

successful Minority AIDS Initiative model. The bill would amend the Public Health Service Act to allow the Secretary of Health and Human Services to make grants to public and private nonprofit health care providers to offer treatment for diabetes in minority communities. The bill would require the Secretary to ensure that such grants cover a variety of diabetes-related health care services, including routine care for diabetic patients, public education on diabetes prevention and control, eye care, foot care, and treatment for kidney disease and other complications of diabetes.<sup>55</sup>

The **Access to Affordable Health Care Act** (S. 158), introduced in January 2007 by Senators Susan Collins (R-ME) and Mary Landrieu (D-LA), contains provisions that would benefit communities at risk for CKD. The Act would amend the Internal Revenue Code to allow deductions for long-term care premiums and tax credits for individuals with long-term care needs. It would also require the Secretary of Health and Human Services to award demonstration grants for states to show the effectiveness of innovative ways to increase access to health insurance; amend the State Children's Health Insurance Program to allow states to extend coverage to qualified children, parents, and pregnant women; to simplify qualification and enrollment requirements; and require the Secretary to provide improved outreach and enrollment for eligible children, homeless individuals, and families. The bill would also require the Secretary to (1) award grants to states for the promotion of healthy lifestyles and for the establishment and operation of worksite wellness programs for small business employers and their employees; (2) expand comprehensive school health education programs; and (3) establish demonstration projects related to providing low-cost, high-quality health care and attracting educators and clinical practitioners to underserved areas.<sup>56</sup>

The panel recommends that the NMA monitor the activity of these and other emerging policies to determine if there are any gaps that may adversely affect the African American CKD population. The panel also recommends that the NMA build strategic partnerships with organizations such as the Association of Black Cardiologists, the National Kidney Foundation, Renal Physicians Association, Transplantation Roundtable, and National Committee for Quality Assurance to augment NMA's efforts to keep the needs of the African American CKD community on the forefront of the national health policy agenda.

## Extended Medicare Coverage

The panel also recognizes that, when it comes to minority health care, changes in health policy may be built on a "one size fits all" model that may conflict with the realities of life and health within communities of color.

An example of one such policy gap involves ESRD patients and payment for medications under the Medicare Part D prescription program. Recent surveys suggest that the patients have total drug costs of \$6,500 per year, with the average out-of-pocket expenses and premiums totaling approximately \$4,050 per year. Patients with ESRD who enrolled in Medicare Part D may find themselves subject to the "doughnut hole" coverage gap, which occurs when drug costs exceed \$2,250 (but are lower than \$5,100). When this occurs,

patients must pay 100% of costs, unless they are qualified for exclusion based on low income or Medicaid eligibility.

The panel recognizes the excessive burden this places on ESRD patients—a predominantly minority population that is already burdened with comorbidities and socioeconomic challenges—and understands how this policy may indirectly lead to medication noncompliance. Thus, the panel recommends that the NMA make a formal stand to support the negotiation of renal drug coverage under Medicare Part D to assist patients facing the coverage gap.

The cost of renal drugs is staggering. Currently, the only Medicare beneficiaries eligible for lifetime Medicare coverage of transplant drugs are (1) those who were and are eligible for Medicare because they are aged or disabled and (2) those whose transplants were paid for by Medicare. This leaves former Medicare or other Medicare patients with limited coverage, or no coverage at all. For a patient who has Medicare only because of kidney failure, Medicare will pay for the transplant and for 36 months of immunosuppressive drug therapy after the month of the transplant. For those patients whose transplants were not originally paid for by Medicare, there is no Part B drug benefit coverage for immunosuppressants. In light of these issues, and the impact they may have on patient survival and medication compliance, the panel recommends that the NMA:

- Urge Congress to extend coverage of immunosuppressive drug therapy for ESRD beneficiaries under Medicare. Extending this coverage allows ESRD patients to pursue and support transplantation, and gives them access to the drugs that they need to survive.
- Support the renegotiation of renal drug prices in order to increase patient access to medications and to increase medication compliance.

Other panel recommendations regarding health policy include the following:

- That the NMA open a dialogue with the Department of Health and Human Services' Office of the Inspector General (OIG) to educate policymakers on how some initiatives, while designed to reduce conflict of interest and fraud by corporate entities, may instead hurt physicians and patients in medically underserved areas. The OIG policies have a chilling effect on corporate contributions to prevention and education campaigns or projects in African American communities. The panel suggests that NMA serve as an intermediary in the development and funding of these prevention and education projects.
- That the NMA develop and issue a formal legal statement expressing concern that the suspension of disparity-related activities by the National Institutes of Health (NIH) during its reevaluation of its Strategic Plan and Budget To Reduce and Ultimately Eliminate Health Disparities, is injurious to the health of African American and other minority communities. Since its introduction in 2002, the NIH National Center on Minority Health Disparities (NCMHD), through the strategic plan, has helped to support communities of color through pro-