

The Build Back Better Act

BY BLAKE MCCREERY-CULLIFER



The huge piece of legislation known as the Build Back Better Act lays the groundwork for many of the healthcare promises Democrats ran on in 2019. If enacted, patients with cancer across the country will benefit from increased access and new fiscal protections, including universal paid family leave. That being said, specific pieces of the Build Back Better Act may have negative consequences for oncology programs and practices nationwide.

A recent Congressional Budget Office score increased the likelihood of passage; the score suggested that the act would only add \$367 billion (about \$1,100 per person in the United States) to the budget deficit over the next decade.

However, given the lack of support for the current version of the bill in the Senate, it is unlikely that the Act will advance without significant alterations. It is our hope that the problematic pieces of this legislation are addressed in future negotiations. Below are some of the high-level changes the bill would make to the U.S. healthcare landscape in its current form.

ACA Marketplace

During the COVID-19 pandemic, Marketplace premiums received additional subsidies and enrollment time frames expanded. Patient advocates applauded these moves. People who lost their jobs because of the pandemic also became eligible for zero-dollar premiums. Since the expansion of subsidies, the Marketplace has seen millions of new beneficiaries enroll in health plans. Though these measures are only temporary and are set to expire in 2022, Section 137301 of the Build Back Better Act would extend premium subsidies and eliminate any income requirements that made the most impoverished ineligible for premium reductions. Additionally, this section extends the break

for those on unemployment insurance through 2025.

Medicaid

At this time, 12 states have chosen not to expand Medicaid. In these states, a coverage gap exists for individuals whose income falls under 138 percent of the federal poverty level. The Build Back Better Act would close this gap under section 137304 by fully subsidizing Marketplace health plans starting in 2022 through 2025. Additionally, these beneficiaries would be eligible for cost-sharing subsidies that would reduce their out-of-pocket costs to 1 percent of overall covered health expenses on average.

Medicare

Currently, most Medicare beneficiaries do not receive coverage for hearing services. Except for specific clinical circumstances found in some Medicare Advantage plans, hearing aid costs can be incredibly high. Section 30901 of the Build Back Better Act seeks to address this issue by creating a pay structure for hearing aids that resembles the current pay structure for most prosthetics. Medicare beneficiaries would be able to obtain hearing aids with a 20 percent coinsurance, every five years, starting in 2023.

Under the current Medicare Part D drug benefit program structure, multiple pay phases exist, such as a deductible, initial coverage phase, coverage gap phase, and catastrophic phase. In other words, beneficiaries maintain some responsibility of drug costs indefinitely. One provision in the Build Back Better Act sets a \$2,000 cap on patient out-of-pocket patient costs for Part D drugs.

The most controversial piece of the Build Back Better Act is found in sections 139001, 139002, and 139003. Many refer to these sections jointly as H.R.3 or the Elijah E. Cummings Lower Drug Costs Now Act. These

sections seek to lower prescription drug costs. The controversy—and concerns—hinges on how lower drug costs would be achieved. These sections seek to amend the non-interference clause that has barred the secretary of Health and Human Services from negotiating drug prices—even when increases in cost exceed inflation. This amendment would compel the secretary to negotiate specific categories of drugs on a defined timeline and mandate a rebate on drugs that were sold at costs that exceeded inflation. It is worth noting one exception: drugs that have biosimilar competitors would be exempt from these negotiations, at least initially.

Concerning cancer care providers, it is critical to know how these provisions would impact overall reimbursement. These changes represent a potentially egregious cut in physician reimbursement. An analysis by Avalere found that “medical oncology, hematology/oncology, and rheumatology practices would experience reductions of 42.9 percent, 41.3 percent, and 48.5 percent, respectively.”¹ Furthermore, Avalere estimated that radiation oncology would see a 39.7 percent reduction in reimbursement.²

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References

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