Order Code RL30593

Medicare: Side-by-Side Comparison of Selected Prescription Drug Bills

Updated September 20, 2000

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Summary

A number of bills have been introduced in the 106th Congress to establish prescription drug coverage for the Medicare population. On June 28, 2000, the House passed the Medicare Rx 2000 Act (H.R.4680, Thomas, et al.). The bill relies on private plans including Medicare+Choice plans to provide drug coverage; federal subsidies would be provided to encourage participation. There would be a maximum limit on beneficiary out-of-pocket costs ("stop-loss" coverage); and assistance would be provided to low-income seniors. The drug benefit and the Medicare+Choice program would be administered by a new Medicare Benefits Administration. The Congressional Budget Office (CBO) cost estimate for the new drug program is $37 billion over the FY2001-FY2005 period and $147 billion over the FY2001-FY2010 period.

There are several other proposals which have received considerable attention to date. These are the President's plan (S. 2342), the Daschle bill (S. 2541), Breaux-Frist 2000 (S. 2807), the Graham/Bryan/Robb bill (S.2758) and the Roth bills (S.3016 and S. 3017). On June 24, 2000, the President announced several modifications to his drug plan including starting the program 1 year earlier and placing a limit on beneficiary out-of-pocket costs. The Congressional Budget Office (CBO) cost estimate of the revised proposal is $98.4 billion over the FY2001-FY2005 period and $337.7 billion over the FY2001-FY2010 period.

There are a number of common themes in many of the major prescription drug bills pending before the Congress. Most would make coverage available to all Medicare beneficiaries on a voluntary basis (though one approach would limit eligibility to those with low-incomes or high drug costs) They would all have a limit on the amount of federal spending for the new benefit. Further, they would all provide assistance for the low-income. There are major differences among the bills in how the benefits would be structured.

It is the degree of reliance placed on the public versus the private sector that characterizes one of the key areas of difference among the various proposals. All of the bills would place some measure of responsibility on the private sector for administration of a drug plan. Some bills would have the government assume all (or most) of the risk for providing the benefit while others would transfer more of the risk to the private entity. Another key difference among the plans is the scope of benefits to be provided. Under some bills a specified level of benefits would be available nationwide. Under other bills, a minimum benefit level would be established. The bills also designate different agencies to administer the new benefit at the federal level.

This report provides a side-by-side comparison of the key components of the *major* plans currently pending before the Congress. It is a companion report to CRS Report RL30584, *Medicare: Selected Prescription Drug Proposals*; that report provides more information on these major bills. Both reports will be updated to reflect any legislative action.

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Medicare: Side-by-Side Comparison of Selected Prescription Drug Bills

The following pages provide a side-by-side comparison of the following bills: 1) the Medicare Rx 2000 Act (H.R. 4680, Thomas, et al.) as passed by the House on June 28, 2000; 2) the Administration bill, the Medicare Modernization Act of 2000 (S. 2342, Moynihan), together with the revisions to the plan announced by the President on June 24, 2000; 3) the Medicare Prescription Drug and Modernization Act of 2000 (S. 2807, the "Breaux-Frist 2000" bill); 4) the Medicare Expansion for Needed Drugs (MEND) Act of 2000 (S. 2541, Daschle et al.) announced at the White House in May 2000; 5) the Medicare Outpatient Drug Act of 2000 (S. 2758, the "MOD bill" or the "Graham/Bryan/Robb" bill); and 6) the Medicare Temporary Drug Assistance Act (S. 3016 and S. 3017). For further information on these bills, see CRS Report RL30584, *Medicare: Selected Prescription Drug Proposals*; that report provides more information on these major bills.

On June 27, 2000, Congressman Gephardt, together with 111 cosponsors, introduced H.R. 4770, the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000. On June 28, 2000, during consideration of H.R. 4680, a point of order was sustained against a motion by Congressman Stark to recommit the bill to the Committee on Ways and Means with instructions to report it back with an amendment in the nature of a substitute inserting the provisions of H.R.4770. The drug provisions of the Gephardt bill are similar to the provisions of S. 2541, the Daschle bill (which is included in this side-by-side). The following are the *major* differences between the Gephardt bill and the Daschle bill. The Gephardt bill would: 1) provide coverage for prescription "medicines" not "drugs"; 2) begin in 2003 rather than 2002; 3) establish the following benefit limits: $2,000 for 2003 and 2004, $3,000 for 2005 and 2006; $4,000 for 2007 and 2008, and $5,000 for 2009 (with the beneficiary still liable for 50% of these costs); 4) increase these limits in future years by the percentage increase in the in per capita expenditures for covered medicines; 5) establish a catastrophic benefit with an out-of-pocket limit not greater than $4,000 (in 2003) and provide funding for the benefit from projected budget surpluses; 6) permit late enrollment in the program, subject to late enrollment penalties, with the amount of such penalties based on the associated costs to the program; 7) specify that the monthly premium would be $25 in 2003 and that the calculation of the premium for future years would exclude the costs associated with the catastrophic benefit; 8) specify that the Secretary would divide the country into an "appropriate number" of service areas and that the entities administering the program in these areas would be labeled "private benefit administrators"; 9) establish additional criteria, including past performance, for competitive selection of private benefit administrators; 10) specify that contracts with participating pharmacies would allow reasonable dispensing and consulting fees for pharmacists; 11) require the benefit administrator to use a pharmacy and therapeutics committee in the development and management of its formulary; and 12) require the benefit administrator to have in place a medication

therapy management program. The Gephardt bill also includes other amendments to the Medicare program including provisions relating to the appeals process, Medicare+Choice program, and payments to providers.

General Approach

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
A new optional benefit would be established under a new Part D. The bill relies on private plans to provide coverage and to bear the financial risk for drug costs; federal subsidies would be provided to encourage participation. Coverage would be provided through prescription drug plans (PDPs) or Medicare+Choice (M+C) plans. Beneficiaries could purchase either a standard plan or an actuarially equivalent plan. A new Medicare Benefits Administration would be established within HHS to administer the benefit.	A new optional drug benefit would be established under a new Part D. (The bill also includes other Medicare provisions). The federal government would bear the financial risk of coverage. The benefit would be administered by entities under contract with the Department of Health and Human Services (HHS). Any entity capable of administering the benefit could compete for the contract. JUNE 24, 2000 REVISION: the Administration announced a revision of the bill. Under the revision, the benefit would begin January 2002 and would include a $4,000 limit on out-of-pocket spending.	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 M+C plan. These private plans would be responsible for assuming the risk of drug costs. All persons would receive a minimum of a 25% discount on that portion of their premium related to qualified prescription drug coverage.	A new optional drug benefit would be established under a new Part D. The federal government would bear the financial risk of coverage. The benefit would be administered by private entities under contract with HHS.	A new optional drug benefit would be established under a new Part D. The benefit would be administered by eligible entities under contract with HHS. The federal government would bear most of the financial risk of coverage. Higher income enrollees would receive a lower contribution from the federal government toward the cot of their Part D premiums.	The bills would establish a new temporary Outpatient Prescription Drug Assistance Program under a new Title XXII of the Social Security Act. Funds would be provided to states (individually or as part of a group) who voluntarily set up prescription drug programs for low-income Medicare beneficiaries. State programs could also provide assistance to Medicare beneficiaries with high drug costs. A state's Title XXII program would be separate from its Medicaid program. The bills would establish a default program, administered by HCFA, for persons residing in states which did not establish a program. The Title XXII program would be repealed if a comprehensive Medicare reform plan, that included coverage for outpatient prescription drugs, was enacted prior to the sunset date. (Both bills are identical except for the definition of low-income, the amounts allocated to the state, and the sunset dates.)

Effective Date

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January 1, 2003.	January 1, 2003. JUNE 24, 2000 REVISION: would move date to January 2002; payments would be made to M+C plans in 2001 for drug benefits.	January 1, 2003.	January 1, 2002.	January 1, 2003	October 1, 2000. Program would sunset December 31, 2003 under S. 3016 and September 30, 2004, under S. 3017.

Covered Populations

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
All Part B enrollees who elected to enroll. A one-time opportunity would be provided for Part A-only beneficiaries.	All Medicare-eligible individuals who elected to enroll.	Beneficiaries enrolled in both Parts A and B who elected to enroll.	All Medicare-eligible individuals who elected to enroll.	All Medicare-eligible persons who elected to enroll.	Eligible persons would be low-income Medicare beneficiaries, and, at state option, beneficiaries with high drug costs. Low- income persons would be those with family income below a state-established level. This level could not exceed 150% of poverty under S. 3016 (175% under S. 3017). A higher level could be established if a state had an existing drug assistance program providing coverage for persons with incomes up to or exceeding 150% of poverty under S. 3016 (175% under S. 3017). Persons eligible for assistance with high drug

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					costs would be those whose family income exceeded the level that would qualify them as low-income and whose out-of-pocket expenditures for drugs exceeded the state-established level. States could establish resources requirements for both programs. The low-income level for the default program would be 150% of poverty. Subject to the availability of funds, the default program would also cover persons whose drug costs exceeded a level specified by HCFA.

Enrollment

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
A 6-month enrollment period would be established at the beginning of the program; an initial 7-month period would be provided for future beneficiaries. An annual election period, similar to that for M+C plans, would allow for changes in enrollment. Late enrollment penalties could apply for persons who did not maintain continuous drug coverage.	An open enrollment period would be established for first year program was in effect. A one-time opportunity would be provided for future beneficiaries (generally upon becoming eligible for Medicare).	There would be a one-time enrollment opportunity. A 6-month enrollment period would be established at the beginning of the program; an initial 7-month period would be provided for future beneficiaries. A special period would be established for person involuntarily losing other coverage. An annual election period, similar to that for M+C plans, would allow for changes in enrollment.	An open enrollment period would be established for first year program was in effect. A one-time opportunity would be provided for future beneficiaries (generally upon becoming eligible for Medicare).	The enrollment process would be similar to that for Part B. Individuals 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. An annual election period, similar to that for M+C plans, would allow for changes in enrollment.	States would establish procedures for state-based programs. HCFA would be required to establish procedures for determining eligibility for the default program.

Nature of Benefits

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
"Qualified coverage" would be either standard coverage or actuarially equivalent coverage. Plans could offer more generous coverage. The Administrator would administer the program in a manner such that all individuals have access to at least two plans. If necessary, Administrator could provide financial incentives to secure such access.	A specified benefit would be available to all enrollees nationwide.	"Qualified coverage" would be either standard coverage or actuarially equivalent coverage. 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. 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.	A specified benefit would be available to all enrollees nationwide.	A specified benefit would be available to all enrollees nationwide.	Drug assistance provided under an approved state plan would be: 1) coverage that was equivalent to that provided in a benchmark benefit package; 2) coverage that had an aggregate actuarial value equivalent to that of a benchmark package, 3) coverage that was provided under an existing state-based program, or 4) another coverage package approved by the Secretary. A state could only choose one of these options. If a state chose to provide coverage equivalent to coverage in a benchmark package, only one benchmark package could be selected.

Scope of Benefit

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Standard coverage in 2003: After $250 deductible, the plan would pay 50% of costs up to the next $2100 (i.e., $1,050 paid by plan, $1,050 paid by beneficiary). The plan would pay no costs for spending between $2,350 and $7,050. The plan would pay 100% of costs when out-of-pocket costs reached $6,000 ($7,050 in total spending). Dollar amounts would be increased annually by annual percent increase in per capita expenditures for covered drugs.	Program would pay 50% of applicable limit: In 2003 and 2004, the program would pay up to $1,000 per person per year (out of the first $2,000 in total spending). In 2005 and 2006, it would pay up to $1,500 (out of the first $3,000 in total spending). In 2007 and 2008, it would pay up to $2,000 (out of the first $4,000 in total spending). In 2009, it would pay up to $2,500 (out of the first $5,000 in total spending). Beginning in 2010, limit would be increased by the increase in the consumer price index (CPI). The bill would include $35 billion for catastrophic coverage for 2006-2010 (specifics not provided). JUNE 24, 2000 REVISION: would move the start date to January 2002 and place a $4,000 out-of-pocket limit on beneficiary liability in 2002 (indexed in future years to drug inflation).	Standard coverage in 2003: After $250 deductible, the plan would pay 50% of costs up to the next $2100 (i.e., $1,050 paid by plan, $1,050 paid by beneficiary). The plan would pay no costs for spending between $2,350 and $7,050. The plan would pay 100% of costs when out-of-pocket costs reached $6,000 ($7,050 in total spending). Dollar amounts would be increased annually by annual percent increase in per capita expenditures for covered drugs. Specific requirements would apply if an entity offered coverage of non-drug benefits and these non-drug benefits included coverage of Medicare cost-sharing charges; in this case the plan would have to cover at least what would be covered under a basic Medigap plan (Plan A).	Program would pay 50% of applicable limit: In 2002-2004, the program would pay up to $1,000 per person per year (out of the first $2,000 in total spending). In 2005-2007, it would pay up to $1,500 (out of the first $3,000 in total spending). In 2008, it would pay up to $2,000 (out of the first $4,000 in total spending). In 2009, it would pay up to $2,500 (out of the first $5,000 in total spending). Beginning in 2010, the limit would be increased by the increase in the CPI.	In 2003: After $250 deductible, the plan would pay 50% of the next $6,500 ($6,750 total spending, $3,500 total out-of-pocket), 25% of the next $2,000 ($8,750 total spending, $4,000 out-of-pocket). The plan would pay 100% of costs when out-of-pocket costs reached $4,000 ($8,750 total spending). Beginning in 2005, the dollar amounts would be increased by the percentage increase in program spending for drugs.	The benchmark packages from which a state could select would be Medicaid coverage offered in the state, coverage offered to state employees, coverage offered through the largest health maintenance organization (HMO), or Federal Employees Health Benefit Plan (FEHBP) coverage provided under the standard Blue Cross and Blue Shield service benefit plan. If an individual was covered under the default program, the benefit would be equivalent to the FEHBP benchmark package

Deductible

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Standard Coverage: $250 (2003).	No deductible.	Standard Coverage: $250 (2003).	No deductible.	$250 (2003). Under certain circumstances, the entity administering the benefit could waive the deductible for generic drugs. (In this case any coinsurance paid would be credited toward the deductible.)	Not specified.

Cost-Sharing

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
For 2003: After deductible, beneficiaries would pay 50% on the next $2,100 of costs.	Beneficiaries would pay 50% of negotiated price up to the coverage limit for a given year. Benefit managers could propose a lower percentage for certain classes of drugs, provided that aggregate costs would not be increased.	For 2003: After deductible, beneficiaries would pay 50% on the next $2,100 of costs.	Beneficiaries would pay 50% of negotiated price up to the coverage limit for a given year. Private entities administering the benefit could propose a lower percentage for certain classes of drugs, provided that aggregate costs would not be increased.	For 2003: After deductible, beneficiaries would pay 50% on the next $6,500 ($6,750 total, $3,500 total out-of-pocket) and 25% of the next $2,000 ($8,750 total, $4000 total out-of-pocket). Under certain circumstances, the entity administering the benefit could reduce cost-sharing. It could also require higher cost-sharing for non-formulary drugs, except where such drugs were determined to be medically necessary.	A plan could not impose any premium or cost-sharing on a beneficiary whose family income was below 100% of the poverty line. Any such charges imposed on other persons would be set on a sliding scale based on income. The annual aggregate of such premiums or cost-sharing for all Medicare beneficiaries in a family could not exceed 5% of the family's annual income.

Premium

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PDPs would establish premiums as part of negotiations with MBA. Premiums could not vary among beneficiaries in a plan provided they maintained continuous drug coverage. Estimated monthly premium for 2003 is $35-$40.	Beneficiaries would pay a premium equal to 50% of program costs. (If a former employer buys coverage for former employees, it would pay premiums equal to 2/3 of the program costs.) Estimated monthly premium would be $26 for 2003. JUNE 24, 2000 REVISION: specifies premium would be $25 in 2002 and would not be increased to reflect cost of placing limit on out-of-pocket expenses.	All plans would be required to charge a uniform premium for individuals enrolled in the plan in the same service area. The Commissioner would pay to each eligible entity the full amount of the premium for each beneficiary minus administrative costs levied on the plan. 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%; this discount would be included as taxable income to the beneficiary.	Beneficiaries would pay a premium equal to 50% of program costs. (Premiums paid by former employers would equal 2/3 of the program cost.)	In general, beneficiaries would pay a premium equal to 50% of program costs; the remaining 50% would be paid by the federal government. (Premiums paid by former employers would equal 2/3 of the program cost.) 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 2003). All beneficiaries would receive a minimum 25% government subsidy.	See cost-sharing, above.

Access to Negotiated Prices

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Plans would have to provide access to negotiated prices (including applicable discounts) even when no benefits are payable.	Prices would be negotiated by benefit managers with manufacturers, wholesalers, and pharmacies. Beneficiaries would have access to these prices even after they hit the cap.	Plans would have to provide access to negotiated prices (including applicable discounts) even when no benefits are payable	Prices would be negotiated by private entities with manufacturers, wholesalers, and pharmacies.	The contracting entities bid would include a proposal for the estimated prices for covered drugs and projected annual increases in prices. Entities contracts with retail pharmacies would provide that charges for drugs could not exceed negotiated prices.	Not specified.

Federal Administration

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NEW AGENCY – Establishes Medicare Benefits Administration (MBA) within HHS.	NEW AGENCY – Not applicable.	NEW AGENCY – Establishes a new executive branch agency, Competitive Medicare Agency (CMA), outside of HHS headed by a Commissioner. An independent 7-member Medicare Competition and Prescription Drug Advisory Board would be set up to advise the Commissioner.	NEW AGENCY – Not applicable.	NEW AGENCY - Not applicable. However, a 19-member Medicare Pharmacy and Therapeutics (P&T) Advisory Committee would be established to advise the Secretary on policies related to administering the new benefit.	NEW AGENCY – Not applicable.
FUNCTIONS – The MBA would: administer both the new Part D (drugs) and Part C (the M+C program); enter into contracts with PDPs; negotiate terms and conditions of contracts with PDPs, establish process to administer subsidy program; make reinsurance payments to PDPs or M+C plans; and determine actuarial value of coverage and annual percent increases in standard coverage levels. The Office of Beneficiary Assistance (OBA) within the MBA would carry out functions related to beneficiaries including enrollment, education, and dissemination of information on appeal rights.	FUNCTIONS – HHS would designate at least 15 service areas nationwide and enter into a contract with one entity to serve as the benefit manager for the area. The initial contract would be awarded for 3-5 years and could be renewed noncompetitively. In addition, the Secretary would determine monthly premiums and conduct Part D enrollment.	FUNCTIONS – The MCA would administer the 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 Commissioner would have responsibility for: 1) coordinating determinations of beneficiary eligibility and enrollment with the Commissioner of Social Security; 2) negotiating the terms and conditions of contracts with entities and entering into and enforcing such contracts; 3)disseminating comparative information regarding	FUNCTIONS – HHS would designate at least 15 service areas nationwide and enter into a contract with one private entity to administer the benefit for the area. The initial contract would be awarded for 2-5 years and would be subject to review after 2 years. In addition, the Secretary would determine monthly premiums and conduct Part D enrollment.	FUNCTIONS: HHS would establish at least 10 different coverage areas nationwide. It would award at least two contracts per area to entities to administer the benefit unless only one entity met the bidding requirements. Each contract would be awarded for 2-5 years. The Secretary would have responsibility for conducting Part D enrollment, disseminating information regarding drug coverage including comparative information on each entity contracting to administer the benefit in the area. The Secretary would determine the part D premium. The Secretary would make determinations (on the basis of tax return information	FUNCTIONS - HHS would review state plans and amendments; these would be considered approved unless the Secretary notified the state or group of states within 45 days of either disapproval or the need for additional information. A default program would be established in a fiscal year for beneficiaries residing in a state which failed to submit a plan to the Secretary by the required date. For purposes of the default program, HCFA would: 1) establish procedures for making eligibility determinations; 2) establish a process for accepting bids, awarding contracts, and making payments to PBMs or other entities under such contracts;

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		benefits and quality; 4) disseminating of appeals rights information; and 5) establishing a Medicare beneficiary education program. The Commissioner would also make reinsurance payments to plans. The Commissioner could establish Medicare Consumer Coalitions to help provide information to beneficiaries.		supplied by the Secretary of the Treasury and any information supplied by the beneficiary) of modified adjusted gross income (AGI) for purposes of determining those high-income persons subject to higher premiums.	and 3) establish policies and procedures for overseeing the provision of assistance under the contracts. For FY 2001 only, HCFA would be permitted to contract with PBMs or other entities without using competitive bidding. Each contract would be for a uniform term of at least 1 year and could be made automatically renewable.

Federal Payments to Plans, Benefit Administrators, or States

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
The Administrator would provide reinsurance payments for excess costs incurred in providing coverage. Percentage of costs subject to reinsurance payments would be increased from 30% for costs over $1,250 to 90% of costs exceeding $1,550 but below $2,300; reinsurance payments also provided for 90% of costs exceeding $6,000 out-of-pocket limit. The Administrator would also be authorized to provide financial incentives to secure access to plans.	Payments would be made to benefit managers under terms of the contract. The Secretary could provide incentives for cost and utilization management including: bonus and penalty incentives to encourage efficiency, incentives for sharing of any benefit savings achieved, and risk sharing arrangements related to benefit payments.	The Commissioner would pay to each entity the full amount of the premium for each beneficiary minus administrative costs levied on the plan. The Commissioner would provide for reinsurance payments equal to 80% of costs exceeding $7,050 (the point at which beneficiary out-of-pocket costs cease).	Payments would be made to private entities administering the benefit under terms of the contract. The Secretary could provide incentives for cost and utilization management including: bonus and penalty incentives to encourage efficiency, incentives for sharing of any benefit savings achieved, and risk sharing arrangements related to benefit payments.	The Secretary would establish procedures for making payments to contracting entities under which entities would be only subject to limited risk. The procedures could include the use of risk corridors tied to performance measures that were agreed to under the contract as well as any other incentives the Secretary determined appropriate.	The Secretary would make quarterly payments to each state with an approved plan from the state's allotment. States would determine payments to any benefit administrator. Under the default program, the contract with the PBM or other entity would specify the amount and manner in which payments would be made to such entity.

Benefit Administration

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The PDP sponsors and M+C organizations would offer plans to beneficiaries. They would provide plan information to beneficiaries; assure access to pharmacies; assure quality; have an appeals process; and maintain records and patient confidentiality. PDP sponsors would have to be licensed by the state or meet alternative requirements.	The benefit manager for an area would: establish, through negotiations, a schedule of prices for drugs; enter into participation agreements with pharmacies; process claims; maintain records comply with program quality requirements; and have in place education activities.	Private entities and M+C plans would offer plans to beneficiaries. They would provide plan information to beneficiaries; have an appeals process; maintain records and patient confidentiality, and have in place cost and utilization management programs. Entities would have to be licensed by the state or meet alternative requirements.	The private entity for an area would: establish, through negotiations, a schedule of prices for drugs; enter into participation agreements with pharmacies; process claims; maintain records and comply with program quality requirements; and have in place education activities.	Contracting entities and M+C plans would offer plans to beneficiaries. They would administer the benefit, provide information to beneficiaries, enter contracts with retail pharmacies, comply with access requirements, have in place appeals procedures, and maintain records and patient confidentiality.	State programs would be administered by the states. A state or group of states would submit a written plan to the Secretary of HHS which 1) described how the state, or group of states, intended to use the funds; and 2) included a description of the budget for the plan (updated periodically as necessary) and details on the planned use of funds, sources of the non-federal share of plan expenditures, and any cost-sharing requirements. A state would be required to submit a plan, which the Secretary found met the applicable requirements, by September 1 prior to the start of the fiscal year, except that the submission for FY2001 would have to occur by December 30, 2000.

Relationship to Medicare+Choice

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If a M+C plan offered prescription drug coverage, it would have to be "qualified coverage." Beneficiaries enrolled in plans offering coverage would have to obtain coverage through the M+C.	Enrollees in managed care plans would receive their benefit through the M+C organization.	If a M+C plan offered prescription drug coverage, it would have to be "qualified coverage." Beneficiaries enrolled in plans offering coverage would have to obtain coverage through the M+C.	Enrollees in managed care plans would receive their benefit through the M+C organization.	Enrollees in managed care plans would receive their benefit through the M+C organization.	No provision.

Cost Controls/Formularies

H.R. 4680 Medicare Rx 2000 Act (Representative Thomas, et al.)	S. 2342 Medicare Modernization Act (Senator Moynihan by request) Administration Bill	S. 2807, Medicare Prescription Drug and Modernization Act of 2000 (Senators Breaux and Frist)	S. 2541 Medicare Expansion for Needed Drugs (MEND) Act of 2000 (Senator Daschle et al.)	S. 2758 Medicare Outpatient Drug (MOD) Act of 2000 (Senator Graham et al.)	S. 3016 and S. 3017 Medicare Temporary Drug Assistance Act (Senator Roth et al.)
Plans could use formularies and other cost and utilization controls, including incentives to use generics. An enrollee would have the right to appeal to obtain coverage for a drug not on formulary if prescribing physician determined that therapeutically similar drug on the formulary was not as effective or had significant adverse effects.	Benefit managers could use formularies and other cost control measures established in their contracts. Beneficiaries would be guaranteed access to off-formulary drugs when medically necessary and would have appeal rights when coverage was denied.	Entities could use cost control mechanisms customarily used in employer-sponsored plans, including formularies, tiered copayments (which places higher cost-sharing for use of brand name instead of generic drugs or use of off-formulary drugs), selective contracting with providers of drugs, and mail order pharmacies. Entities would be required to have a process for beneficiaries to appeal denials of coverage based on application of the formulary.	Private entities administering the benefit could use formularies and other cost control measures established in their contracts. Beneficiaries would be guaranteed access to off-formulary drugs when medically necessary and would have appeal rights when coverage was denied.	Contracting entities could use mechanisms to provide benefits economically including formularies, alternative distribution methods and generic drug substitution. Formularies would have to comply with standards established by the Secretary in consultation with the Medicare Pharmacy and Therapeutics Advisory Committee. Entities would be required to cover nonformulary drugs when determined to be medically necessary.	Not specified.

Low-Income Subsidies

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BENEFICIARIES AT OR BELOW 135% OF POVERTY – Premium subsidy equal to 100% of premium for standard coverage (or actuarially equivalent) coverage. Cost sharing would be nominal; subsidy could not exceed 95% of maximum amount that could be incurred for standard coverage. ABOVE 135% AND BELOW 150% OF POVERTY – Sliding scale premium subsidy from 100% (at 135% of poverty) to 0% (at 150%). No cost-sharing subsidy.	BENEFICIARIES AT OR BELOW 135% OF POVERTY – Medicaid would pay Part D drug premiums and coinsurance charges (up to the benefit limit). ABOVE 135% AND BELOW 150% OF POVERTY – Medicaid would pay, on a sliding scale, based on income, a portion of the premium. No cost-sharing subsidy. For "Qualified Medicare drug beneficiaries" (persons with incomes between 100% and 150% of poverty and assets below $4,000 for an individual and $6,000 for a couple) benefits would be paid 100% by the federal government for persons not otherwise eligible for full Medicaid benefits.	BENEFICIARIES AT OR BELOW 135% OF POVERTY-Individuals would have a discount on their premium equal to 100% of the value of standard drug coverage provided under the plan. Beneficiary cost-sharing for such individuals would be nominal. ABOVE 135% AND BELOW 150% OF POVERTY – There would be a sliding scale discount on their premiums ranging from 100% of the value of standard drug coverage at 135% of poverty to 25% of such value at 150% of poverty. No cost-sharing subsidy.	BENEFICIARIES AT OR BELOW 135% OF POVERTY–Medicaid would pay Part D drug premiums and coinsurance charges (up to the benefit limit). ABOVE 135% AND BELOW 150% OF POVERTY – Medicaid would pay, on a sliding scale based on income, a portion of the premium. No cost-sharing subsidy. For "qualified Medicare drug beneficiaries" (persons with incomes between 100% and 150% of poverty and assets below $4,000 for an individual and $6,000 for a couple) benefits would be paid 100% by the federal government for persons not otherwise eligible for full Medicaid benefits.	BENEFICIARIES AT OR BELOW 135% OF POVERTY– Medicaid would pay Part D premiums, coinsurance, and deductible amounts. Regular federal/state matching would apply for those below 120% of poverty; 100% federal matching would apply for those between 120/% and 135% of poverty. ABOVE 135% AND BELOW 150% OF POVERTY – Beneficiaries would pay a reduced premium, calculated on a sliding scale basis. The federal matching rate would be 100%.	The Secretary would make quarterly payments to each state with an approved plan from the state's allotment. BENEFICIARIES AT OR BELOW 135% OF POVERTY - The federal payment from the allotment would be 100% of the costs incurred. ALL OTHER LOW-INCOME BENEFICIARIES AND, IF APPLICABLE, BENEFICIARIES WITH HIGH DRUG COSTS - The federal payment would equal an enhanced federal matching rate, defined as the federal matching rate for the state's Medicaid program plus 30% of the percentage point difference between this rate and 100%. In no case could the federal rate exceed 85%.

Relationship to Medicaid

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Part D would be the primary payor with Medicaid paying remaining costs for dual eligibles. There would be a phase-in of federal assumption of Medicaid responsibility for premiums and cost-sharing for dual eligibles. States would make eligibility determinations with phase-in of increasing matching rates for these activities. Medicaid drug price rebates would not apply for dual eligibles where a PDP or M+C plan had already negotiated discounts under Part D.	States could choose to pay Part D premiums and cost-sharing for those persons dually eligible for Medicare and *full* Medicaid benefits instead of providing drug benefits through Medicaid. If they elected this option, States would have to cover all dually eligible persons under Part D, buy all prescriptions for such individuals according to Part D requirements, and cover drugs in excess of the Part D limits. For persons below 100% of poverty, Medicaid would have to pay Part D premium and cost-sharing charges. For all persons below 100% of poverty, the current federal/state matching rate would apply. (See also LOW-INCOME SUBSIDIES, above). Medicaid drug price rebates would not apply to prescription drugs purchased under Part D.	The new Title XXII would be the primary payer with Medicaid paying remaining costs for dual eligibles. There would be a phase-in of federal assumption of Medicaid responsibility for premiums and cost-sharing for dual eligibles. States would make eligibility determinations with phase-in of increasing matching rates for these activities.	States could choose to pay Part D premiums and cost-sharing for those persons dually eligible for Medicare and *full* Medicaid benefits instead of providing drug benefits through Medicaid. If they elected this option, states would have to cover to all dually eligible persons under Part D, buy all prescriptions for such individuals according to Part D requirements, and cover drugs in excess of the Part D limits. For persons below 100% of poverty, Medicaid would have to pay Part D premium and cost-sharing charges. For all persons below 100% of poverty, the current federal/state matching rate would apply. (See also LOW-INCOME SUBSIDIES, above). Medicaid drug price rebates would not apply to prescription drugs purchased under Part D.	Part D would be the primary payor with Medicaid paying remaining costs for dual eligibles. States would make eligibility determinations for persons below 150% of poverty. Regular federal/state matching would apply for those below 120% of poverty; 100% federal matching would apply for those between 120/% and 150% of poverty.	The new program would be separate from Medicaid. Persons eligible for drug benefits under Medicaid would not be eligible for benefits under Title XXII. The one exception is the case of a state which had established a drug program for Medicare beneficiaries under a Medicaid waiver.

Relationship to Private Plans

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Medigap					
No new Medigap prescription drug policies could be issued after January 1, 2003. Beneficiaries currently enrolled in Medigap plans with drug coverage could keep that coverage. Beneficiaries terminating enrollment in a Medigap policy with a drug benefit would be guaranteed enrollment in a non-drug policy if enrollment occurred within 63 days of prior coverage.	Medigap policies would be revised to conform to the revised program structure.	No new Medigap prescription drug policies could be issued after January 1, 2003. Beneficiaries currently enrolled in Medigap plans with drug coverage could keep that coverage. Beneficiaries terminating enrollment in a Medigap policy with a drug benefit would be guaranteed enrollment in a non-drug policy if enrollment occurred within 63 days of prior coverage.	Not specified.	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 either the Part D deductible or for more than 90% of the Part D coinsurance.	A policyholder could request suspension of benefits and premiums payable under a Medigap policy during the period the policyholder was covered under a state program or the default program. The policyholder would automatically be reinstated in the Medigap plan if they notified the plan within 90 days of the loss of coverage under the state program or the default program.
Relationship to Group Health Plans					
Qualified retiree plans would be eligible for reinsurance subsidies. The sponsor of the plan would be required to attest that coverage met requirements for qualified coverage.	Employers would receive a partial subsidy if their retiree health coverage for drugs was at least as good as the Part D benefit; the subsidy would equal **b** of the amount the government would pay toward the premium if the individual were enrolled in Part D The Secretary would make these premium subsidy payments to the health plan sponsor used by the employer.	Qualified retiree plans would be eligible for reinsurance subsidies. The sponsor of the plan would be required to attest that coverage met requirements for qualified coverage.	Employers would receive a partial subsidy if their retiree health coverage for drugs was at least as good as the Part D benefit; the subsidy would equal to **b** of the amount the government would pay toward the premium if the individual were enrolled in Part D The Secretary would make these premium subsidy payments to the health plan sponsor used by the employer.	Employers and other sponsors of employer-based retiree coverage would receive a partial subsidy if their retiree health coverage for drugs was at least as good as the Part D benefit; the subsidy would equal to **b** of the amount the government would pay toward the premium if the individual were enrolled in Part D.	No federal matching funds would be available to the extent a private insurer would have been obligated to provide assistance but for an exclusion provision in its insurance contract; private insurers covered under this provision would include group health plans, service benefit plans, and health maintenance organizations.

Accounting Mechanism

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A separate account — the Medicare Prescription Drug Account — would be established within the Part B trust fund. Payments under Part D would be kept separate from all other Part B funds.	A separate account — the Prescription Drug Insurance Account — would be set up within the Part B trust fund. Premiums would be credited to the account and benefit payments made from the account.	A separate account — the Medicare Prescription Drug Account — would be established within the Part B trust fund. Payments under the new Title XXII would be kept separate from all other Part B funds. The annual reporting requirements for the Board of Trustees of the Part A and Part B trust funds would be expanded to include a 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 for benefits; a historical overview of spending; 10-year and 50-year projections; and overall spending from general revenues in relation to gross domestic product (GDP) growth.	A separate account — the Prescription Drug Insurance Account — would be set up within the Part B trust fund. Premiums would be credited to the account and benefit payments made from the account.	Part D premiums would be credited to the Part B trust fund, and Part D costs would be paid from the Part B trust fund. Part D costs would be excluded from the determination of the Part B premium. The bill would authorize the appropriation of such sums as are necessary, beginning in FY2001, for the administration of the Part D program.	S. 3016 would appropriate the following amounts for purposes of making allotments to the states: $1.2 billion in FY2001, $4.2 billion in FY2002, $9.0 billion in FY2003, and $3.0 billion in FY2004. The amounts under S. 3017 would be: $1.3 billion in FY 2001; $4.6 billion in FY 2002; $9.7 billion in FY 2003; and $13.0 billion in FY 2004. The Secretary would allocate the amount appropriated in a fiscal year to the states with approved plans. The amount available for allocation would be reduced by any amounts made available to the territories (0.25% from the total amount available). The amount allocated to each state would bear the same ratio to the total allotment amount as the ratio of the number of the state Medicare beneficiaries below 150% of poverty (175% under S. 3017) bore to the number of such beneficiaries in all states with plans. A minimum allotment available to any state would be 0.5 percent of total allotments

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					(after subtracting amounts for territories); if needed to meet this requirement, allotments otherwise determined would be proportionately adjusted. If a state did not submit a plan to the Secretary by the required date, 90% of the allotment for the state would be made available to the Secretary for purposes of administering the default program; the other 10% would be redistributed among states with plans.