provision. **Appendix A** includes relevant demonstration projects and pilot programs that are scheduled to expire during the first session of the 117th Congress or that expired in the 116th Congress. **Appendix B** provides new expiration dates for provisions and demonstration projects or pilot programs that were included in CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*, but are beyond the scope of this report.

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Overview

This report describes selected health care-related provisions that are scheduled to expire during the first session of the 117th Congress (i.e., during calendar year [CY] 2021). For purposes of this report, *expiring provisions* are defined as portions of law that are time-limited and will lapse once a statutory deadline is reached, absent further legislative action. The expiring provisions included in this report are any identified provisions related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance programs and activities. The report also includes any identified expiring provisions among other health care-related provisions enacted or extended in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10).[1] In addition, the report describes health care-related provisions within the same scope that expired during the 116th Congress (i.e., during CY2019 or CY2020). Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant provision is included in this report.

The two types of provisions discussed in this report generally are enacted in the context of *authorization laws* and thus typically are within the purview of congressional authorizing committees. The duration for which a provision is in effect usually is regarded as creating a timeline for legislative decisionmaking. In choosing this timeline, Congress navigates tradeoffs between the frequency of congressional review and the stability of funding or other legal requirements that pertain to the program.

- The first type of provision in this report provides or controls *mandatory spending*, meaning it provides temporary funding, temporary increases or decreases in funding (e.g., Medicare provider bonus payments), or temporary special protections that may result in changes in funding levels (e.g., Medicare funding provisions that establish a floor).[2]
- The second type of provision in this report defines *the authority of government agencies or other entities to act*, usually by authorizing a policy, project, or activity.[3] Such provisions also may temporarily delay the implementation of a regulation, requirement, or deadline, or they may establish a moratorium on a particular activity.

[1] This report is the latest in a series of reports in which the Congressional Research Services (CRS) has tracked health care-related expiring provisions related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance. CRS also has tracked a group of other health-related provisions that were enacted or extended in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), which have been periodically extended with Medicare, Medicaid, CHIP, and private health insurance provisions. Any applicable provisions within these categories are included in the CRS health care-related expiring provisions report for a given year.

[2] *Mandatory spending* is controlled by authorization acts; *discretionary spending* is controlled by appropriations acts. For further information, see CRS Report R44582, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*.

[3] For further information about these types of authorization provisions, see CRS Report R42098, *Authorization of Appropriations: Procedural and Legal Issues*.

Expiring health care provisions that are predominantly associated with discretionary spending activities—such as discretionary authorizations of appropriations and authorities for discretionary user fees—are excluded from this report.[4]

Certain types of provisions with expiration dates that otherwise would meet the criteria set forth above also are excluded from this report. Some of these provisions are excluded because they are transitional or routine in nature or because they have been superseded by congressional action that otherwise modifies their intent. For example, statutorily required Medicare payment rate reductions and payment rate rebasings that are implemented over a specified period are not considered to require legislative attention and are excluded from this report.

The report is organized as follows: **Table 1** lists the relevant provisions scheduled to expire in CY2021. **Table 2** lists the relevant provisions that expired during CY2020 or CY2019. The provisions in each table are organized by expiration date and by applicable health care-related program. The report then describes each listed provision and provides a legislative history of that provision. The summaries are grouped by provisions scheduled to expire in CY2021 followed by those that expired in CY2020 or CY2019.[5]

In the appendixes, **Table A-1** lists any demonstration projects and pilot programs related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance programs and activities or to other health care-related demonstration projects and pilot programs enacted or extended in the ACA or extended under MACRA that are scheduled to expire in CY2021.[6] **Table A-2** lists relevant demonstration projects and pilot programs that expired during the 116th Congress. **Table B-1** lists the status of provisions included in CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*, that were beyond the scope of this report. **Table B-2** lists demonstration projects and pilot programs included in R46331 that were not included in this report. **Table C-1** lists all laws that created, modified, or extended the health care-related expiring provisions described in this report.

Table 1. Provisions Expiring in the 117th Congress, First Session
(CY2021)

Expires After	Health Care-Related Program		Provision[a]	CRS Contact
6/30/2021	Medicare	Exclusion of Complex Rehabilitative Manual Wheelchairs from Medicare Competitive Acquisition Program	SSA §1847(a) 42 U.S.C. §1395w-3(a)	Paulette Morgan

[4] The Congressional Budget Office (CBO) is required to compile this information each year under §202(e)(3) of the Congressional Budget Act of 1974 (P.L. 93-344, as amended). For information on provisions set to expire on or before September 30, 2021, see CBO, *Expired and Expiring Authorizations of Appropriations: Fiscal Year 2021*, May 5, 2021, at https://www.cbo.gov/publication/57023.

[5] Within each section, the provisions are further organized by Social Security Act (SSA) and Public Health Service Act (PHSA) title and section. A third category includes provisions that are found elsewhere (e.g., the Internal Revenue Code [IRC]). Freestanding provisions (i.e., new laws) may be grouped in any section with related programs.

[6] This report is the latest in a series of health care-related expiring provisions reports for which CRS has been tracking Medicare, Medicaid, CHIP, or private health insurance. CRS has also tracked a group of other health related provisions that were enacted or extended in the ACA (P.L. 111-148) or extended under MACRA (P.L. 114-10), which have been periodically extended with Medicare, Medicaid, CHIP, and private health insurance provisions. Any applicable provisions within these categories are included in the report in a given year.

Expires After	Health Care-Related Program		Provision[a]	CRS Contact
9/30/2021	Medicaid	Additional Medicaid Funding and FMAP Rate for the Territories	SSA §1108 42 U.S.C. §1308	Alison Mitchell
9/30/2021	Private Health Insurance	Preserving Health Benefits for Workers	ARPA §9501	Ryan Rosso
12/31/2021	Medicare	Extension of Temporary Suspension of Medicare Sequestration	2 U.S.C. §901a(6)	Patricia A. Davis
12/31/2021	Medicare	Home Health Prospective Payment System Add-On for Rural Counties	SSA §1895 42 U.S.C. §1395fff note	Phoenix Voorhies
12/31/2021	Medicare	Reporting Requirements with Respect to Clinical Diagnostic Laboratory Tests	SSA §1834A(a)(1)(B) 42 U.S.C. §1395m-1(a)(1)(B)	Jim Hahn
12/31/2021	Medicare	Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021	SSA §1848 42 U.S.C. §1395w-4(t)	Jim Hahn
12/31/2021	Private Health Insurance	Application of Premium Tax Credit in Case of Individuals Receiving Unemployment Compensation During 2021	IRC §36B 26 U.S.C. §36B	Bernadette Fernandez
12/31/2021	Private Health Insurance	Exemption for Telehealth Services	IRC §223 26 U.S.C. §223	Ryan Rosso
12/31/2021	Private Health Insurance	Health Coverage Tax Credit	IRC §35 26 U.S.C. §35	Bernadette Fernandez
12/31/2021	Private Health Insurance	Temporary Special Rules for Health and Dependent Care Flexible Spending Arrangements	§214 of Division EE of the Consolidated Appropriations Act, 2021 (P.L. 116-260)	Ryan Rosso
12/31/2021	Private Health Insurance	Reduced Cost-Sharing	42 U.S.C. §18071	Bernadette Fernandez

Source: Congressional Research Service (CRS).

Notes: ARPA = American Rescue Plan Act of 2021 (P.L. 117-2); CY = Calendar Year; FMAP = Federal Medical Assistance Percentage; IRC = Internal Revenue Code; SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. Citations in statute and the U.S.C. are provided where available.

Table 2. Provisions That Expired in the 116th Congress
(CY2019 and CY2020)

Expired After	Health Care-Related Program		Provision[a]	Contact
9/30/2019	Other	Pregnancy Assistance Fund	ACA §10212	Adrienne Fernandes-Alcantara
9/30/2019	Medicare	Funding for Implementation of §101 of MACRA	MACRA §101(c)(3))	Jim Hahn
9/30/2019	Medicare	Priorities and Funding for Measure Development	SSA §1848(s) 42 U.S.C. §1395w-4(s)	Amanda Sarata
9/30/2019	Medicare	Extension of Blended Site Neutral Payment Rate For Certain LTCH Discharges	SSA §1886(m)(6)(B)(i) 42 U.S.C. §1395ww(m)(6)(B)(i)	Marco Villagrana
9/30/2019	Medicare	Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site-Neutral Payment for Certain LTCHs	SSA §1886(m)(6)(F) 42 U.S.C. §1395ww(m)(6)(F))	Marco Villagrana
12/31/2019	Medicare	Transitional Payment Rules for Certain Radiation Therapy Services	SSA §1848 42 U.S.C. 1395w-4(b)(11)	Jim Hahn
9/30/2020	CHIP	Increase to E-FMAP	SSA §32105(b) 42 U.S.C. §1397ee(b)	Alison Mitchell
9/30/2020	Medicare	MACRA Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas	SSA §1848(q) 42 U.S.C. §1395w-4(q)	Jim Hahn
12/31/2020	Medicare	Home Health Prospective Payment System Rural Add-On for High-Utilization Counties	SSA §1895 42 U.S.C. §1395fff note	Phoenix Voorhies

Source: CRS.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148); CHIP = State Children's Health Insurance Program; CY = Calendar Year; E-FMAP = Enhanced Federal Medical Assistance Percentage; LTCH = Long-Term Care Hospital; MACRA = Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10); SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. Citations in statute and the U.S.C. are provided where available.

CY2021 Expiring Provisions

Social Security Act (SSA) Title XVIII: Medicare

Exclusion of Complex Rehabilitative Manual Wheelchairs from Medicare Competitive Acquisition Program (SSA §1847(a); 42 U.S.C. §1395w-3(a))

Background

Medicare covers a variety of durable medical equipment (DME) when medically necessary and prescribed by a physician. The amount Medicare will pay for most DME is determined in one of two ways. First, in *competitive bidding* geographic areas, Medicare payments for selected items are determined by bids (or estimates of the cost for providing the item) submitted by winning DME suppliers. Second, outside of competitive bidding areas, payments are determined through statutorily specified formulas (*fee schedules*) that are adjusted based on information from the competitive bidding process, when such information is available. Not all items of DME are competitively bid; therefore, not all items outside of competitive bidding areas have their fee schedule payments adjusted based on competitive bidding information. Competitive bidding tends to result in lower payment amounts for DME than the fee schedules, so adjusting the fee schedules based on competitive bidding can result in lower payments.

Certain items of DME were statutorily excluded from the competitive bidding program, including Group 3 complex rehabilitative power wheelchairs and their accessories. Group 2 complex rehabilitative power wheelchairs and their accessories were not excluded and were competitively bid in the first round of the program (January 1, 2011, through December 31, 2013). In general, the differences between Group 2 and Group 3 complex rehabilitative power wheelchairs are related to the number of different power accessories that can be plugged into the chair and to the chair's power, durability, and performance. Certain accessories can be used with either Group 2 or Group 3 chairs and were part of the competitive bidding process.

The Secretary of the Department of Health and Human Services (HHS) published final regulations on November 6, 2014, that would have adjusted the fee schedule payments for wheelchair accessories based on information from the competitive bidding program regardless of the type of wheelchair the accessory was used with, effective January 1, 2016, for areas outside of competitive bidding areas. However, the Patient Access and Medicare Protection Act (PAMPA; P.L. 114-115) prohibited the Secretary from using information from the competitive bidding program to adjust the fee schedule payments for accessories furnished in conjunction with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. The Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of the 21st Century Cures Act; P.L. 114-255) delayed by six months (to July 1, 2017) the date on which the Secretary could begin using information from competitive bidding to adjust the fee schedule rates for accessories used with Group 3 complex rehabilitative power wheelchairs. However, effective July 1, 2017, the Secretary extended the policy of paying for accessories used with Group 3 complex rehabilitative power wheelchairs based on fee schedule amounts that had not been adjusted based on competitive bidding.

Relevant Legislation

- **Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division N, Section 106,** expanded the types of wheelchairs excluded from competitive

bidding to include complex rehabilitative *manual* wheelchairs, as determined by the Secretary, as well as specified pediatric wheelchairs and custom-built wheelchairs. Section 106 also prohibited the Secretary from using information from competitive bidding to adjust the fee schedule amounts for accessories and cushions furnished with those chairs during the period beginning January 1, 2020, and ending June 30, 2021.

Current Status

The prohibition on using information from competitive bidding to adjust fee schedule amounts for accessories and cushions furnished with complex rehabilitative manual wheelchairs, as well as specified pediatric wheelchairs and custom-built wheelchairs, expires after June 30, 2021.

Extension of Temporary Suspension of Medicare Sequestration (2 U.S.C. §901a(6))

Background

The Budget Control Act of 2011 (BCA; P.L. 112-25) provided for increases in the debt limit and established procedures designed to reduce the federal budget deficit, including the creation of the Joint Select Committee on Deficit Reduction. The joint committee's failure to propose deficit-reduction legislation that was subsequently enacted into law by a mandated deadline triggered automatic spending reductions, including the *sequestration* (i.e., across-the-board reductions) of mandatory spending in FY2013 through FY2021. Subsequent legislation extended the sequestration of mandatory spending through FY2030. Medicare benefits are funded through mandatory spending and are subject to reductions under such sequestration.[7]

Section 256(d) of the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) contained special rules for the Medicare program in the event of a sequestration. Among other things, it specified that for Medicare, sequestration is to begin the month after the annual sequestration order has been issued and to continue for one calendar year. Subsequent sequestration orders are to begin the first month after the previous order ends. Therefore, as the initial sequestration order was issued March 1, 2013, Medicare sequestration began April 1, 2013, and is currently scheduled to continue through March 31, 2031.

Under a BCA mandatory sequestration order, Medicare benefit payments cannot be reduced by more than 2%. With the exception of suspensions related to the Coronavirus Disease 2019 (COVID-19) pandemic (see "Relevant Legislation," below), Medicare benefit-related payments—which include payments to health care providers, Medicare Advantage, and Part D plans—have been subject to 2% reductions since April 1, 2013.

Relevant Legislation

- **Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), Section 3709,** waived the application of sequestration to the Medicare program from May 1, 2020, through December 31, 2020, and extended the sequestration of mandatory spending for an additional year, through FY2030. Medicare plans and providers received their full (non-reduced) payments for health care services provided during this time period.

[7] For additional information, see CRS Report R45106, *Medicare and Budget Sequestration*.

- **Consolidated Appropriations Act, 2021 (P.L. 116-260), Division N, Title 1, Section 102,** extended the temporary suspension of sequestration from January 1, 2021, through March 31, 2021.
- **To Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes (P.L. 117-7), Section 1,** extended the suspension of sequestration through December 31, 2021.[8]

Current Status

The sequestration of Medicare benefit payments has been suspended through December 31, 2021. After this date, Medicare payments to plans and providers for health care services will again be reduced by the sequester amount.

Home Health Prospective Payment System Add-On for Rural Counties (SSA §1895; 42 U.S.C. §1395fff note)

Background

Federally certified home health (HH) agencies receive increased payments under the HH prospective payment system (PPS) for Medicare HH care episodes furnished to beneficiaries in rural areas. Before the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123), when provided by legislation, the HH *rural add-on* was a fixed percentage increase to the HH PPS that was applied uniformly to Medicare HH care episodes provided in rural counties.

Under BBA 2018, the rural add-on was applied unvaryingly for the first year in which the legislation extended the increased payment, providing a 3% rural add-on payment to Medicare HH episodes furnished in any rural county that began in CY2018. After CY2018, BBA 2018 provided HH agencies a 3%, 2%, and 1% HH PPS add-on payment for services furnished in rural counties beginning during CY2019, CY2020, and CY2021, respectively, unless the Medicare HH services were (or are) furnished in a rural county with one of the two below-described designations, in which case alternative add-on payments were (or are) provided:

- For HH episodes furnished to beneficiaries who reside in *low-population-density counties*, defined as rural counties with a population density of six or fewer individuals per square mile, BBA 2018 provided 4%, 3%, 2%, and 1% HH PPS add-on payments for services beginning during CY2019, CY2020, CY2021, and CY2022, respectively.
- For HH episodes provided to beneficiaries who reside in *high-utilization counties*, defined as rural counties in the top quartile of all counties rendering HH services (by the number of HH episodes furnished per 100 Medicare eligibles), BBA 2018 provided 1.5% and 0.5% HH PPS add-on payments for HH episodes beginning in CY2019 and CY2020, respectively. BBA 2018 provided no add-on payment for episodes furnished in high-utilization counties that begin in CY2021 or CY2022.

[8] To offset the costs of extending the Medicare sequestration suspension, P.L. 117-7 also made adjustments to the percentage reductions applicable in the final year of sequestration, FY2030.

Under BBA 2018, rural counties were to be categorized only once and such determination was to apply to payment for HH episodes through CY2022.[9]

Relevant Legislation

- **Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000; P.L. 106-554), Section 508,** established a 10% add-on to Medicare's HH PPS rates for HH episodes provided to beneficiaries in rural areas beginning April 1, 2001, through March 31, 2003.
- **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173), Section 421,** provided a 5% add-on for services beginning April 1, 2004, through March 31, 2005.
- **Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Section 5201,** provided a 5% add-on for services beginning January 1, 2006, through December 31, 2006.
- **ACA, Section 3131,** provided a 3% add-on for services beginning April 1, 2010, through December 31, 2015.
- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), Section 210,** provided a 3% add-on for services beginning January 1, 2016 through December 31, 2017.
- **BBA 2018, Section 50208,** provided a 3% add-on for services beginning in CY2018. BBA 2018 provided a 3%, 2%, and 1% add-on for services beginning in CY2019, CY2020, and CY2021, respectively, unless the services were provided in a low-population-density or high-utilization rural county. For services provided in low-population-density counties, BBA 2018 provided a 4%, 3%, 2%, and 1% add-on for services beginning in years CY2019, CY2020, CY2021, and CY2022, respectively. For services furnished in high-utilization counties, BBA 2018 provided a 1.5% and 0.5% add-on for services beginning in CY2019 and CY2020, respectively.

Current Status

After December 31, 2021, HH agencies are no longer set to receive an add-on payment for services provided in rural counties that are not designated as low-population-density counties.

Reporting Requirements with Respect to Clinical Diagnostic Laboratory Tests (SSA §1834A(a)(1)(B); 42 U.S.C. §1395m-1(a)(1)(B))

Background

Outpatient clinical laboratory services are paid under the Medicare Clinical Laboratory Fee Schedule (CLFS). Prior to 2018, CLFS payment rates were based on historical laboratory charges. The Protecting Access to Medicare Act (PAMA; P.L. 113-93) established a new method for determining clinical laboratory payments beginning in 2018, with Medicare CLFS payment rates based on reported private insurance payment amounts.

[9] Rural add-on payment designations by county can be found at Centers for Medicare and Medicaid Services (CMS), "Home Health Agency (HHA) Center," at https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

Per PAMA, the Centers for Medicare and Medicaid Services (CMS) was to collect data from clinical laboratories (aside from advanced diagnostic laboratory tests, for which PAMA also altered payment, coding, and coverage) about private payer payment rates beginning in 2016. The new payment system was to be phased in from 2017 through 2022; during the phase-in period, payment could not be reduced, compared with the payment amount in the preceding year, by more than a statutorily specified limit. For each year 2017-2019, the CLFS payment reduction limit was to be 10%, and for each year 2020-2022, the payment reduction limit was to be 15%. Beginning in 2018, CMS set CLFS rates based on the weighted median of private payer rates for each laboratory service, collected from applicable laboratories. These CLFS payment rates are national and do not vary based on geography.

Relevant Legislation

- **Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Division N, Section 105,** modified the schedule for implementing the new CLFS payment system and reporting requirements. A period during which there would be no reporting required from diagnostic laboratories was established from January 1, 2020, through December 31, 2020. The first required reporting period was set to begin January 1, 2021, and end March 31, 2021, with subsequent reporting periods required every three years thereafter. The phase-in schedule was modified so that the payment reduction limit was to be 10% for each year from 2017 through 2020 and 15% for each year from 2021 through 2023.
- **CARES Act, Section 3718,** delayed the reporting requirements under the new CLFS payment methodology and made additional revisions to the payment reduction limits during the phase-in schedule. The provision extended the initial period during which no reporting is required to the period beginning January 1, 2021, through December 31, 2021, with the first required reporting period to begin January 1, 2022, and end March 31, 2022. For 2021, there is no payment reduction (i.e., 0% limit) during the phase-in of the private payer rate implementation schedule.

Current Status

The payment reduction limit is set to be 15% for 2022 through 2024, when the private payer rate is to be fully implemented.

Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021 (SSA §1848; 42 U.S.C. §1395w-4(t))

Background

Medicare Part B covers medically necessary physician services and medical services provided by some nonphysician practitioners. Covered nonphysician practitioner services include, but are not limited to, those provided by physician assistants, nurse practitioners, certified registered nurse anesthetists, and clinical social workers. Certain limitations apply for services provided by chiropractors and podiatrists. A number of Part B services are paid under the Medicare Physician Fee Schedule (MPFS), including services of physicians, nonphysician practitioners, and therapists. There are over 7,000 service codes under the MPFS. CMS adjusts the MPFS and resultant payments each year to reflect changes in service codes (definitions, additions, and other modifications) and certain mandated policy objectives. These modifications are subject to a

budget-neutrality requirement such that projected expenditures under the MPFS based on the new adjustments do not increase or decrease by more than $20 million from the prior year's expenditures.

The COVID-19 pandemic continues to place financial stress on many health care providers and suppliers, including physicians and nonphysician practitioners. In areas where the impact of COVID-19 was severe, some health care organizations faced a surge in demand for health care services to treat those affected by the virus. Simultaneously, during the early weeks of the pandemic, fewer patients sought care for nonemergency services out of caution, as well as in response to pleas to allow resources to be directed to responding to COVID-19-related needs. Additionally, to respond to the changes in demand for their services during the COVID-19 public health emergency, some health care providers and suppliers postponed furnishing elective and other nonemergency services, constraining revenue.

Relevant Legislation

- **Consolidated Appropriations Act, 2021, Division N, Title I, Section 101,** provided an increase of 3.75% in payments for services furnished and billed under the MPFS in 2021. These MPFS adjustments are to be exempt from the budget-neutrality requirement for years after 2021. Three billion dollars is to be transferred from the General Fund of the Treasury to the Federal Supplementary Medical Insurance (Part B) Trust Fund for this purpose, available until expended, with additional amounts to be transferred as necessary.

Current Status

The 3.75% increase in MPFS payments will expire for services furnished after December 31, 2021.

SSA Title XIX: Medicaid

Additional Medicaid Funding and Federal Medical Assistance Percentage Rate for the Territories (SSA §1108; 42 U.S.C. §1308)

Background

Medicaid financing for the territories (i.e., America Samoa, the Commonwealth of the Northern Mariana Islands [CNMI], Guam, Puerto Rico, and the U.S. Virgin Islands [USVI]) differs from Medicaid financing for the 50 states and the District of Columbia.[10] Federal Medicaid funding to the states and the District of Columbia is open-ended, but Medicaid programs in the territories are subject to annual federal capped funding.

Federal Medicaid funding for the territories comes from a few different sources. The permanent source of federal Medicaid funding for the territories is the annual capped funding. Since July 1, 2011, the annual capped funding for the territories has been supplemented by additional funding sources available for a limited time provided through various laws. Prior to the availability of these additional Medicaid funding sources, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year.

[10] For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

The federal share of most Medicaid expenditures is determined by the federal medical assistance percentage (FMAP) rate. The regular FMAP rates for the 50 states and DC are determined annually and vary by state according to each state's per capita income. The rates can range from 50% to 83%. By contrast, the regular FMAP rate for the territories is set in statute and does not vary according to each territory's per capita income.

Relevant Legislation

- **ACA, Section 2005, as modified by Section 10201**
  - **Additional federal Medicaid funding** was provided to the territories totaling $6.3 billion. The funding was available between July 1, 2011, and September 30, 2019.
  - **The regular FMAP rate was increased** from 50% to 55% for the territories.
- **ACA, Section 1323**
  - **Additional federal Medicaid funding** in the amount of $1.0 billion was provided to the territories that did not establish health insurance exchanges.[11] This funding was available from January 1, 2014, through December 31, 2019.
- **Consolidated Appropriations Act, 2017 (P.L. 115-31), Division M, Title II, Section 202**
  - **Additional federal Medicaid funding** was provided for Puerto Rico in the amount of $295.9 million. This funding was available through September 30, 2019.
- **BBA 2018, Section 20301**
  - **Additional federal Medicaid funding** was provided for Puerto Rico in the amount of $3.6 billion and for USVI in the amount of $106.9 million. This funding was further increased by $1.2 billion for Puerto Rico and $35.6 million for USVI because certain conditions were met.[12] This funding was available January 1, 2018, through September 30, 2019.
  - **The regular FMAP rate** for Puerto Rico and USVI was increased from 55% to 100% (i.e., fully federally funded) for this additional federal Medicaid funding.
- **Additional Supplemental Appropriations for Disaster Relief Act, 2019 (P.L. 116-20), Title VIII, Section 802**
  - **Additional federal Medicaid funding** was provided for CNMI in the amount of $36 million for the period of January 1, 2019, through September 30, 2019.
  - **The regular FMAP rate was increased** from 55% to 100% for the $36 million in additional federal Medicaid funding provided for CNMI. For American Samoa and Guam, the regular FMAP was increased from 55% to

[11] Because none of the territories established exchanges, the territories all received additional federal Medicaid funds. The provision specified that Puerto Rico receive $925 million, and the Secretary of the Department of Health and Human Services (HHS) distributed the remaining funding among the other four territories.

[12] The certain conditions were that the HHS Secretary needed to certify that each territory (i.e., Puerto Rico and the U.S. Virgin Islands [USVI]) has taken steps to (1) report reliable data to the Transformed-Medicaid Statistical Information System and (2) establish a Medicaid Fraud Control Unit.

100% for the territories' share of the $6.3 billion in additional Medicaid federal funding provided in the ACA.

- **Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59), Division B, Title III, Section 1302**
  - **The regular FMAP rate** for territories was increased from 55% to 100% for October 1, 2019, through November 21, 2019.
- **Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69), Section 1302**
  - **The regular FMAP rate** for the territories was increased from 55% to 100% for November 22, 2019, through December 20, 2019.
- **Further Consolidated Appropriations Act, 2020, Division N, Title I, Section 202**
  - **Additional federal Medicaid funding** was provided for the territories totaling $3.0 billion for FY2020 and $3.1 billion for FY2021.
  - **The regular FMAP rates** for the territories were increased from 55% to 83% for American Samoa, CNMI, Guam, and USVI and from 55% to 76% for Puerto Rico for part of FY2020 (i.e., December 21, 2019, through September 30, 2020).[13]
- **Family First Coronavirus Response Act (P.L. 116-127), Division F, Section 6009**
  - **The additional federal Medicaid funding** amounts were increased to $3.1 billion for FY2020 and $3.2 billion for FY2021.[14]

Current Status

The additional Medicaid federal funding and the increased regular FMAP rates expire after September 30, 2021.

Other CY2021 Expiring Provisions

Application of Premium Tax Credit in Case of Individuals Receiving Unemployment Compensation During 2021 (IRC §36B; 26 U.S.C. §36B)

Background

Individuals (and families) who meet income and other eligibility criteria receive federal financial assistance in the form of a premium tax credit (PTC), which reduces the cost of purchasing health insurance offered through exchanges. The credit amount is calculated according to a formula that

[13] The federal medical assistance percentage (FMAP) rates for the remainder of FY2020 and FY2021 could be reduced if the territories do not comply with certain program integrity requirements.

[14] Section 6008 of the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) increases the FMAP rate for all states, the District of Columbia, and the territories by 6.2 percentage points beginning January 1, 2020, and ending on the last day of the calendar quarter in which is the last day of the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency period. As a result, in FY2020 and FY2021, during this period, the FMAP rate for American Samoa, CNMI, Guam, and USVI is 89.2% and the FMAP rate for Puerto Rico is 82.2%. For more information about the FFCRA FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

generally provides larger amounts to individuals with lower incomes. Unemployment compensation (UC) generally counts toward the calculation of income; therefore, receipt of UC affects the amount of income used to determine eligibility for and the amount of the PTC.[15]

Relevant Legislation

- **ACA, Section 1401,** authorized the PTC, specified the eligibility criteria for claiming the credit, specified the formula to calculate the credit, and made conforming amendment to the *U.S. Code* for purposes of financing the credit.
- **American Rescue Plan Act of 2021 (ARPA; P.L. 117-2), Section 9663,** expanded eligibility for and increased the amount of the PTC for individuals who receive UC in 2021. It temporarily deemed individuals who receive UC for any week in CY2021 to have met the PTC income eligibility criteria for tax year 2021. It also temporarily disregarded any household income above 133% of the federal poverty level (FPL) for purposes of determining the credit amount.

Current Status

The PTC rules applicable to individuals who receive UC will expire after December 31, 2021.

Exemption for Telehealth Services (IRC §223; 26 U.S.C. §223)

Background

A health savings account (HSA) is a tax-advantaged account that individuals can use to pay for unreimbursed medical expenses (e.g., deductibles, co-payments, coinsurance, and services not covered by insurance).[16]

Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified high-deductible health plan (HDHP), do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return.

To be considered an HSA-qualified HDHP, a health plan must meet several criteria: (1) it must have a deductible above a certain minimum level, (2) it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and (3) it can cover only specified services before the deductible is met.

For example, if a health plan satisfied the first two of these criteria and provided coverage for preventive care services and prescription drugs before the deductible is met, that health plan would not be considered an HSA-qualified HDHP because it provides prescription drug benefits before the deductible is met.

Disqualifying coverage is generally considered any other health coverage that is not an HSA-qualified HDHP or that provides coverage for any benefit covered under an individual's HSA-qualified HDHP. Some types of health coverage are not considered disqualifying for purposes of being eligible to establish and contribute to an HSA.

[15] For additional background about the premium tax credit, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[16] For more information on health savings accounts (HSAs), see CRS Report R45277, *Health Savings Accounts (HSAs)*.

Relevant Legislation

- **MMA, Section 1201,** authorized HSAs.
- **CARES Act, Section 3701,** allowed HSA-qualified HDHPs to provide telehealth and other remote care services before the deductible is met and still be considered an HSA-qualified HDHP. It also provided that telehealth and other remote care would not be considered disqualifying coverage that would prevent an otherwise eligible individual from being HSA-eligible. These rules apply to services provided on or after January 1, 2020, with respect to plan years that begin on or before December 31, 2021.[17]

Current Status

The temporary HSA eligibility rules regarding telehealth and other remote care will expire for plans that begin after December 31, 2021.

Health Coverage Tax Credit (IRC §35; 26 U.S.C. §35)

Background

The Health Coverage Tax Credit (HCTC) subsidizes 72.5% of the cost of qualified health insurance for eligible taxpayers and their family members. Potential eligibility for the HCTC is limited to two groups of taxpayers. One group is composed of individuals eligible for Trade Adjustment Assistance (TAA) allowances because they experienced qualifying job losses. The other group consists of individuals whose defined-benefit pension plans were taken over by the Pension Benefit Guaranty Corporation because of financial difficulties. HCTC-eligible individuals are allowed to receive the tax credit only if they either cannot enroll in certain other health coverage (e.g., Medicaid) or are not eligible for other specified coverage (e.g., Medicare Part A). To claim the HCTC, eligible taxpayers must have *qualified health insurance* (i.e., specific categories of coverage, as specified in statute). The credit is financed through a permanent appropriation under 31 U.S.C. §1324(b)(2); therefore, HCTC financing is not subject to the annual appropriations process.

Relevant Legislation

- **Trade Act of 2002 (P.L. 107-210), Sections 201-203,** authorized the HCTC, specified the eligibility criteria for claiming the credit, and made conforming amendment to the *U.S. Code* for purposes of financing the credit.
- **American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), Part VI: TAA Health Coverage Improvement Act of 2009,** expanded eligibility for and subsidy of the HCTC, including retroactive amendments, and provided $80 million total for FY2009 and FY2010 to implement the enacted changes to the HCTC.
- **Trade Adjustment Assistance Extension Act of 2011 (P.L. 112-40), Section 241,** established a sunset date of before January 1, 2014.

[17] Internal Revenue Service (IRS), "COVID-19 Guidance Under §125 Cafeteria Plans and Related to High Deductible Health Plans," Notice 2020-29, at https://www.irs.gov/pub/irs-drop/n-20-29.pdf.

- **Trade Preferences Extension Act of 2015 (P.L. 114-27), Section 407,** retroactively reauthorized the HCTC and established a new sunset date of before January 1, 2020.
- **Further Consolidated Appropriations Act, 2020**, **Section 146,** established a new sunset date of before January 1, 2021.
- **Consolidated Appropriations Act, 2021, Division EE, Section 134,** established a new sunset date of before January 1, 2022.

Current Status

Authorization for the HCTC expires after December 31, 2021.

Preserving Health Benefits for Workers (ARPA §9501)

Background

Private-sector employers that have at least 20 employees and offer health insurance benefits to their employees are required to provide qualified individuals (and their families) who experience specified qualifying events with the option of enrolling in Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) continuation coverage (i.e., of continuing their coverage under the employer's group health insurance plan).[18] *Specified qualifying events* include both voluntary and involuntary termination of employment, a reduction in hours, and other statutorily defined events; the qualifying event also must result in an individual losing health insurance coverage. State and local government workers are covered by similar federal COBRA requirements. In addition, many states have enacted "mini-COBRA" laws, which require that continuation coverage be offered to employees of smaller firms.

Under federal COBRA rules, eligible individuals who experience qualifying events must be notified of their right to elect COBRA coverage. In accordance with such notification, eligible individuals have the right to elect COBRA coverage within an election period, defined as (at least) 60 days from the later of two dates: (1) the date coverage would be lost due to the qualifying event or (2) the date on which the beneficiary is sent notice of his or her right to elect COBRA coverage. An individual electing COBRA coverage ordinarily will receive the same coverage that he or she was receiving immediately before the qualifying event. In general, the COBRA coverage for the employee and the employee's spouse and dependent children must be allowed to continue for 18 months from the date of the qualifying event. In certain circumstances, an employer may cut short COBRA coverage or be required to extend such coverage according to statutory limits.

When offering COBRA coverage to qualified individuals, employers are permitted to charge the covered beneficiary a premium for COBRA continuation coverage that is 102% of the employer-sponsored insurance premium. In other words, the COBRA premium can equal the sum of (1) the portion of employer-sponsored insurance premium normally paid by the employee, (2) the portion of the premium normally paid by the employer (if any), and (3) an additional 2% administrative fee. For disabled individuals who qualify for an additional 11 months of COBRA coverage (i.e., qualify for 29 total months of COBRA coverage), the employer may charge up to 150% of the premium for these additional months.

[18] For more information on Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

Relevant Legislation

- **ARPA, Section 9501,** provided temporary premium assistance for COBRA continuation coverage for certain individuals who lost employer-based health insurance as a result of an involuntary termination or a reduction in hours—specifically, a 100% premium subsidy of COBRA coverage during the period beginning April 1, 2021, and ending September 30, 2021. It also provided employers (or, in some instances, multiemployer plans or insurers) with a refundable payroll tax credit to reimburse the employers for unpaid premium amounts.

Current Status

ARPA COBRA premium assistance will no longer be available to applicable COBRA coverage provided after September 30, 2021.

Reduced Cost Sharing (42 U.S.C. §18071)

Background

Certain individuals (and families) who are enrolled in health plans through health insurance exchanges and are eligible for the PTC also may receive federal assistance that reduces their cost-sharing requirements. To receive cost-sharing reductions (CSRs), individuals must meet income and other eligibility criteria. There are two types of CSRs, and both types provide larger subsidies to individuals with lower incomes. UC generally counts toward the calculation of income, so receipt of UC affects the amount of income used to determine eligibility for and the amount of CSRs.[19]

Relevant Legislation

- **ACA, Section 1402,** established and specified the two types of CSRs and specified the eligibility criteria for receiving the CSRs.
- **ARPA, Section 2305,** expanded eligibility for and the amount of CSRs for eligible individuals who receive UC during CY2021. It temporarily deemed individuals who receive UC for any week in CY2021 to have met the CSR income eligibility criteria for plan year 2021. It also temporarily disregarded any household income above 133% FPL for purposes of determining the level of CSRs.

Current Status

The CSR rules applicable to individuals who receive UC will expire after December 31, 2021.

[19] For additional background about the cost-sharing reductions, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

Temporary Special Rules for Health and Dependent Care Flexible Spending Arrangements (§214 of Division EE of the Consolidated Appropriations Act, 2021)

Background

Health flexible spending arrangements (FSAs) are employer-established benefits that reimburse employees for certain medical expenses.[20] Employers generally offer health FSAs through a cafeteria plan, which allows employees to reduce their taxable salaries and instead put such money, pretax, toward a qualified benefit. Participation in a health FSA is tied to a set period of time (plan year), which generally lasts 12 months and does not need to follow the calendar year. Plan years are associated with the year in which the plan starts (e.g., a health FSA with a plan year that begins in July 2021 follows 2021 health FSA rules).

When FSAs are funded through a cafeteria plan, employees elect an annual amount to contribute to their FSAs prior to the start of a plan year; that amount generally cannot be changed during the plan year, except in limited circumstances (e.g., change in family status). Over the course of the plan year, the employee contributes amounts to the FSA that sum to the elected amount. The maximum amount an employee can contribute to a health FSA is $2,750 in 2021. Employers also may provide limited contributions.

The total health FSA election amount must be made available to employees at the start of the plan year, even though the contributions typically are spread throughout the year. For example, an employee who elects to contribute $2,400 to his or her health FSA for a given plan year ($200 a month) would be able to access all $2,400 on the first day of the plan year, even if he or she has contributed only $200.

When offered as a cafeteria plan benefit, health FSAs generally are subject to cafeteria plan rules. One such rule is a use-or-lose rule that prevents any cafeteria plan benefit from providing deferred compensation. As such, health FSA plans have only a limited ability to permit unused health FSA balances to be used after the end of the plan year. In general, employers must incorporate one of three mutually exclusive policies for the treatment of an employee's unused health FSA balances at plan year's end:

1. Employees forfeit unused balances, which then revert to the employer.
2. Employees are given a "grace period" of up to 2½ months after the end of the plan year. Employees can be reimbursed for expenses incurred during this additional time. At the end of the grace period, unused amounts are forfeited and revert to the employer. For example, medical expenses incurred by March 15, 2021, could be reimbursed from FSA contributions for a January-December 2020 plan year.
3. Employees may carry over a limited amount of unused health FSA funds into the next FSA plan year (up to $550 in 2020 contributions).

To the extent that an individual has a health FSA balance after the end of the grace period or has a balance that exceeds the allowable carryover amount (where applicable), such amounts are forfeited to the employer.

[20] Flexible spending arrangements (FSAs) also may be offered for dependent-care expenses. Given this product's focus on health care-related expiring provisions, this report covers only health FSA expiring provisions.

Because health FSAs generally are available only to current employees of employers offering such benefit, a terminated employee may forfeit his or her FSA balance. In some instances, individuals may be able to retain access to their health FSAs through COBRA continuation coverage. If an employee is terminated mid-plan year having withdrawn more money from an FSA than he or she contributed, the employee generally cannot be charged for the negative balance.

Relevant Legislation

- **Consolidated Appropriations Act, 2021, Division EE, Section 214,** established temporary health FSA rules. Specifically, employers who offer health FSAs are allowed to provide the following flexibilities:
  - Allow employees to carry over unused health FSA balances from FSAs that end in 2020 or 2021.
  - Extend grace periods from 2½ months to 12 months for health FSAs that end in 2020 or 2021.
  - Allow individuals who stop participating in an FSA (e.g., as a result of termination) in CY2020 or CY2021 to continue to access unused balances through the end of the applicable FSA plan year.
  - Allow employees to prospectively modify their contribution amounts in the middle of a plan year that ends in 2021.

Current Status

Individuals who stop participating in a health FSA after December 31, 2021, will not be able to access unused balances through the end of the applicable health FSA plan year.[21] All other temporary FSA flexibilities will not apply to health FSAs that end after December 31, 2021.

CY2019 and CY2020 Expired Provisions

Other Health Care-Related Provisions

Pregnancy Assistance Fund (42 U.S.C. §18201-42 U.S.C. §18204)

Background

The Pregnancy Assistance Fund (PAF) program focused on meeting the educational, social service, and health needs of vulnerable expectant and parenting individuals and their families during pregnancy and the postnatal period. The program identified eligible populations as expectant and parenting teens; college students; and women of any age who experience domestic violence, sexual violence, sexual assault, or stalking. HHS administered the PAF program, and funding was awarded competitively to the 50 states, DC, U.S. territories, and tribal entities (hereinafter, *state grantees*) that applied successfully. Grantees could use funds (1) to establish, operate, or maintain pregnancy or parenting services at institutions of higher education, high

[21] For employers that provide this flexibility, employees who stopped participating in a health FSA in CY2021 may continue to receive reimbursements that applied when the employee stopped participating in the health FSA through the end of the plan year. This extended period may extend beyond CY2021 if the FSA has a non-calendar plan year that spans parts of 2021 and 2022.

schools, or community service providers; (2) to provide, in partnership with the state attorney general's office, certain legal and supportive services for women who experience domestic violence, sexual violence, sexual assault, or stalking while they are pregnant or parenting an infant; and (3) to support, either directly or through a sub-grantee, public awareness about PAF services for the expectant and parenting population that is eligible for the program.

Relevant Legislation

- **ACA, Section 10212,** established the PAF and provided $25 million annually from FY2010 through FY2019.

Current Status

Funding for the PAF authorized under the ACA expired after September 30, 2019.

SSA Title XVIII: Medicare

Home Health Prospective Payment System Rural Add-On for High-Utilization Counties (SSA §1895; 42 U.S.C. §1395fff note)

Background

HH agencies receive increased payments under the HH PPS for Medicare HH care episodes furnished to beneficiaries in rural areas. Before BBA 2018, when provided by legislation, the HH rural add-on was a fixed percentage increase to the HH PPS that was applied uniformly to Medicare HH care episodes provided in rural counties.

Under BBA 2018, the add-on was applied unvaryingly for the first year in which the legislation extended the increased payment, providing a 3% rural add-on payment to Medicare HH episodes furnished in any rural county that began in CY2018. After CY2018, BBA 2018 provided HH agencies a 3%, 2%, and 1% HH PPS add-on payment for services furnished in rural counties beginning during CY2019, CY2020, and CY2021, respectively, unless the Medicare HH services were (or are) furnished in a rural county with one of the two below-described designations, in which case alternative add-on payments were (or are) provided:

- For HH episodes furnished to beneficiaries who reside in low-population-density counties, defined as rural counties with a population density of six or fewer individuals per square mile, BBA 2019 provided 4%, 3%, 2%, and 1% HH PPS add-on payments for services beginning during CY2019, CY2020, CY2021, and CY2022, respectively.
- For HH episodes provided to beneficiaries who reside in high-utilization counties, defined as rural counties in the top quartile of all counties rendering HH services (by the number of HH episodes furnished per 100 Medicare eligibles), BBA 2018 provided 1.5% and 0.5% HH PPS add-on payments for HH episodes beginning in CY2019 and CY2020, respectively. BBA 2018 provided no add-on payment for episodes furnished in high utilization counties that begin in CY2021 or CY2022.

Under BBA 2018, rural counties were to be categorized only once and such determination was to apply to payment for HH episodes through CY2022.[22]

Relevant Legislation

- **BIPA 2000, Section 508,** established a 10% add-on to Medicare's HH PPS rates for HH episodes provided to beneficiaries in rural areas beginning April 1, 2001, through March 31, 2003.
- **MMA, Section 421,** provided a 5% add-on for services beginning April 1, 2004, through March 31, 2005.
- **DRA, Section 5201,** provided a 5% add-on for services beginning January 1, 2006, through December 31, 2006.
- **ACA, Section 3131,** provided a 3% add-on for services beginning April 1, 2010, through December 31, 2015.
- **MACRA, Section 210,** provided a 3% add-on for services beginning January 1, 2016, through December 31, 2017.
- **BBA 2018, Section 50208,** provided a 3% add-on for services beginning in CY2018. BBA 2018 provided a 3%, 2%, and 1% add-on for services beginning in CY2019, CY2020, and CY2021, respectively, unless the services were provided in a low-population-density or high-utilization rural county. For services provided in low-population-density counties, BBA 2018 provided a 4%, 3%, 2%, and 1% add-on for services beginning in CY2019, CY2020, CY2021, and CY2022, respectively. For services furnished in high-utilization counties, it provided a 1.5% and 0.5% add-on for services beginning in CY2019 and CY2020, respectively.

Current Status

After December 31, 2020, HH agencies no longer received add-on payments for services provided in rural counties designated as high-utilization counties.

Medicare Access and CHIP Reauthorization Act of 2015 Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas (SSA §1848(q)(11); 42 U.S.C. §1395w-4(q)(11))

Current Law

MACRA made several fundamental changes to how Medicare pays for physician and practitioner services by (1) changing the methodology for determining the annual updates to the conversion factor; (2) establishing new methods for paying for professional services under Medicare Part B, including a merit-based incentive payment system (MIPS) to consolidate and replace several existing incentive programs and to apply value and quality adjustments to the MPFS; and (3) establishing the development of, and participation in, alternative payment models (APMs).[23]

[22] Rural-add-on-payment designations by county can be found at CMS, "Home Health Agency (HHA) Center," https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

[23] For more information on Section 101 of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

To provide technical assistance to small practices and practices in health professional shortage areas, MACRA required the HHS Secretary to enter into contracts or agreements with appropriate entities (such as quality-improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to MIPS-eligible professionals in practices of 15 or fewer professionals. MACRA required that, under the technical assistance program, priority be given to professionals in rural areas, health professional shortage areas, or practices with low composite scores under the new payment system. The guidance and assistance were to be provided with respect to the MIPS performance categories or with respect to how to transition to the implementation of and participation in an APM.

For purposes of implementing the technical assistance program, $20 million from the Federal Supplementary Medical Insurance (SMI) Trust Fund was made available to CMS for each of FY2016-FY2020. These amounts were to be available until expended.

Relevant Legislation

- **MACRA, Section 101,** provided for the transfer of $20 million from the Medicare SMI Trust Fund for each of FY2016 through FY2020.

Current Status

No funds to support the technical assistance program have been authorized beyond FY2020.

Funding for Implementation of Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA Section 101(c)(3))

Background

Section 101 of MACRA made fundamental changes to the way Medicare payments to physicians are determined and updated.[24] To implement the payment modifications in Section 101 of MACRA, the law authorized the transfer of $80 million from the SMI Trust Fund for each fiscal year beginning with FY2015 and ending with FY2019. The amounts transferred were to be available until expended.

Relevant Legislation

- **MACRA, Section 101,** provided for the transfer of $80 million from the Medicare SMI Trust Fund for each of FY2015 through FY2019.

Current Status

Appropriated funds to support the activities under this subsection were not enacted for FY2020 or subsequent fiscal years.

[24] For more information on §101 of MACRA, see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

Priorities and Funding for Measure Development (SSA §1848(s); 42 U.S.C. §1395w-4(s))

Background

Social Security Act (SSA) Section 1848(s) required the HHS Secretary to develop a plan, to be updated as needed, for the development of quality measures for use in the MIPS program. The subsection also required the Secretary to enter into contracts or other arrangements to develop, improve, update, or expand quality measures, in accordance with the plan. In entering into contracts, the Secretary was to prioritize developing measures of outcomes, patient experience of care, and care coordination, among other things. The HHS Secretary, through CMS, annually reports on the progress made in developing quality measures under this subsection.

Relevant Legislation

- **MACRA, Section 102,** provided for the transfer of $15 million from the Medicare SMI Trust Fund for each of FY2015 through FY2019.

Current Status

Appropriated funds to support the activities under this subsection have not been enacted for FY2020 or subsequent fiscal years. However, funds appropriated prior to FY2020 are available for obligation through the end of FY2022.

Temporary Extension of Long-Term Care Hospital Site-Neutral Payment Policy Transition Period (SSA §1886(m)(6)(B)(i); 42 U.S.C. §1395ww(m)(6)(B)(i))

Background

Medicare pays long-term care hospitals (LTCHs) for certain inpatient hospital care under the LTCH prospective payment system (LTCH PPS); payments under the LTCH PPS typically are higher than payments for inpatient hospital care under the inpatient prospective payment system (IPPS). The Pathway for SGR (Sustainable Growth Rate) Reform Act of 2013 (PSRA; P.L. 113-67) amended the law so that the LTCH PPS payment is no longer available for all LTCH discharges but instead is available only for those LTCH discharges that meet specific clinical criteria. Specifically, LTCHs are paid under the LTCH PPS if a Medicare beneficiary either (1) had a prior three-day intensive-care-unit stay at a hospital paid under the IPPS immediately preceding the LTCH stay or (2) is assigned to an LTCH PPS case-mix group that is based on the receipt of ventilator services for at least 96 hours and had a prior hospital stay at a hospital paid under the IPPS immediately preceding the LTCH stay. Discharges involving patients who have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation do not qualify for the LTCH PPS rate. Subsequent legislation provided for other criteria to temporarily receive payment under the LTCH PPS (see section "Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site-Neutral Payment for Certain LTCHs (SSA §1886(m)(6)(F); 42 U.S.C. §1395ww(m)(6)(F))").

The PSRA specified that, for LTCH discharges that did not qualify for the LTCH PPS based on these clinical criteria, a site-neutral payment rate similar to the PPS for IPPS was to be phased-in. The *site-neutral rate* was defined as the lower of an "IPPS-comparable" per diem amount, as defined in regulations, or the estimated cost of the services involved.

Relevant Legislation

- **PSRA, Section 1206(a),** established patient criteria for payment under the LTCH PPS and a site-neutral payment rate for LTCH patients who do not meet these criteria. During a phase-in period for discharges in cost-reporting periods beginning in FY2016 and FY2017, LTCHs received a blended payment amount based on 50% of what the LTCH would have been reimbursed under the LTCH PPS rate and 50% of the site-neutral payment rate. For cost-reporting periods beginning in FY2018 and subsequent years, the LTCH was to receive the site-neutral payment rate.
- **BBA 2018, Section 51005,** extended the transition period to site-neutral Medicare payments for LTCH patients who do not meet the patient criteria for an additional two years, to include discharges in cost-reporting periods beginning in FY2018 and FY2019. During this period, LTCHs continued to receive the 50/50 blended payment for discharges that did not meet certain LTCH PPS criteria.

Current Status

The extended transition period to site-neutral payments, during which LTCHs received a blended payment for discharges that did not meet the patient criteria, expired for discharges occurring in cost-reporting periods beginning in FY2020 and subsequent years.

Temporary Exception for Certain Spinal Cord Conditions from Application of the Medicare LTCH Site-Neutral Payment for Certain LTCHs (SSA §1886(m)(6)(F); 42 U.S.C. §1395ww(m)(6)(F))

Background

Medicare pays LTCHs for inpatient hospital care under the LTCH PPS, and payments under the LTCH PPS typically are higher than payments for inpatient hospital care under the IPPS. Effective for cost-reporting periods beginning in FY2016, LTCHs are paid the LTCH PPS rate for patients that meet one of the following two criteria: the patient (1) had a prior three-day intensive-care-unit stay at a hospital paid under the IPPS immediately preceding the LTCH stay or (2) is assigned to an LTCH PPS case-mix group that is based on the receipt of ventilator services for at least 96 hours and had a prior hospital stay at a hospital paid under the IPPS immediately preceding the LTCH stay. Discharges involving patients who have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation do not qualify for the LTCH PPS rate. For LTCH discharges that did not qualify for the LTCH PPS based on these criteria, a site-neutral payment rate was phased in for cost-reporting periods beginning in FY2016-FY2019. Subsequent legislation provided for other criteria to temporarily receive payment under the LTCH PPS. (See section "Temporary Extension of Long-Term Care Hospital Site-Neutral Payment Policy Transition Period (SSA §1886(m)(6)(B)(i); 42 U.S.C. §1395ww(m)(6)(B)(i))" for details related to site-neutral payment.)

Relevant Legislation

- **Cures Act, Division C, Section 15009,** established an additional temporary criterion for payment under the LTCH PPS related to certain spinal cord conditions for discharges occurring in cost-reporting periods FY2018 and FY2019. Specifically, the LTCH PPS rate would apply to an LTCH discharge if

all of the following conditions were met: (1) the LTCH was a not-for-profit on June 1, 2014; (2) at least 50% of the LTCH's CY2013 LTCH PPS-paid discharges were classified under LTCH diagnosis-related groups associated with catastrophic spinal cord injuries, acquired brain injury, or other paralyzing neuromuscular conditions; and (3) the LTCH during FY2014 discharged patients (including Medicare beneficiaries and others) who had been admitted from at least 20 of the 50 states, as determined by the HHS Secretary based on a patient's state of residency.

Current Status

The authority for the temporary criterion related to certain spinal cord conditions to receive payment under the LTCH PPS expired for discharges occurring in cost reporting periods beginning in FY2020 and subsequent years.

Transitional Payment Rules for Certain Radiation Therapy Services (SSA §1848(b)(11); 42 U.S.C. §1395w-4(b)(11))

Background

Currently, Medicare payments for services of physicians and certain nonphysician practitioners, including radiation therapy services, are made on the basis of the MPFS.

To set payment rates under the MPFS, relative values units (RVUs) are assigned to each of more than 7,000 service codes that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the relative work and other inputs involved in performing one service with the inputs involved in providing other physicians' services. The relative values are adjusted for geographic variation in input costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

CMS, which is responsible for maintaining and updating the MPFS, continually modifies and refines the methodology for estimating RVUs. CMS is required to review RVUs no less than every five years; the ACA added the requirement that the HHS Secretary periodically identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the MPFS.

In determining adjustments to RVUs used as the basis for calculating Medicare physician reimbursement under the MPFS, the HHS Secretary has authority, under previously existing law and as augmented by the ACA, to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures.

Through the Innovation Center, CMS has announced a radiation oncology (RO) alternative payment model (APM) that aims to improve the quality of care for cancer patients receiving radiotherapy while moving toward an episode-based rather than fee-for-service payment system. Under the potentially misvalued codes authority, in 2015, the HHS Secretary identified certain radiation therapy codes as being potentially misvalued. However, because of concerns that the existing code set did not accurately reflect the radiation therapy treatments identified, CMS created several new codes during the transition to an episodic APM.

Relevant Legislation

- **PAMPA, Section 3,** required CMS to apply the same code definitions, work RVUs, and direct inputs for the practice expense RVUs in CY2017 and CY2018 as applied in CY2016 for these transition codes, effectively keeping the payments for these services unchanged, subject to the annual update factor. PAMPA exempted these radiation therapy and related imaging services from being considered as potentially misvalued services under CMS's misvalued codes initiative for CY2017 and CY2018. PAMPA also instructed the HHS Secretary to report to Congress on the development of an episodic APM under the Medicare program for radiation therapy services furnished in non-facility settings.
- **BBA 2018, Section 51009,** extended the restrictions through CY2019.
- **Consolidated Appropriations Act, 2021, Division CC, Title 1, Section 133,** delayed the start date for the RO model until no earlier than January 1, 2022.

Current Status

The payment restrictions expired after December 31, 2019.

SSA Title XXI: State Children's Health Insurance Program

Increase to Enhanced Federal Medical Assistance Percentage (SSA §2105(b); 42 U.S.C. §1397ee(b))

Background

The federal government's share of CHIP expenditures (including services and administration) is determined by the enhanced federal medical assistance percentage (E-FMAP) rate. The E-FMAP rate is based on the FMAP rate, which is the federal matching rate for the Medicaid program. The FMAP formula compares each state's average per capita income with average U.S. per capita income. FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%.

The E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30%. Statutorily, the E-FMAP (or federal matching rate) can range from 65% to 85%. For some CHIP expenditures, the federal matching rate is different from the E-FMAP rate. For instance, the matching rate for translation and interpretation services is the higher of 75% or states' E-FMAP rate plus 5 percentage points.

Relevant Legislation

- **ACA, Section 2101,** included a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100%) for most CHIP expenditures from FY2016 through FY2019.
- **Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes (P.L. 115-120), Section 3005,** extended the increase to the E-FMAP rate for one year, through FY2020. However, for FY2020, the increase to the E-FMAP was 11.5 percentage points instead of 23 percentage points.

Current Status

The increase to the E-FMAP expired after September 30, 2020.

Appendix A. Demonstration Projects and Pilot Programs

This appendix applies to selected health care-related demonstration projects and pilot programs with portions of law that are time-limited and will lapse once a statutory deadline is reached, absent further legislative action. The relevant expiring demonstration projects and pilot programs are any related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance programs and activities, or they are health care-related demonstration projects and pilot programs that were enacted or extended in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). **Table A-1** lists the relevant demonstration projects and pilot programs that are scheduled to expire during the first session of the 117th Congress (i.e., during calendar year [CY] 2021). **Table A-2** lists any relevant demonstration projects and pilot programs that expired in CY2019 or CY2020.

Although the Congressional Research Service (CRS) has attempted to be comprehensive, it cannot guarantee that every relevant demonstration project and pilot program is included here.

Table A-1. Demonstration Projects and Pilot Programs Set to Expire in the 117th Congress, First Session

(CY2021)

Expires After	Health Care-Related Program		Provision	CRS Contact
9/30/2021	Medicare	Independence at Home Demonstration	SSA §1866E 42 U.S.C. §1395cc-5	Jim Hahn

Source: Congressional Research Service.

Notes: CY = Calendar Year; SSA = Social Security Act; U.S.C. = *U.S. Code*.

Table A-2. Demonstration Projects and Pilot Programs That Expired in the 116th Congress

(CY2019 and CY2020)

Expired After	Health Care-Related Program		Provision	CRS Contact
11/30/2020	Other	Demonstration Projects to Address Health Professions Workforce Needs	SSA §2008(c) 42 U.S.C. §1397g	Elayne Heisler

Source: Congressional Research Service.

Notes: CY = Calendar Year; SSA = Social Security Act; U.S.C. = *U.S. Code*.

Appendix B. Provisions Included in the Previous CRS Health Care-Related Expiring Provisions Report

This appendix provides information on the provisions that were included in the previous Congressional Research Service (CRS) report on health care-related expiring provisions (CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*), hereinafter referred to as *R46331*, but were not detailed in this report.

As does this report, R46331 included identified expiring provisions (of the same two types discussed herein) related to Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or private health insurance programs and activities. R46331 also included other health care-related provisions that were enacted or extended in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) or extended under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). R46331 covered extensions through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) and described health care-related provisions that, at the time of publication, expired during the first session of the 116th Congress (i.e., during calendar year [CY] 2019).

Some of the provisions detailed in R46331 fell within the scope of this report. Such provisions expired in CY2019 or CY2020. **Table B-1** includes the provisions detailed in R46331 that remain expired or were extended to dates beyond the first session of the 117th Congress (i.e., after CY2021). The third column in **Table B-1** provides each provision's expiration date as it was in R46331. The fourth column reflects updated information, providing the current expiration date for provisions extended pursuant to congressional modification. For more detailed background information on the provisions included in **Table B-1**, see CRS Report R45781, *Health Care-Related Expiring Provisions of the 116th Congress, First Session*, and R46331.

The demonstration projects or pilot programs that did not expire in the 116th Congress but were included in R46331 are listed in **Table B-2**. These demonstration projects or pilot programs are not scheduled to expire at the end of the session in question, nor did they expire in the previous Congress.

Table B-1. Provisions Included in the Previous CRS Health Care-Related Expiring Provisions Report That Were Not Included in This Report

Health Care-Related Program		Provision	Expires After Date as of CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*	Current Expiration: Expires After	CRS Contact
Medicaid	Protections for Recipients of Home and Community-Based Services Against Spouse Impoverishment	SSA §1924 42 U.S.C. 1396r-5 note	11/30/2020	9/30/2023	Kirsten Colello
Medicare	Outreach and Assistance for Low-Income Programs	MIPPA §119 42 U.S.C. §1395b-3 note	11/30/2020	9/30/2023	Kirsten Colello

Health Care-Related Program		Provision	Expires After Date as of CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*	Current Expiration: Expires After	CRS Contact
Medicare	Quality Measure Selection	SSA §1890A 42 U.S.C. §1395aaa-1	11/30/2020	9/30/2023	Amanda Sarata
Medicare	Contract with a Consensus-Based Entity Regarding Performance Measurement	SSA §1890(d) 42 U.S.C. §1395aaa	11/30/2020	9/30/2023	Amanda Sarata
Medicare	Floor on Work Geographic Practice Cost Indices	SSA §1848(e)(1) 42 U.S.C. §1395w-4(e)(1)(E)	11/30/2020	12/31/2023	Jim Hahn
Other	Sexual Risk Avoidance Education Program	SSA §510 42 U.S.C. §710	11/30/2020	9/30/2023	Adrienne Fernandes-Alcantara
Other	Personal Responsibility Education Program	SSA §513 42 U.S.C. §713(f)	11/30/2020	9/30/2023	Adrienne Fernandes-Alcantara
Other	Community Health Centers Fund[a]	ACA §10503 42 U.S.C. §254b-2(b)(1)(F)	11/30/2020	9/30/2023	Elayne Heisler
Other	Special Diabetes Programs for Indians	PHSA §330C 42 U.S.C. §254c-3(c)(2)	11/30/2020	9/30/2023	Elayne Heisler
Other	Special Diabetes Programs for Type I Diabetes	PHSA §330B 42 U.S.C. §254c-2(b)(2)	11/30/2020	9/30/2023	Elayne Heisler
Other	National Health Service Corps Appropriations[b]	ACA §10503 42 U.S.C. §254q	11/30/2020	9/30/2023	Elayne Heisler
Other	Teaching Health Centers[c]	PHSA §340H 42 U.S.C. §254b-2(H)	11/30/2020	9/30/2023	Elayne Heisler

Source: Congressional Research Service.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148); MIPPA = Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275); PHSA = Public Health Service Act; SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. Community Health Centers Fund provides funding for the Health Center Program, which is authorized in PHSA §330 (42 U.S.C. §254b). Health centers funded by the Community Health Center Fund received additional appropriations under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2).

b. The Community Health Center Fund provides funding for the National Health Service Corps program, which is authorized in PHSA §§ 331-338N (42 U.S.C. §§254d-254). This program received additional appropriations under ARPA.

c. This program received additional appropriations under ARPA.

Table B-2. Demonstration Projects and Pilot Programs Included in the Previous CRS Health Care-Related Expiring Provisions Report That Were Not Included in This Report

Health Care-Related Program		Provision	Expiration Date as of CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*	Current Expires After Date	CRS Contact
Medicaid/Other	Demonstration Program to Improve Community Behavioral Health Clinics[a]	PAMA §223(f) 42 U.S.C. §1396a	11/30/2020	9/30/2023	Alison Mitchell
Medicaid	Money Follows the Person Rebalancing Demonstration[b]	DRA §6071 42 U.S.C. §1396a note	11/30/2020	9/30/2023	Kirsten Colello
Medicare	Medicare IVIG Access Demonstration[c]	SSA §1833 42 U.S.C. §1395l	12/31/2020	12/31/2023	Cliff Binder

Source: Congressional Research Service.

Notes: DRA = Deficit Reduction Act of 2005 (P.L. 109-171); IVIG = Intravenous Immune Globulin; PAMA = Protecting Access to Medicare Act of 2014 (P.L. 113-93); SSA = Social Security Act; U.S.C. = *U.S. Code*.

a. PAMA established the Demonstration Program to Improve Community Mental Health Services for eight states to implement Certified Community Behavioral Health Clinics (CCBHCs). The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) added two states to the demonstration program.

b. Extended and amended most recently by the Consolidated Appropriations Act, 2021 (P.L. 116-260). The provision made changes to the institutional residency requirement by reducing the minimum stay for participant eligibility from 90 days to 60 days and allowed for days admitted for short-term rehabilitation to count toward the minimum stay. It made certain changes to state application requirements and provided additional funding for technical assistance, oversight, and quality assurance and improvement systems. It further required reports from the Secretary of the Department of Health and Human Services on best practices and from the Medicaid and CHIP Payment and Access Commission on qualified home and community-based settings criteria. States that do not currently participate in the Money Follows the Person demonstration may be eligible to apply for grant funding. For more information, see Medicaid.gov, "Money Follows the Person," at https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html.

c. Extended, expanded participation, and amended most recently by the Consolidated Appropriations Act, 2021. For more information, see Centers for Medicare and Medicaid Services, "Medicare Intravenous Immune Globulin (IVIG) Demonstration," at https://innovation.cms.gov/innovation-models/ivig.

Appendix C. Laws That Created, Modified, or Extended Current Health Care-Related Expiring Provisions

Table C-1. Laws That Created, Modified, or Extended Current Health Care-Related Expiring Provisions

P.L. Number	Abbreviation	Act Title
P.L. 97-248	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
P.L. 101-239	—	Omnibus Budget Reconciliation Act of 1989
P.L. 101-508	OBRA 90	Omnibus Budget Reconciliation Act of 1990
P.L. 104-191	HIPPA	Health Insurance Portability and Protection Act of 1996
P.L. 104-193	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
P.L. 105-33	BBA 97	Balanced Budget Act of 1997
P.L. 106-113	BBRA 99	Balanced Budget Refinement Act of 1999
P.L. 106-554	BIPA 2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
P.L. 107-210	—	Trade Act of 2002
P.L. 107-360	—	An Act to Amend the Public Health Service Act with Respect to Special Diabetes Programs for Type 1 Diabetes and Indians
P.L. 108-40	WREA 2003	Welfare Reform Extension Act of 2003
P.L. 108-74	—	State Children's Health Insurance Program Allotments Extension Act
P.L. 108-89	—	An Act to Extend the Temporary Assistance for Needy Families Block Grant Program, and Certain Tax and Trade Programs, and For Other Purposes
P.L. 108-173	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003[a]
P.L. 108-210	WREA 2004	Welfare Reform Extension Act of 2004
P.L. 108-262	—	TANF and Related Programs Continuation Act of 2004
P.L. 108-308	—	Welfare Reform Extension Act, Part VIII
P.L. 109-4	WREA 2005	Welfare Reform Extension Act of 2005
P.L. 109-19	—	TANF Extension Act of 2005
P.L. 109-91	—	QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005
P.L. 109-171	DRA	Deficit Reduction Act of 2005
P.L. 109-432	TRHCA	Tax Relief and Health Care Act of 2006
P.L. 109-482	—	National Institutes of Health Reform Act of 2006
P.L. 110-48	—	An Act to Provide for the Extension of Transitional Medical Assistance, and Other Provisions
P.L. 110-90	—	TMA, Abstinence Education, and QI Programs Extension Act of 2007
P.L. 110-92	—	Making Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes
P.L. 110-116	—	Department of Defense Appropriations Act of 2008

P.L. Number	Abbreviation	Act Title
P.L. 110-137	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes
P.L. 110-149	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes
P.L. 110-173	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007[b]
P.L. 110-275	MIPPA	Medicare Improvements for Patients and Providers Act of 2008[c]
P.L. 111-3	CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009[d]
P.L. 111-5	ARRA	American Recovery and Reinvestment Act of 2009[e]
P.L. 111-148	ACA	Patient Protection and Affordable Care Act of 2010[f]
P.L. 111-152	HCERA	Health Care and Education Reconciliation Act of 2010[g]
P.L. 111-309	MMEA	Medicare and Medicaid Extenders Act of 2010
P.L. 112-40	—	Trade Adjustment Assistance Extension Act of 2011
P.L. 112-78	TPTCCA	Temporary Payroll Tax Cut Continuation Act of 2011
P.L. 112-96	MCTRJCA	Middle Class Tax Relief and Job Creation Act of 2012
P.L. 112-240	ATRA	American Taxpayer Relief Act of 2012[h]
P.L. 113-67	BBA 13/ PSRA	Continuing Appropriations Resolution of 2014, which includes Division A, the Bipartisan Budget Act of 2013, and Division B, the Pathway for SGR Reform Act of 2013
P.L. 113-93	PAMA	Protecting Access to Medicare Act of 2014
P.L. 113-198	—	An Act to Provide for the Extension of the Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals Through 2014
P.L. 114-10	MACRA	Medicare Access and CHIP Reauthorization Act of 2015[i]
P.L. 114-27	—	Trade Preferences Extension Act of 2015
P.L. 114-112	—	An Act to Provide for the Extension of the Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals Through 2015
P.L. 114-113	—	Consolidated Appropriations Act of 2016
P.L. 114-115	PAMPA	Patient Access and Medicare Protection Act
P.L. 114-255	Cures Act	The 21st Century Cures Act[j]
P.L. 115-31	—	Consolidated Appropriations Act, 2017
P.L. 115-63	—	Disaster Tax Relief and Airport and Airway Extension Act of 2017
P.L. 115-96	—	An Act to amend the Homeland Security Act of 2002 to require the Secretary of Homeland Security to issue Department of Homeland Security-wide guidance and develop training programs as part of the Department of Homeland Security Blue Campaign, and for other purposes
P.L. 115-120	—	Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes
P.L. 115-123	BBA 2018	Bipartisan Budget Act of 2018[k]
P.L. 116-3	—	Medicaid Extenders Act of 2019
P.L. 116-16	—	Medicaid Services Investment and Accountability Act of 2019

P.L. Number	Abbreviation	Act Title
P.L. 116-20	—	Additional Supplemental Appropriations for Disaster Relief Act, 2019
P.L. 116-39	—	The Sustaining Excellence in Medicaid Act of 2019
P.L. 116-59	—	Continuing Appropriations Act, 2020, and Health Extenders Act of 2019
P.L. 116-69	—	Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019
P.L. 116-94	—	Further Consolidated Appropriations Act, 2020
P.L. 116-127	FFCRA	Families First Coronavirus Response Act[l]
P.L. 116-136	CARES Act	Coronavirus Aid, Relief, and Economic Security Act[m]
P.L. 116-159	—	Continuing Appropriations Act, 2021 and Other Extensions Act
P.L. 116-215	—	Further Continuing Appropriations Act, 2021, and Other Extensions Act
P.L. 116-260	—	Consolidated Appropriations Act, 2021
P.L. 117-2	ARPA	American Rescue Plan Act of 2021[n]
P.L. 117-7	—	To prevent across-the-board direct spending cuts, and for other purposes

Source: Congressional Research Service (CRS).

Notes:

a. See CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, and CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*.

b. See CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

c. See CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

d. See CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*.

e. The Health Information Technology for Economic and Clinical Health Act was incorporated into ARRA. A description of the Medicare provisions in that bill can be found in CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*.

f. See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

g. See CRS Report R41124, *Medicare: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (P.L. 111-148)*.

h. See CRS Report R42944, *Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012*.

i. See CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

j. See CRS Report R44720, *The 21st Century Cures Act (Division A of P.L. 114-255)*, and CRS Report R44730, *Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)*.

k. See CRS Report R45126, *Bipartisan Budget Act of 2018 (P.L. 115-123): Brief Summary of Division E—The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act*, and CRS Report R45136, *Bipartisan Budget Act of 2018 (P.L. 115-123): CHIP, Public Health, Home Visiting, and Medicaid Provisions in Division E*.

l. See CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*.

m. See CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)*.

n. See CRS Report R46777, *American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions*.

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