

December 19, 2003

This is one of a series of periodic reports from NHeLP's Washington office, reporting briefly on recent and forthcoming developments relating to federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments, which can be sent to Mara Youdelman at youdelman@healthlaw.org.

SUBJECTS COVERED

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HAPPY HOLIDAYS

Everyone at the National Health Law Program wishes you, your families, friends and loved ones a happy, healthy and safe holiday season!

ROUNDUP OF THE 108TH CONGRESS, FIRST SESSION

MEDICARE PRESCRIPTION DRUGS

On December 8th, President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173). Along with many provisions not addressing prescription drugs, the law creates a new Medicare "Part D" benefit that will offer prescription drug coverage to individuals eligible for Medicare. Enrollment is voluntary for all Medicare recipients except those who are also eligible for Medicaid, who will have to enroll in Part D if they wish to have any drug coverage at all. Coverage will be available through specialized drug plans or as part of the benefit offered by a managed care organization.

Most beneficiaries will pay a monthly premium (that will vary across the country but is expected to average about \$35/month), have a \$250 deductible and pay 25 percent for most prescription drugs (up to an initial coverage limit of \$2250; after \$2250, beneficiaries will have to pay 100 percent of the costs until a catastrophic coverage level of \$5100 in drug expenses is reached). The bill includes subsidies for low-income beneficiaries. Beneficiaries below 135 percent of the FPL (approximately \$12,000/year for singles and \$16,400/year for couples) and who meet an asset test will have no premiums or deductibles. Beneficiaries who are below 100 percent FPL will pay \$1 for generic drugs and \$3 for brand name drugs; beneficiaries between 100-135 percent FPL will pay \$2 and \$5, respectively. Some subsidies continue on a sliding scale for low-income beneficiaries up to 150 percent FPL.

Part D will not be administered by HHS but rather by private prescription drug plans (PDP). Each plan must comply with certain standards but will develop its own drug formulary. Each PDP formulary must include at least two drugs per therapeutic class, although the PDP will define its therapeutic classes. There are no standardized formulary requirements; so coverage of a given drug could vary significantly by region and among PDPs. While beneficiaries who are prescribed a drug that is not on a PDP's formulary can purchase the drug themselves, they may not count those costs towards the Part D deductible or as out of pocket expenses needed to reach the catastrophic coverage threshold.

Dual eligible beneficiaries "those eligible for both Medicare and Medicaid" will have to join the new Part D, because the Act, for the first time, prohibits Medicaid from paying for virtually any prescription drugs for anyone who could participate in Part D. On the other hand, Part D may, depending on the nature of the drug coverage ultimately offered by the private plans, represent a major improvement for many low-income people with incomes below 135 percent of poverty, as many states currently limit Medicaid, and thereby prescription drug coverage, to those elderly and disabled whose incomes are at or below 74 percent of the federal poverty level.

Many of the details for implementation remain to be addressed through rulemaking. HHS has proposed rules for the interim drug "discount cards" which it expects to issue as early as June

2004. These discount cards will provide limited interim relief in the form of discounts – predicted to be 10-15 percent – on drug prices until the Part D benefit becomes effective in 2006. Individuals below 135 percent FPL will not have to pay an enrollment fee for the discount card and will receive up to \$600 towards drug purchases in addition to the discounts. Individuals up to 100 percent FPL will pay 5 percent coinsurance while individuals between 100-135 percent FPL will have a 10 percent coinsurance. Other beneficiaries will have to purchase the discount card. The proposed rules can be viewed at <http://www.cms.hhs.gov/discountdrugs>.

LEGISLATION AFFECTING IMMIGRANTS

The Immigrant Children's Health Improvement Act (ICHIA), which would have allowed states to enroll lawfully present immigrant pregnant women and children in Medicaid and SCHIP, was included in the Senate's version of the Medicare prescription drug bill. During the conference negotiations, ICHIA was included until the waning hours, when senior Republicans in the Senate and House conditioned their support of the bill on its removal.

The Medicare prescription drug bill does include \$1 billion in new funds (for FY 2005-08) for hospitals that treat a significant number of undocumented immigrants. Allotment is based in part on the number of undocumented immigrants residing in a state. Additional funding is provided to the six states with the highest number of apprehensions of undocumented immigrants.

One proposal is likely to come to a vote next year as part of an agreement reached with Rep. Dana Rohrabacher (R-CA) to obtain his vote of in favor of the Medicare prescription drug bill. Rep. Rohrabacher opposed the funding for hospitals described above and is drafting legislation that would require some health care providers to report undocumented immigrants to the Border Patrol within two hours of initiating treatment. The bill's actual provisions – which healthcare providers would be covered, how it would be implemented – remain unclear pending introduction of the legislation.

QI-1 EXTENDED

The Medicare prescription drug bill extended the Medicare QI-1 program through September 30, 2004.

MINORITY HEALTH BILL

On October 21, 2003, the Democratic House and Senate leadership as well as the Congressional Hispanic, Asian Pacific, Native American and Black Caucuses announced introduction of the Healthcare Equality and Accountability Access Act of 2003 (S.1833/H.R. 3459). This bill builds on the Minority Health and Health Disparities Research and Education Act of 2000. Among its many provisions, the bill would provide funding to address language barriers and create a dedicated office within the Department of Health and Human Services to coordinate access to oral interpretation and translation of written materials by healthcare providers across the country. The bill also would require the collection of racial, ethnic and primary language data throughout federal health programs. Additional titles of the bill provide funding for research, and allow enrollment of pregnant women and parents in SCHIP and lawfully present immigrant pregnant women and children in Medicaid and SCHIP.

JUDICIAL NOMINATIONS

To date, the Senate has confirmed 168 judicial nominees for the federal bench. In early November, Republicans held almost 40 hours of continuous debate on three judges who were subject to a filibuster – Priscilla Owen, Carolyn Kuhl, and Janice Rogers Brown. The extended debate failed to obtain the 60 votes needed to end the filibusters. Currently, 4.7 percent of federal judgeships are vacant. According to the Leadership Conference on Civil Rights, this is the lowest vacancy rate in the past 13 years.

RESOURCES:

The Center on Budget and Policy Priorities has released an issue brief, “Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers”. It, and other CBPP publications explaining the new Medicare bill, are available at www.cbpp.org.

The Kaiser Family Foundation has released "Coordinating Medicaid and Medicare Prescription Drug Coverage: Findings from a Focus Group Discussion with Medicaid Directors" (November 2003). It is available at www.kff.org.

FEDERAL FACTOID:

The total cost of the Medicare Prescription Drug Improvement and Modernization Act of 2003 is estimated at \$400 billion over 10 years. As part of that legislation, private health insurers will receive \$1.3 billion in the next two years as encouragement to participate in Medicare; rural Medicare providers obtained a rescission of a scheduled 1.6 percent reimbursement cut in 2004; home health agencies will receive a one-year 5 percent payment increase for serving patients in rural areas; and doctors, who previously faced a scheduled 4.5 percent cut in Medicare payments in 2004, will get a 1.5 percent payment increase.