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Medicare: Selected Prescription Drug Proposals in the 107th Congress

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Summary

Medicare, the nationwide health insurance program for the aged and disabled, does not cover most outpatient prescription drugs. On several occasions, the Congress has considered providing coverage for at least a portion of beneficiaries' drug costs. The issue received renewed attention in the 106th Congress. However, there was no consensus on how the coverage should be structured.

The issue has again received attention in the 107th Congress. The FY2002 Budget Resolution provides $300 billion over the FY2003-FY2011 period for a Medicare reserve fund for Medicare reform and prescription drug coverage. A number of bills have been introduced, though at this writing no bill has been introduced or acted on by any of the three committees of jurisdiction (House Ways and Means, House Energy and Commerce, and Senate Finance).

The drug provisions of Medicare proposals introduced in both the 106th and 107th Congresses contain a number of common themes. In general, they would make coverage available to all Medicare beneficiaries on a voluntary basis. They would place a limit on the amount of federal spending for the new benefit, thereby requiring beneficiaries (or their supplementary insurance) to pay the remaining costs. Further, they would provide assistance for low-income persons. However, there are a number of significant differences between the bills. These include the degree of reliance and financial risk placed on the private sector versus the public sector, the definition and scope of benefits, the federal administrative structure, and implementation of low-income subsidies.

It is generally agreed that if Congress were to enact a drug benefit this year, it would take several years before the program could be implemented. As an interim measure, President Bush announced June 14, 2001, the creation of a Medicare Prescription Drug Discount program. This program, which could be administered as early as fall 2001, provides for the endorsement by Medicare of qualified privately-administered prescription drug discount cards. Beneficiaries could obtain these cards either free of charge or for a nominal enrollment charge; the card would provide access to discounts on prescription drugs. While this does not establish a Medicare drug benefit, it is designed to give seniors access to similar kinds of discounts as are available to the under age 65 population under private insurance plans.

This report provides a side-by-side comparison of *bills introduced in the 107th Congress that have received the most attention.* To date these are S. 358, introduced by Senators Breaux and Frist, and S. 1135, introduced by Senator Graham et al. This report is a companion report to CRS Report RL30819, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*; that report includes a discussion of the major benefit design questions that would need to be addressed as the Congress develops a drug benefit. This report will be updated to reflect any legislative action.

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Introduction

Medicare, the nationwide health insurance program for the aged and disabled, does not cover most outpatient prescription drugs. The absence of an adequate prescription drug benefit has been of concern to policymakers since the enactment of Medicare in 1965. On several occasions, the Congress has considered providing coverage for at least a portion of beneficiaries' drug costs. The issue received renewed attention in the 106th Congress. However, there was no consensus on how the coverage should be structured.

The issue has again received attention in the 107th Congress. A number of bills have been introduced, though at this writing no bill has been introduced or acted on by any of the three committees of jurisdiction (House Ways and Means, House Energy and Commerce, and Senate Finance).

One of the key concerns in designing a drug benefit is the potential costs and how costs would increase over time. Another issue is the appropriate role of both the federal government and the private sector in assuming the financial risk of coverage and administering the benefit. Some observers suggest that a drug benefit should be added directly to Medicare while others recommend alternative approaches for assuring coverage for the target population. A further consideration is whether a major new benefit should be added until structural reforms are made to the Medicare program as a whole.[1]

It is generally agreed that if Congress were to enact a drug benefit this year, it would take several years before the program could actually be implemented. As an interim measure, President Bush announced June 14, 2001, the creation of a Medicare Prescription Drug Discount program. This program, which could be administered as early as fall 2001, provides for the endorsement by Medicare of qualified privately-administered prescription drug discount cards. Beneficiaries could obtain these cards either free of charge or for a nominal enrollment charge; the card would provide access to discounts on prescription drugs. While this does not establish a drug benefit, it is designed to give seniors access to similar kinds of discounts as are available to the under age 65 population under private insurance plans.

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[1]For a discussion of the major issues that would need to be addressed as Congress considers policy options, see: CRS Report RL30819, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*, by Jennifer O'Sullivan.

Legislation

106th Congress

A number of bills were introduced in the 106th Congress which would have established a prescription drug benefit for Medicare beneficiaries. Some measures added a new benefit to the Medicare program itself. Other proposals provided a new drug benefit through another federal or state program. Still other measures focused on private insurance coverage. Some other bills focused on the prices seniors pay for drugs.

The House passed the Medicare Rx 2000 Act (H.R. 4680, as amended) on June 28, 2000. The House bill relied on private insurance companies and other private sector entities to provide coverage. These entities were to be partially subsidized for assuming the risk of prescription drug costs. At a minimum, plans would have had to provide "qualified coverage." "Qualified coverage" was defined as "standard coverage" or coverage that was actuarially equivalent (i.e., had an equivalent dollar value). "Standard coverage" was defined as having: 1) a deductible ($250 in 2003), 2) then 50% cost-sharing up to an initial coverage limit (the next $2,100 in 2003, accounting for $1,300 in total out-of-pocket costs ($1,050 plus $250 deductible) and $2,350 total spending); 3) then no coverage until the beneficiary had out-of-pocket costs of $6,000 ($7,050 in total spending; and 4) once the beneficiary reached the $6,000 catastrophic limit full coverage would be provided. Low-income seniors would receive assistance for premiums and costs not paid by the new benefit. The drug benefit and the Medicare+Choice program were to be administered by a new Medicare Benefits Administration.

Several other measures received considerable attention in the 106th Congress. These included proposals offered by President Clinton (S. 2342) and similar Democratic bills (S. 2541 and H.R. 4770), measures introduced by Senators Breaux and Frist (S. 1895 and S. 2807), and a bill introduced by Senators Graham and Robb. The Senate Finance Committee held a number of hearings but did not report a bill.[2]

107th Congress

Status of Legislation. The issue of prescription drug coverage is again receiving considerable attention in the 107th Congress. The FY2002 Budget Resolution provides $300 billion over the FY2003-FY2011 period for a Medicare reserve fund for Medicare reform and prescription drug coverage.[3] As of this writing, the three committees of

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[2]For discussion of the House-passed bill as well as other major bills considered in the 106th Congress see: CRS Report RL30584, *Medicare: Selected Prescription Drug Proposals in the 106th Congress*, by Jennifer O'Sullivan; and CRS Report RL30593, *Medicare: Side-by-Side Comparison of Selected Prescription Drug Bills*, by Jennifer O'Sullivan and Heidi Yacker.

[3]For a further discussion of Medicare financing and other structural reform issues see: CRS Report RL31058, *Medicare Structural Reform: Background and Options*, by Jennifer (continued...)

jurisdiction have indicated that they are working on bills which would address both drug coverage as well as other reform items. However, committee bills have not yet been introduced.

Several other bills have been introduced. To date the two that have received the most attention are: 1) S. 358, the "Medicare Prescription Drug and Modernization Act of 2001 (Breaux and Frist, also known as "Breaux-Frist 2"); and 2) S.1135, the Medicare Reform Act of 2001 (Graham et al.). Both are similar, but not identical, to measures introduced in the 106th Congress.

Overview of Major Proposals

Proposals introduced in both the 106th and 107th Congresses contain a number of common themes. In general, they would make coverage available to all Medicare beneficiaries on a voluntary basis. They would have a limit on the amount of federal spending for the new benefit. Beneficiaries would be expected to assume specified costs of the new benefit in the form of premiums and cost-sharing charges. The bills generally would pay most or all of these charges for the low-income (generally persons below 135% of poverty). Other individuals would have a limit on out-of-pocket costs (a "catastrophic limit").

There are, however, a number of significant differences between the bills. These include the degree of reliance and financial risk placed on the private sector versus the public sector, the definition and scope of benefits, the federal administrative structure, and implementation of low-income subsidies.

Private vs. Public Sector Responsibility. Virtually all proposals would place some measure of responsibility on the private sector for administration of a drug plan. It is the degree of reliance placed on the public versus the private sector that is one of the key areas of difference among the various proposals.

Last year's House-passed bill would have provided access to a drug-only benefit through private insurance companies and other entities who wished to offer the benefit. This year's Breaux-Frist 2 plan would also provide access to a drug benefit through private entities or Medicare+Choice plans. Under these proposals, most of the financial risk for the cost of covered benefits would be placed on the entities administering the benefit.

Under the House-passed bill, the Administrator of the new Medicare Benefits Administration would have administered the program in a manner such that eligible individuals would be assured access to at least two plans. If necessary to ensure access, the Administrator would have been authorized to provide financial incentives. The Breaux-Frist 2 bill specifically requires the Commissioner of a new Competitive Medicare Agency

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[3](...continued)
O'Sullivan, Hinda Ripps Chaikind, and Sibyl Tilson.

(CMA) to develop procedures for the provision of standard prescription drug coverage to each beneficiary residing in an area where there were no private entities providing coverage. The Commissioner could establish procedures that permitted partial risk-sharing arrangements if the Commissioner determined that this would generate bids in areas with no Medicare Prescription Plus plans or Medicare+Choice plans providing coverage. Under both bills, the private plans would be at risk for any costs in excess of federal subsidy payments and federal reinsurance payments. Reinsurance payments are made to cover a portion of the costs paid by plans for individuals exceeding the catastrophic out-of-pocket limit.

Under the Graham bill, the new benefit would be administered at the federal level like other Medicare benefits and the federal government would bear most of the financial risk of coverage. The actual operation of the benefit would be through contracts with private entities such as pharmaceutical benefit managers (PBMs). PBMs currently administer the drug benefit, including negotiating price discounts, for many private insurance plans. Under the Graham bill, a portion of the administrative fees for these entities would be put at risk; specifically, an adjustment would be made in administrative payments to ensure that entities complied with requirements relating to performance goals.

Scope of Benefits. Another key difference among proposals is the scope of benefits. Under the Graham bill there would be *one specific benefit* available to all enrollees nationwide. Conversely, under last year's House-passed bill and Breaux-Frist 2 there would be a *minimum* benefit level established. Under the House-passed bill and Breaux-Frist 2, the minimum benefit (referred to as "qualified coverage") would be either specified "standard coverage" or alternative coverage, provided it was actuarially equivalent to standard coverage and had the same limit on out-of-pocket spending.

Administration. Medicare is currently administered by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). Prior to June 14, 2001, this agency was known as the Health Care Financing Administration (HCFA). Several of the proposals would establish a new entity to administer the drug benefit at the federal level. Under the last year's House-passed plan, a new Medicare Benefits Administration (MBA) would have been established (outside of HCFA, but within HHS) to administer the drug benefit and Medicare+Choice. Under Breaux-Frist 2, a new Competitive Medicare Agency (outside of HHS) would be established to administer the drug benefit and Medicare+Choice; an independent Medicare Competition and Prescription Drug Advisory Board would be set up to advise the Commissioner of this agency. Under the Graham bill, the benefit would be administered by CMS; an advisory committee would be established to advise the Secretary on policies related to the drug benefit.

Low-Income. Under current law, some low income aged and disabled Medicare beneficiaries are also eligible for drug coverage under Medicaid. Those persons *entitled to full Medicaid protection* generally have prescription drug coverage. Some groups receive more limited Medicaid benefits. Qualified Medicare Beneficiaries (QMBs) are persons with incomes below poverty and resources below $4,000; these persons receive Medicaid assistance for Medicare cost-sharing and premium charges. Specified Low

Income Beneficiaries (SLIMBs) meet the QMB definition except that their income limit is above the QMB level; the SLIMB limit is 120% of poverty. QMBs and SLIMBs only receive drug benefits if they are also entitled to full Medicaid coverage. Under a temporary program, the SLIMB level can be extended to certain persons under 135% of poverty who are not otherwise eligible for Medicaid.

All of the major proposals would provide significant assistance to persons below 135% of poverty – in terms of premiums that would have to be paid for coverage and/or cost sharing once persons used benefits. The plans provide for no, or very limited, beneficiary liability for covered services for this population group. Some of the proposals would extend the low-income assistance protections to persons at slightly higher income levels. The proposals differ in what portion of the costs of low-income subsidies would be paid under the current federal-state Medicaid program and what portion would be fully paid by the federal government.

President Bush's Medicare Drug Discount Program

On July 12, 2001, the President announced the *President's Framework to Strengthen Medicare*. This document included the outlines for Medicare reform and prescription drug coverage. It did not include statutory language; instead the Administration intends to work with the Congress in developing legislation.

On the same day, the President announced a new national drug discount program for Medicare beneficiaries. The Administration intends to implement the program administratively; that is, no legislation will be requested.[4] This discount program is viewed as an interim step until a legislative reform package, including both a drug benefit and other Medicare reforms, is enacted.

The drug discount program is intended to give seniors access to similar kinds of discounts as are available to the under age 65 population under private insurance plans. Under the discount plan, Medicare will endorse and promote qualified privately-administered prescription drug discount cards. Approved card sponsors (PBMs and similar entities) will make the cards available either free or at a one-time enrollment charge (not to exceed $25). Beneficiaries could enroll in only one Medicare-endorsed card program at a time; they could change enrollment on a semi-annual basis.

Approved card sponsors will be required to enroll all Medicare beneficiaries willing to participate. They must provide a discount on at least one brand and/or generic drug in each therapeutic class. They will be required to offer a national or regional pharmacy network, providing strong retail access. Applicants are urged to include a mail-order service as part of their program; however, mail-order only plans will not be approved.

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[4]On July 17, 2001, the National Association of Chain Drug Stores and the National Community Pharmacy Association filed a suit against HHS stating that the Administration violated the Administrative Procedures Act in the way the it established the program.

Medicare will require approved card sponsors to publish the discounted prices. Approved plans could not charge fees to CMS.

The discount program is a private program; it is not financed by federal dollars. The federal oversight role is limited to annual certification of plans based on specified criteria including membership thresholds, pharmacy network thresholds, and the inclusion of all therapeutic classes in the discount program.

Card sponsors will be required to participate in and help finance a Consortium to handle all enrollment and eligibility functions as well as publicize comparative information on the different discounted drug prices and quality enhancements available from various card sponsors. By October 1, 2001, the Consortium will be required to implement a system to permit seniors to compare card programs on such factors as formulary content, networks and discounts. By October 1, 2002, the Consortium would be expected to help consumers comparison shop by providing them with the actual discounted prices associated with various card programs, including information on generic and formulary alternatives.

CMS intends to launch a major education campaign in the fall of 2001. On July 16, 2001, CMS published the requirements for endorsement. Medicare's endorsement will be based on qualification requirements relating to experience, customer service, discounts and access. The endorsement will be for 14 months. The first endorsement cycle would be effective November 1, 2001-December 31, 2002.

Summary of Major Proposals

Table 1 is a side-by-side comparison of *bills introduced in the 107th Congress that have received the most attention to date.* As noted earlier, no committee bills have been introduced to date. The summary is limited to the prescription drug provisions, though the bills may contain other Medicare provisions.

The summary highlights the major features of the bills. The first items provide a broad overview (Title, General Approach, Previous Versions, and Effective Date). This is followed by beneficiary coverage items (Eligible Populations, Program Enrollment, Plan Enrollment, and Information for Beneficiaries). Next is a discussion of benefits (Nature of Benefits, Scope of Benefits, Premium, Deductible, Cost-Sharing, and Updates to Deductible and Cost-Sharing Amounts). The next items relate to drugs (Drug Pricing and Payment, Access to Negotiated Prices, and Covered Drugs). The next items relate to administration (New Federal Agency, Federal Administration, Definition of Eligible Entity, Establishment of Plans/Benefits, Access, Federal Payments to Plans or Benefit Administrators, and Assumption of Risk). This is followed by plan requirements (Plan Requirements, Cost Controls/Formularies, Beneficiary Protections, and Pharmacies). The next items relate to existing programs which supplement Medicare benefits (Relationship to Medicare+Choice, Relationship to Private Plans, and Relationship to Medigap). Then the low-income provisions are reviewed (Low-Income Subsidies and Relationship to

Medicaid). Finally, other administrative and financing items are outlined (Reports, Accounting Mechanism, Financing, and CBO Cost Estimate).

Table 1. Side-by-Side Comparison of Selected Prescription Drug Bills Introduced in the 107th Congress

Title

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Medicare Prescription Drug and Modernization Act of 2001	Medicare Reform Act of 2001

General Approach

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner of the newly established Competitive Medicare Agency (CMA) would be required to establish a Prescription Drug and Supplemental Benefit program under Title XXII of the Social Security Act. Eligible beneficiaries would voluntarily enroll and receive access to covered outpatient drugs and, in certain cases, other supplemental benefits through enrollment in either a Medicare Prescription Plus plan offered by a private entity or a Medicare+Choice plan. These entities would assume most of the risk of benefit costs. All persons would receive a minimum of a 25% discount on that portion of their premium related to qualified prescription drug coverage. All current Medicare benefits would be guaranteed and be unaffected by the new program. (The bill also includes provisions that establish the CMA, modify the Medicare+Choice program, and establish Medicare Consumer coalitions.)	A new voluntary benefit would be established under a new Part D. The benefit would be administered by the Secretary of Health and Human Services (HHS). Enrolled beneficiaries would obtain coverage through either a Medicare+Choice plan or through enrollment in a plan offered by an eligible entity under contract with HHS. The federal government would bear most of the financial risk of coverage. (The bill also includes other Medicare provisions; these would expand coverage of preventive benefits, create an independent panel to make coverage decisions, set up a demonstration program to improve Medicare+Choice, provide for management improvements to the traditional Medicare program, and income-relate the Part B premium.)

Previous Versions

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
This bill, is frequently referred to as "Breaux-Frist 2". It is similar, but not identical to S. 2807 (Breaux and Frist) from the 106th Congress which was also known as Breaux-Frist 2. "Breaux Frist 1" (S. 357 in the 107th Congress, S. 1895 in the 106th Congress) provides for more extensive Medicare reforms.	The drug portion of this bill is similar to S. 10 (Daschle), though there are a number of differences between the two bills. S. 10 is very similar, but not identical to, S.Amdt. 3598 (Robb) to H.R. 4577, submitted on June 22, 2000 (106th Congress) and not agreed to on the same date by a 44-53 roll call vote. The Senate amendment was very similar, but not identical to S. 2758, the Medicare Outpatient Drug Act (the MOD Act) introduced on June 20, 2000, by Senators Graham, Bryan, Robb, et.al.

Effective Date

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
January 2004	January 1, 2004

Eligible Populations

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
All Medicare beneficiaries enrolled in both Parts A and B who elected to enroll.	All Medicare beneficiaries (enrolled in Part A, Part B, or both) who elected to enroll.

Program Enrollment

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would establish an enrollment process which would be similar to that established for Medicare Part B. Beneficiaries would have a one-time enrollment opportunity. For current beneficiaries this would be the 6-month period beginning November 2003; for future beneficiaries it would be the same 7-month period applicable for initial Part B enrollment. A special enrollment period would be established for persons involuntarily losing other drug coverage under Medicaid, a group health plan, Medigap, a state pharmaceutical assistance program, or veterans coverage; persons would be required to enroll within 63 days of losing other coverage.	The Secretary would establish an enrollment process which would be similar to that for Medicare Part B (including provisions deeming persons enrolled when they first become eligible). An individual's initial enrollment opportunity would generally occur when an individual first became eligible for Medicare. The Secretary would establish an initial open enrollment period for current enrollees. Late enrollment penalties, similar to those applicable under Part B, would apply for persons who did not enroll during their initial enrollment period. Late enrollment penalties would not apply in cases where an individual was 1) previously covered under a group health plan (including a qualified retiree prescription drug plan) which provided coverage at least equal to the value of Part D coverage; and 2) such coverage terminated, or ceased to provide or reduced the value of coverage below the Part D level within the previous 60 days. Late enrollment penalties would also not apply for persons losing their eligibility for drug coverage under Medicaid, a state pharmaceutical assistance program, or veterans coverage within the previous 60 days.

Plan Enrollment

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would establish a process, consistent with that established for Medicare+Choice, for individuals to make an annual election to enroll in a Medicare Prescription Plus Plan offered by an entity serving their geographic area.	The Secretary would establish a process through which beneficiaries enrolled in Part D, but not in a Medicare+Choice plan, would make an annual election to enroll in a plan offered by an eligible entity. The rules would be similar to, and coordinate with, those for Medicare+Choice enrollment.

Information for Beneficiaries

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would establish a process, similar to that established for Medicare+Choice to broadly disseminate information. The information activities would be coordinated with other required information activities, including those for Medicare+Choice. The Commissioner could establish Medicare Consumer Coalitions (nonprofit entities primarily composed of beneficiaries) to help provide information to beneficiaries; such sums as may be necessary would be authorized for this purpose.	The Secretary would conduct activities to broadly disseminate information regarding drug coverage. To the extent practicable, this information would be made available 30 days prior to a beneficiary's first enrollment period. Information would include comparative information for each eligible entity on: 1) benefits provided, including prices beneficiaries will be charged, preferred pharmacies used, formularies, and appeals processes; 2) quality and performance; 3) beneficiary cost-sharing; 4) results of consumer satisfaction surveys; and 5) additional information as determined by the Secretary. The information activities would be coordinated with other required information activities including those for Medicare+Choice. The Secretary could contract with Medicare Consumer Coalitions (nonprofit entities made up primarily of beneficiaries) to conduct information activities; such sums as may be necessary would be authorized for this purpose.

Nature of Benefits

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
"Qualified coverage" would be either "standard coverage" or "actuarially equivalent coverage" (i.e., having an equivalent dollar value). Plans could offer more generous drug coverage; they could also offer supplemental non-drug benefits. If an entity offered more generous coverage, it would also be required to offer a Medicare Prescription Plus plan in the area meeting minimum coverage criteria only.	A specified benefit would be available to all enrollees nationwide.

Scope of Benefits

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.
"Standard coverage" would be defined as having a deductible ($250 in 2004), 50% cost-sharing up to the initial coverage limit (the next $2,100 in 2004 (accounting for $1,300 in total out-of-pocket costs and $2,350 total spending), then no coverage until the beneficiary had out-of-pocket costs of $6,000 ($7,050 in total spending); once the beneficiary reached the $6,000 catastrophic limit full coverage would be provided. The annual dollar amounts would be increased by the increase in average per capita aggregate expenditures for drugs by Medicare beneficiaries for the year ending the previous July. Plans could offer a package that was actuarially equivalent to the standard package, subject to certain conditions, including having a limit on out-of-pocket costs the same as that under standard coverage. A Medicare Prescription Plus plan could provide more generous drug benefits. It could also offer coverage of non-drug benefits subject to certain conditions. If these non-drug benefits included coverage of any Medicare cost-sharing charges and related charges specified as core benefits under Medigap, the plan would have to cover at least all such charges that would be covered under Medigap Plan A. If an entity offered more generous coverage, it would also be required to offer a Medicare Prescription Plus plan in the area meeting qualified coverage criteria only. Further, the Commissioner would have to find that the benefits were not designed to result in favorable selection of beneficiaries.	The benefit would be subject to a deductible ($250 in 2004), 50% coinsurance until beneficiary out-of-pocket costs reached a specified level ($3,500 in 2004), and then 25% coinsurance until out-of-pocket costs reached the out-of-pocket limit ($4,000 in 2004).

Premium

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
A plan would be required to charge a uniform premium for individuals enrolled in the plan in the same service area. Beneficiaries would pay the premium amount (less any discount) in the same manner as Part B premiums are paid (generally as a deduction from an individual's social security check). All beneficiaries would receive a discount of at least 25% of the value of standard coverage. (The low income would receive a larger discount, see below.) This discount would be included as taxable income to the beneficiary.	Beneficiaries would pay a monthly premium equal to 50% of estimated average per capita program costs; premiums paid by former employers would equal two-thirds of the total. The remaining amount would be paid by the federal government. Premiums would be collected in the same way as Part B premiums; for most persons this is a deduction from social security checks. Higher income beneficiaries would receive a lower premium contribution from the federal government. Individuals with adjusted gross incomes between $75,000 and $100,000 and couples with adjusted gross incomes between $150,000 and $200,000 would have the government premium contribution reduced from 50% to 25%, calculated on a sliding scale basis. (These income amounts would be adjusted for inflation as measured by the consumer price index for years after 2004.) All beneficiaries would receive a minimum 25% government subsidy.

Deductible

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
In 2004, the deductible for standard coverage would be $250.	The benefit would be subject to an annual deductible ($250 in 2004). An entity offering a plan could waive the deductible for generic drugs if: 1) the Secretary determined that the waiver was tied to performance goals established by the Secretary; and 2) would not result in an increase in federal costs. In this case, any coinsurance paid with respect to a generic drug would be credited toward the deductible.

Cost-Sharing

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
"Standard coverage" would be defined as having 50% cost-sharing up to the initial coverage limit (the next $2,100 after the $250 deductible in 2004, accounting for total spending of $2,350), and full coverage after an annual limit in out-of-pocket spending ($6,000 in 2004). Thus in 2004, the beneficiary would pay the first $250, $1,050 of the next $2,100 (with the plan paying the other $1,050), and all costs for drug spending between $2,350 and $7,050. The plan would pay in full for all costs over $7,050 ($6,000 in out-of-pocket costs). Out-of-pocket costs counting toward the limit would include costs paid by a state program but not those covered as benefits under other third-party coverage.	In 2004, beneficiary cost-sharing would equal 50% of costs until out-of-pocket costs totaled $3,500. At this point, beneficiary cost-sharing would be reduced to 25%. There would be no cost sharing once out-of-pocket costs reached $4,000. Thus, assuming no waiver of the deductible, the beneficiary would pay 100% of the first $250, 50% of the next $6,500 ($6,750 total, $3,500 total out-of-pocket), and 25% of the next $2,000 ($8,750 total, $4,000 total out-of-pocket). Any remaining costs would be paid by the program. An entity administering the benefit could reduce the cost-sharing if the Secretary determined that the reduction was tied to performance goals and such reduction would not increase federal costs. Entities could also require higher cost-sharing for drugs not on their formulary (see below), except that higher cost-sharing would not be permitted if the drug was determined to be medically necessary (based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence) to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary.

Updates to Deductible and Coverage Limits

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The annual dollar amounts would be increased by the increase in average per capita aggregate expenditures for drugs by Medicare beneficiaries for the year ending the previous July.	The dollar amounts would be increased in future years (beginning in 2005) by the percentage increase in average per capita expenditures under the program in the preceding year over such expenditures in 2004.

Drug Pricing and Payment

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The entity would determine payments and would be expected to negotiate discounts.	The contracting entity's bid would include a proposal for the estimated prices for covered drugs and projected annual increase in prices. The entity would be expected to negotiate discounts.

Access to Negotiated Prices

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Both standard and actuarially equivalent coverage would have to provide beneficiaries access to negotiated prices, even when the plan was under no obligation to pay for the benefits. The entity or Medicare+Choice plan would issue a drug discount card.	Plans would provide that beneficiaries would have access to negotiated prices (including applicable discounts) regardless of the fact that no or only partial benefits are paid because of the application of the deductible or coinsurance.

Covered Drugs

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
In general, coverage would be extended to outpatient prescription drugs meeting FDA criteria, biological products, and insulin. Drugs currently covered under Medicare would continue to be covered under the basic program. Drugs excluded under Medicaid would not be covered, except those for smoking cessation.	In general, coverage would be extended to outpatient prescription drugs meeting FDA criteria, biological products, and insulin. Prescription drugs and biological products meeting the criteria but also available over-the-counter would also be covered. Drugs currently covered under Medicare would continue to be covered under the basic program. Drugs excluded under Medicaid would not be covered, except those for smoking cessation. All therapeutic classes of covered outpatient drugs would be covered.

New Federal Agency

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
An independent agency, the Competitive Medicare Agency would be set up in the executive branch outside of HHS. The Agency would administer the Medicare Prescription Drug and Supplemental Benefit Program under the new Title XXII and the Medicare+Choice program. (HHS would retain responsibility for the traditional fee-for-service program.) The head of the Agency would be a Commissioner appointed by the President, with the advice and consent of the Senate, for a 6-year term. The Commissioner and the Secretary of HHS would consult on an ongoing basis to ensure coordination of programs and would exchange data as appropriate. The Commissioner would prepare an annual budget for the agency that would be submitted to the President and Congress without revision, together with the President's budget for the Agency. The Commissioner would serve as a member of the Board of Trustees of the Medicare trust funds. An independent 7-member Medicare Competition and Prescription Drug Advisory Board would be set up to advise the Commissioner on policies related to the new program and Medicare+Choice (see below).	Not applicable. However, a new Medicare Prescription Drug Advisory Committee would be established to advise the Secretary on policies related to the drug benefit (see below).

Federal Administration

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would establish a Prescription Drug and Supplemental Benefit Program. The Commissioner would establish a program enrollment process and a process through which beneficiaries would enroll, on an annual basis, in a Medicare Prescription Plus plan. The Commissioner of the new agency would have responsibility for: 1) coordinating determinations of beneficiary eligibility and enrollment under Title XVIII and the new drug program with the Commissioner of Social Security; 2) entering into and enforcing contracts with entities for the offering of Medicare Prescription Plus plans; 3) disseminating comparative information regarding benefits and quality; 4) dissemination of appeals rights information; and 5) establishing a Medicare beneficiary education program. The Commissioner would also establish processes for determining the actuarial value of prescription drug coverage and for determining the annual percentage increase in coverage limits. The Commissioner would review proposed plans based on information submitted by eligible entities and approve or disapprove the proposal. The Commissioner would have the same authority to negotiate terms and conditions of premiums and other terms of the plans as the Director of the Office of Personnel Management has with respect to Federal Employee Health Benefits plans. An independent 7-member Medicare Competition and Prescription Drug Advisory Board would be set up to advise the Commissioner on policies related to the new program and Medicare+Choice. Three members would be appointed by the President (no more than two from the same party), two by the President pro tempore of the Senate (each from a different party) and two by the Speaker of the House (each from a different party). The Board would submit reports to the Commissioner and the Congress as determined appropriate. It would be required to submit reports directly to Congress; no officer or agency could require that they be submitted to any federal officer or agency for prior review or approval.	The Secretary would: 1) establish a Part D enrollment process for beneficiaries; 2) establish an annual process for beneficiary enrollment with eligible entities; and 3) conduct information activities. The Secretary would establish a competitive bidding process for the award of contracts to eligible entities to administer and deliver the drug benefit. At least 10 different coverage areas would be established. The Secretary would consider the comparative merits of each bid based on past performance and other factors. At least two contracts would be awarded in each area unless only one entity met the bidding requirements. Each contract would be awarded for 2-5 years. The Secretary would approve marketing material and application forms. The Secretary could not award a contract unless the entity agreed to comply with terms and conditions specified by the Secretary including those relating to: 1) quality and financial standards; 2) procedures to ensure proper utilization and avoidance of adverse drug reactions; 3) patient protections; 4) procedures to control fraud, abuse, and waste; and 5) submission of reports; 6) approval of marketing material and application forms; and 7) maintenance of records. A 19-member Medicare Prescription Drug Advisory Committee would be established to advise the Secretary on policies related to development of: 1) guidelines for implementation and administration of the benefit; 2) standards for contracting entities for their Pharamacy and Theurapeutic (P&T) committees; 3) standards for entities for determining if a drug is medically necessary to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary; 4) standards for defining therapeutic classes and adding new classes to the formulary; 5) procedures to evaluate bids from eligible entities; and 6) procedures to ensure that contracting entities are in compliance with Part D requirements. The Committee membership would be representative of physicians (nine members), pharmacists (four members), Centers for Medicare and Medicaid Services (one member), actuaries, pharmacoeconomists, researchers and appropriate experts (four members), and emerging drug technologies (one member).

Definition of Eligible Entity

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
An eligible entity would be any risk-bearing entity the Commissioner determined to be appropriate to administer the benefit including a pharmaceutical benefit management company; a wholesale or retail pharmacist delivery system; an insurer (including an insurer that offers Medigap policies); another entity, or any combination of these.	An eligible entity would be any entity the Secretary determined to be appropriate to administer the benefit including: a pharmacy benefit management company (PBM); retail pharmacy delivery system; health plan or insurer; a state (through mechanisms established under a Medicaid state plan); any other entity approved by the Secretary; or any combination of such entities if the Secretary determined that the combination increased the scope or efficiency of the provision of benefits and was not anticompetitive.

Establishment of Plans/Benefits

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Each entity intending to offer a plan would be required to submit to the Commissioner information on coverage provided, actuarial value of the coverage, monthly premium to be charged for the coverage, and the service area for the plan. The Commissioner could approve a service area only if the Commissioner found that it was not designed so as to discriminate based on health status, economic status, or prior receipt of health care of eligible beneficiaries. Further, the benefit package could not be designed so as to lead to favorable selection of beneficiaries.	An entity's bid (which could include multiple areas) would include: 1) a proposal for the estimated prices for covered drugs, projected annual increase in prices, including differentials between formulary and nonformulary prices, if applicable; 2) the amount the entity would charge the government for administering the benefit; 3) a statement regarding whether the entity would waive the deductible for generic drugs and how the waiver is tied to performance goals; 4) a statement of whether there would be any coinsurance reduction and how that is tied to performance goals; 5) a detailed description of performance goals; 6) a detailed description of access to pharmacy services including whether the entity would use a preferred pharmacy network, and if so, whether the entity would offer access outside the network and what the coinsurance would be; 7) the procedures for modifying a formulary, if one is used; 8)a detailed description of any ownership or shared financial interests with other entities involved in delivering the drug benefit; 9) a description of the entity's estimated marketing and advertising expenditures; and 10) other information deemed necessary by the Secretary. Eligible entities would be required to offer drugs on a regional basis, except that the Secretary could permit coverage on a partial regional basis if the region was at least the size of the commercial service area of the entity and the area was not smaller than a state.

Access

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would develop procedures for the provision of standard prescription drug coverage to each beneficiary residing in an area where there were no Medicare Prescription Plus plans or Medicare+Choice plans providing coverage. The Commissioner could establish procedures that permit partial risk-sharing arrangements (that is the government would share some of the costs) if the Commissioner determined that this would generate bids in areas with no Medicare Prescription Plus plans or available Medicare+Choice plans providing qualified drug coverage.	The Secretary would develop procedures for the provision of covered drugs to each eligible beneficiary that resides in an area not covered by a contract. The Secretary would also develop procedures to ensure that each beneficiary that resides in different areas in a year is provided benefits throughout the year.

Federal Payments to Plans and Benefit Administrators

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The Commissioner would pay to each eligible entity the full amount of the premium for each beneficiary minus administrative costs levied on the plan. The Commissioner would provide a process for notifying eligible entities of low-income persons eligible for reduced cost-sharing and for reimbursement of the amount of such reductions. The Commissioner would provide for reinsurance payments to Medicare Prescription Plus plans, Medicare+Choice plans providing qualified prescription drug coverage, and qualified retiree drug plans. In 2004, the reinsurance payment would cover 80% of costs exceeding $7,050 (the point at which beneficiary out-of-pocket payments cease). This amount would be increased in future years by the percentage increase in average per capita aggregate expenditures for drugs by Medicare beneficiaries for the year ending the previous July. The payment method would be determined by the Commissioner and could use an interim payment system based on estimates.	The Secretary would establish procedures for making payments to eligible entities.

Assumption of Risk

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The entity would be required to assume full financial risk for the cost of covered benefits except: 1) as covered by federal reinsurance payments for high cost enrollees; and 2) as provided for under any partial risk sharing arrangements developed by the Commissioner to encourage bids (see Access, above). The entity could obtain insurance or make other arrangements for the cost of coverage provided to enrollees.	A portion of an entity's *administrative fees* would be put at risk. An adjustment would be made in payments for administration to ensure that the entity complies with requirements related to: 1) quality service (including sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member support services and timely action with regard to appeals); 2) quality clinical care (including notification to prevent adverse drug reactions and specific clinical suggestions to improve health); and 3) control of Medicare costs (including generic substitution, price discounts and other factors that do not reduce access to necessary drugs). The Secretary would determine the percentage of payments that would be tied to performance goals; however, the percentage could not be set at a level that jeopardized the ability of an eligible entity to administer and deliver the benefits in a quality manner.

Plan Requirements

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
An entity would have to be licensed as a risk-bearing entity in each state in which it offered a Medicare Prescription Plus plan. Alternatively it could meet solvency and other standards established for entities not licensed by the state. It would also have to meet beneficiary protection requirements (see below). An entity's contract with the Commissioner could cover more than one Medicare Prescription Plus plan. The Commissioner would establish standards for eligible entities. As is the case for Medicare+Choice, the standards established for plans would supersede state laws to the extent they were inconsistent. The following state standards would be specifically preempted: benefit requirements, requirements relating to inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).	Entities would have to meet specified requirements including those relating to quality and financial standards, beneficiary protections (see below), and procedures to control fraud and abuse. The entity would be required to submit annual reports on: 1) prices that the entity is paying for drugs; 2) prices enrolles will be charged; 3)administrative costs; 4) utilization of benefits; and 5) marketing and advertizing expenditures.

Cost Controls/Formularies

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
An entity offering a Medicare Prescription Plus plan or Medicare+Choice plan could use cost control mechanisms customarily used in employer-sponsored health care plans that offer coverage for outpatient prescription drugs. These include formularies, tiered copayments, selective contracting with providers of outpatient prescription drugs, and mail order pharmacies. Entities using formularies would be required to include drugs within all therapeutic categories and classes of covered drugs (although not necessarily all drugs within such categories and classes). Entities would have a process for beneficiaries to appeal denials of coverage based on application of the formulary.	Contracting entities could employ mechanisms to provide benefits economically including formularies, alternative distribution methods, and generic drug substitution. They could use mechanisms to encourage beneficiaries to select cost-effective drugs or less costly means of receiving drugs including use of pharmacy incentive programs, therapeutic interchange programs, and disease management programs. They could also encourage pharmacy providers to inform beneficiaries of price differences between generic and nongeneric drugs and to provide medication therapy management programs. Any formulary would have to comply with standards established by the Secretary in consultation with the Medicare Prescription Drug Advisory Committee. The entity would be required to use a pharmacy and therapeutics committee to develop and implement the formulary. The formulary would be required to include at least two drugs from each therapeutic class (unless only one drug was available in the class) unless clinically inappropriate, and a generic substitute (if available) if more than two drugs were available in a class and it was not clinically inappropriate. Further, the contracting entity would be required to develop procedures for modification of the formulary and to disclose to current and prospective beneficiaries related information. Entities would be required to cover nonformulary drugs when determined medically necessary (based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence) to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary. Entities could require higher cost-sharing for nonformulary drugs except when such nonformulary drug is determined medically necessary. They could educate prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of formulary drugs. Further, they could request prescribing providers to consider a formulary drug prior to dispensing of a nonformulary drug so long as the requirement did not unduly delay provision of the drug.

Beneficiary Protections

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
An entity offering a Medicare Prescription Plus plan would be required to disclose in a clear, accurate and standardized form to each enrollee information on access to covered outpatient drugs, formulary provisions, cost-sharing requirements and grievance and appeals procedures. Beneficiaries would have the right to obtain more detailed information on request. Plans would also be required to furnish beneficiaries information on benefits provided. Further, plans would be required to provide access to negotiated prices, even when the plan is under no obligation to pay for the benefits. Plans would be required to establish cost and drug utilization management, quality assurance, and fraud and abuse control programs. Entities would be required to have meaningful procedures for resolving grievances and protecting confidentiality and accuracy of enrollee records. Further they would be required to provide enrollees access to expedited coverage determinations and a procedure for reconsideration and appeals of benefit denials; these requirements would be the same as those applicable for Medicare+Choice plans. Entities would also assure that premiums charged are the same for all individuals enrolled in a plan.	Contracting entities would be required to comply with requirements relating to: 1) quality; 2) drug utilization review procedures to ensure proper utilization and compliance, and avoidance of adverse drug reactions; 3) procedures to guarantee patient confidentiality and timely transfer of records; and 4) procedures for working with the Secretary to deter medical errors related to the provision of drugs. Entities would be required to ensure that covered drugs are accessible and convenient to beneficiaries by 1) offering services 24 hours a day and 7 days a week for emergencies; and 2) if a pharmacy network is used, the network complies with standards. The entity would be required to have procedures to assure that charges for drugs do not exceed the negotiated price and the retail pharmacy dispensing the drug does not charge the beneficiary more than the beneficiary's obligation. The entity would also be required to have procedures to determine if a non-formulary drug is medically necessary (based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence) to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary. Further, entities would have to have procedures (comparable to those applicable for Medicare+Choice) to ensure timely internal and external review and resolution of denials of coverage and complaints. Beneficiaries would be provided with information on appeals procedures at the time of enrollment.

Pharmacies

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
No provision.	The entity would be required to ensure than any retail pharmacy that it contracts with meets minimum quality and technology standards. If the entity uses a preferred pharmacy network, the network would be required to meet minimum access standards; in establishing the standards, the Secretary would take into account reasonable distances to pharmacy services in both urban and rural areas.

Relationship to Medicare+Choice

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
A Medicare+Choice enrollee would obtain benefits through the Medicare+Choice plan if the plan provided qualified drug coverage. A Medicare+Choice plan could not offer drug coverage (other than that already required under Medicare) unless the coverage was at least qualified prescription drug coverage and the plan complied with the beneficiary protections required for Medicare Prescription Plus plans. Medicare+Choice plans would be required to compute and publish: a) a premium for drug benefits that is separate from other coverage; b) the ratio of the actuarial value of standard drug coverage to the actuarial value of drug coverage offered under the plan; and c) the portion of the premium attributable to standard benefits. Medicare+Choice organizations would be permitted to reduce the amount of premiums charged.	Medicare+Choice plans would be required to offer Part D drug benefits. Enrollees electing the drug benefit would receive these benefits through the plan. Capitation payments to the plans would be adjusted accordingly with a separate calculation made for Part D benefits. Medicare+Choice enrollees could not be required to pay deductible or coinsurance charges that exceed those specified under Part D.

Relationship to Private Plans

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Qualified retiree prescription drug plans would be eligible for reinsurance payments. Qualified coverage would be defined as employment-based retiree health coverage meeting certain requirements. The sponsor of the plan would be required to annually attest to the Commissioner (and to provide such other assurances as required by the Commissioner) that coverage met the requirements for qualified prescription drug coverage. The sponsor and the plan would have to maintain and provide access to records needed to ensure the adequacy of coverage and accuracy of payments made.	The Secretary would be authorized to develop an Employer Incentive Program under which employers and other sponsors of employment-based retiree coverage that is at least equivalent to that under the new Part D would receive incentive payments. Such payments would be made in behalf of beneficiaries who obtained drug coverage under the sponsors plan rather than Medicare. The incentive payment would equal two-thirds of the premium amount the beneficiary would otherwise pay if the individual were enrolled in Part D. Plan sponsors would be required to provide certain assurances and information to the Secretary.

Relationship to Medigap

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
No Medigap policy that provided coverage for prescription drugs could be sold to an individual after January 1, 2004, unless it replaced a policy for an individual that included drug coverage. Individuals enrolled in the new Title XXII program who terminated enrollment in a Medigap policy with prescription drug coverage or another policy with drug coverage would be guaranteed enrollment in a Medigap non-drug policy if enrollment occurred within 63 days of the termination of prior coverage.	The 3 of the 10 standardized Medigap plans offering drug coverage would have to be revised to complement, not duplicate Part D. The revised drug packages could not offer coverage for the Part D deductible or for more than 90% of the Part D coinsurance.

Low-Income Subsidies

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Low-income persons would receive a discount on their premiums (based on the value of standard coverage). Individuals with incomes below 135% of poverty (and assets below $4,000) would have a discount equal to 100% of the value of standard drug coverage provided under the plan. Beneficiary cost-sharing for such individuals would be nominal. For individuals between 135% and 150% of poverty, there would be a sliding scale discount on their premiums ranging from 100% of such value at 135% of poverty to 25% of such value at 150% of poverty. There would be no cost-sharing subsidy for this group. The maximum amount of cost-sharing subsidy that could be provided for an enrollee under 135% of poverty could not exceed 95% of the maximum amount of cost-sharing that could be incurred for standard coverage. Beneficiary cost-sharing for these persons would be nominal as determined by the Commissioner. A plan could waive or reduce the amount of cost-sharing otherwise applicable.	Medicaid would cover Part D premiums, coinsurance, and deductible for persons below 135% of poverty. (Coinsurance and deductible amounts would be based on drug payment amounts determined under Part D not Medicaid.) Beneficiaries between 135% and 150% of poverty would pay a reduced Part D premium, calculated on a sliding scale basis.

Relationship to Medicaid

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
The new Title XXII coverage would be primary to any drug benefits under Medicaid. The plan would require states to make eligibility determinations for low- income subsidies; there would be a 5 year phase-in of increased matching rates for this activity so that there would be full federal funding beginning in 2008. Dual eligibles (i.e., persons eligible for Medicare and full Medicaid benefits, including drugs) would have their low-income subsidy costs picked up by Medicaid. Over a 5 year period the federal matching rate for these costs would be increased to cover 50% of what would otherwise be state costs. (For example, if the regular state matching rate for Medicaid costs was 40%, the state matching rate for low income subsidies would be 20% after 5 years.) States would be required to maintain Medicaid benefits as a wrap around to Medicare benefits for dual eligibles; states could require that these persons elect Medicare drug coverage.	Low-income subsidies would be provided through Medicaid. The current federal-state matching rate would apply for those below 120% of poverty. The federal matching rate would be 100% for those between 120% and 135% of poverty. The federal matching rate would be 100% for premiums for those between 135% and 150% of poverty.

Reports

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
By January 1, 2003, the Commissioner would be required to submit a report on permitting Part B only individuals to enroll. The Commissioner would be required to submit an annual report on the administration of the new drug benefit and Medicare+Choice. The annual reporting requirements for the Board of Trustees of the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) trust funds would be expanded. The Board would be required to submit a combined report on the two trust funds as well as the Medicare Prescription Drug Account. The report would include information on total amounts obligated from the general revenues of the Treasury in the past year for benefits; a historical overview of spending; 10-year and 50-year projections; and overall spending from general revenues in relation to GDP growth. A report on the effectiveness of Medicare Consumer Coalitions (if the Commissions were established) would be due by December 31, 2004.	HHS would be required to report, within 2 years of enactment, on the feasibility and advisability of: 1) establishing a uniform format for pharmacy benefit cards; and 2) development of systems to electronically transfer prescriptions.

Accounting Mechanism

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
A Medicare Prescription Drug Account would be created within the Part B trust fund. Funds provided under the new Title XXII to the Account would be kept separate from all other funds within Part B. Program costs would be paid from the Account. The Commissioner could levy on Medicare Prescription plans and Medicare+Choice plans providing qualified drug coverage an assessment to pay the estimated expenses of the Commissioner for administering the new Title XXII. The assessments would be deposited in the Medicare Prescription Drug Account.	A Prescription Drug Account would be created within the Part B trust fund. Funds provided under the new program to the Account would be kept separate from all other funds within Part B. Program costs would be paid from the Account.

Financing

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Appropriations would be made from the general fund to cover program costs exceeding premium collections and other fees. Appropriations for administrative expenses of the Competitive Medicare Agency would be authorized on a biennial basis. Such funds as may be necessary would be authorized to be appropriated out of the Trust Funds to carry out the purposes of the Agency.	Appropriations would be made from the general fund to cover program costs exceeding premium collections.

CBO Cost Estimate

S. 358 ("Breaux-Frist 2")	S. 1135 (Graham et al.)
Not available. However, on June 11, 2001, CBO presented an updated estimate of S. 2807, "as introduced by Senators Breaux and Frist and modified in discussion with staff." This bill from the 106th Congress is similar to S. 358 from this Congress. The CBO's updated estimate of S. 2807, which presumes an implementation date of 2004, is $175.9 billion for the FY2002-2011 period.	Not available. However, on June 11, 2001, CBO presented an updated estimate of S.Amdt. 3598 to H.R. 4577 from the 106th Congress; the drug provisions of this bill (S. 1135) are similar to that amendment though there are a number of differences between the two versions. The CBO's updated estimate of the amendment, which presumes an implementation date of 2004, is $318.2 billion for the FY2002-2011 period.