A Side-by-Side Comparison of Selected Medicare Prescription Drug Coverage Proposals

August 2000

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OVERVIEW

Medicare generally covers the costs of prescription drugs received in inpatient facilities and of drugs that cannot be self-administered. But with a few exceptions, Medicare does not cover the costs of outpatient prescription drugs. While many Medicare beneficiaries have some coverage for prescription drugs through Medicare+Choice (M+C) plans, Medigap, retiree health plans, or Medicaid, an estimated 13 million have no coverage at all and many who do have coverage are finding their drug benefits eroding. This document provides a side-by-side comparison of the Medicare prescription drug provisions of four major federal proposals. The major proposals compared include:

- **Clinton/Moynihan (S. 2342). The Medicare Modernization Act,** modified to add a stop-loss benefit, would provide beneficiaries with an entitlement to prescription drug coverage under a new Medicare Part D, beginning in 2002. The Secretary would contract with one private entity in an area to manage the benefit. Beneficiaries would pay a uniform, national premium set to cover 50% of the costs of the new drug benefit, that would be deducted from Social Security checks. The benefit would be phased-in to cover at full implementation 50% of the beneficiary's annual drug costs up to $5,000 (indexed after 2009) in spending with Medicare paying $2,500 of that total. The Federal government would pay 100% of prescription drug costs above the stop-loss threshold amount ($4,000 in 2002), indexed annually to overall inflation in prescription drugs. Full premium and cost-sharing subsidies would be covered for beneficiaries with incomes up to 135 percent of the poverty level. with premium subsidies declining between 135 and 150% of poverty. M+C plans providing equal or better drug coverage would be eligible for full subsidies. Employer-sponsored plans offering equal or better drug coverage would be eligible for subsidies.

- **House-Passed Plan (H.R. 4680). The Medicare Rx 2000 Act** (passed by the House of Representatives June 28, 2000) would provide beneficiaries with an entitlement to choose among at least two subsidized drug plans, beginning in 2003, under a new Part D of Medicare. Plans would be required to offer a standard drug benefit or one that is at least actuarially equivalent. The government would provide a premium subsidy, equivalent to 35%of benefit payments, for qualified drug coverage through re-insurance payments to plans. Premium levels would depend upon the plan selected by the beneficiary, and would be collected directly from individuals. After a $250 deductible, plans would cover drug costs up to $2,100 in 2003 subject to a 50 percent coinsurance, and 100% of drug expenditures after the stop-loss threshold amount of $6,000 in 2003. The deductible, benefit limits, and stop-loss threshold amounts would be indexed to the rate of growth in Medicare per capita drug expenditures. Full premium and cost-sharing subsidies would be covered for individuals with incomes up to 135 percent of the poverty level, with premium subsidies declining on a sliding scale basis for beneficiaries with incomes between 135 and 150% of poverty. M+C plans that elect to offer prescription drugs would be required to provide an equivalent or better outpatient drug benefit to all enrollees electing Part D. M+C and employer-sponsored retiree health plans could receive re-insurance subsidies if they provided actuarially equivalent or better drug coverage. Prescription drug coverage would be administered by a new Medicare Benefits Administration.

- **Breaux/Frist (S. 2807). The Medicare Prescription Drug and Modernization Act** would provide beneficiaries with an entitlement to prescription drug coverage through Medicare Prescription Plus plans or Medicare+Choice plans, beginning in 2003. Premium levels would depend upon the plan selected by the beneficiary, and would be deducted from Social Security checks. Beneficiaries would receive a premium subsidy equal to 25 percent of the actuarial value of standard coverage, that would be included in beneficiaries' taxable income for that year. After a $250 deductible, plans would cover prescription drug costs up to $2,100 in 2003 subject to a 50% coinsurance. The federal government would pay 100% of drug expenditures after a stop-loss threshold of $6,000 in 2003. The deductible, benefit limits, and stop-loss threshold amounts would be indexed to the rate of growth in Medicare per capita drug expenditures. Full premium and cost-sharing subsidies would be provided for individuals with incomes up to 135 percent of the poverty level, with premium subsidies declining on a sliding scale basis for beneficiaries with incomes between 135 and 150% of poverty. Plans would provide standard coverage, or coverage with at least comparable actuarial value, and could offer additional drug and other benefits. M+C and employer-sponsored retiree health plans could receive re-insurance subsidies if they provided actuarially equivalent or better drug coverage. Prescription drug coverage would be administered by a new Competitive Medicare Agency.

- **Graham/Bryan/Robb (S. 2758). The Medicare Outpatient Drug Act of 2000** would provide beneficiaries with an entitlement to outpatient prescription drug coverage under Medicare, beginning in 2003. Beneficiaries would pay a premium set to cover 50% of the costs of the new drug benefit, deducted from Social Security checks. For beneficiaries with adjusted gross incomes >$75,000 ($150,000 for joint returns), with income levels indexed annually. The Federal subsidy would decline to 25% on a sliding scale. Full premiums and cost-sharing subsidies would be covered for beneficiaries with incomes up to 135 percent of the poverty level. Between 135 and 150% of poverty, the low-income premium subsidy declines to zero on a linear sliding scale. After a $250 deductible in 2003, the program would cover 50% of drug expenditures up to $6,750. For expenditures between $6,750 and $8,750, the coinsurance would be 25 percent. The Federal government would pay 100% of costs above $8,750 in 2003. Deductible and stop-loss amounts would be indexed annually. M+C plans would be required to provide an equivalent or better outpatient drug benefit to all Part D enrollees. Employer-sponsored retiree health plans could receive subsidies if they provided equal or better drug coverage. Beneficiaries would choose a benefit manager (from at least 2 in each area) in a process similar to the M+C election.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS—JULY 2000

	Current Law	Clinton/Moynihan	House-Passed	Breaux/Frist 2000	Graham/Bryan/Robb
Bill Number and Official Title	Not applicable.	S. 2342. Medicare Modernization Act as revised June 24, 2000.	H.R. 4680. Medicare Rx 2000 Act. (Passed June 28, 2000)	S. 2807, The Medicare Prescription Drug and Modernization Act of 2000.	S. 2758. The Medicare Outpatient Drug Act of 2000
General approach	Medicare Part B does not generally cover outpatient prescription drugs. Nearly one-third of beneficiaries without any coverage. The remainder get coverage through Medicare HMOs (Medicare+Choice), Medicaid, employer-sponsored retiree coverage, or Medigap.	Universal entitlement to subsidized outpatient prescription drug coverage integrated into the Medicare program for all beneficiaries. Effective January 1, 2002.	Universal entitlement to choose among at least two subsidized drug plans with standardized actuarial value. Effective January 1, 2003.	Universal entitlement to drug coverage through Medicare Prescription Plus plan or Medicare+Choice plan. Effective January 1, 2003.	Universal entitlement to subsidized outpatient prescription drug coverage integrated into the Medicare program for all beneficiaries. Effective January 1, 2003
PARTICIPATION					
Participation/Enrollment	See General approach above.	Voluntary. Available to anyone enrolled in Part A or B. One-time enrollment upon becoming eligible.	Voluntary. One-time enrollment available to all Part B enrollees upon becoming eligible. Additional one-time opportunity for Part A-only beneficiaries. First-time enrollment and annual election of particular plan overseen by new Medicare Benefits Administration (MBA).	Voluntary. Available to anyone enrolled in Parts A and B. One-time enrollment upon becoming eligible. No option for late enrollment unless beneficiary loses qualified drug coverage. First-time enrollment and annual election of particular plan overseen by Commissioner of new Competitive Medicare Agency (CMA).	Voluntary. Available to anyone enrolled in Part A or B. One-time enrollment upon becoming eligible. Annual beneficiary election of entity to administer the benefit in process similar to Medicare+Choice annual elections.

	Current Law	Clinton/Moynihan	House-Passed	Breaux/Frist 2000	Graham/Bryan/Robb
PREMIUMS AND SUBSIDIES					
Beneficiary premiums/ Government subsidies of beneficiary premiums	Not applicable.	Beneficiaries would pay an estimated $25 premium in 2002 (50% of program costs, excluding the cost of the stop loss) with the federal government paying the remainder. The federal government would be responsible for 100% of costs associated with the stop-loss protection. No variation among beneficiaries in a given plan. See Employer-sponsored retiree coverage below for additional subsidies to employers providing Medicare drug benefits.	Plans set premims, negotiated with the MBA. Estimated $35-$40/month in 2003. No variation among beneficiaries in a given plan. Higher premiums permitted for late enrollees and those with a lapse in coverage of 63 days or more. Federal government provides reinsurance subsidies to plans for 30% of costs incurred for each beneficiary between $1,251 and $1,350, 50% between $1,351 and $1,450, 70% between $1,451 and $1,550, 90% between $1,551 and $2,350, and 90% of costs above $7,050.	Beneficiaries receive a premium subsidy equal to 25 percent of the actuarial value of standard coverage. This subsidy is included in beneficiaries' taxable income for that year. Actual premiums paid by beneficiaries will depend upon plan selected. Federal government provides additional reinsurance subsidy equal to 80 percent of all drug costs, once the $6,000 catastrophic limit is met.	Federal government and beneficiary each pay 50%. For beneficiaries with adjusted gross incomes >$75,000 ($150,000 for joint returns), Federal subsidy reduces to 25% on a sliding scale. Late enrollees pay a premium penalty, as determined by the Secretary**.** No other variation among beneficiaries in a given plan. See Employer-sponsored retiree coverage below for additional subsidies to employers providing Medicare drug benefits.

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Government low-income subsidies	See Medicaid below.	For beneficiaries below 135% of the federal poverty level, Medicaid pays full premiums and co-insurance for drug coverage. Between 135%-150%, low-income premium subsidy declines to zero on a linear sliding scale. QMB asset tests (resources less than twice the limit for SSI) apply to all low-income subsidies. States determine eligibility.	For beneficiaries below 135% of federal poverty level, full government subsidy of premium, and 95% of other cost sharing. Between 135%-150%, low-income premium subsidy declines to zero on a linear sliding scale. QMB asset tests (resources less than twice the limit for SSI) apply to all low-income subsidies. States determine eligibility.	For beneficiaries below 135% of federal poverty level, full government subsidy of premium, and 95% of other cost sharing. Between 135%-150%, low-income premium subsidy declines to zero on a linear sliding scale. QMB asset tests (resources less than twice the limit for SSI) apply to all low-income subsidies. States determine eligibility.	Medicaid pays premiums, deductibles and co-insurance for drug coverage for beneficiaries up to 120% of the federal poverty level. Between 120%-135% federal government pays premiums, deductibles, and co-insurance. Between 135%-150%, low-income premium subsidy declines to zero on a linear sliding scale. QMB asset tests (resources less than twice the limit for SSI) apply to all low-income subsidies. States determine eligibility.
Financing of subsidies	Not applicable.	Federal/state matching rates apply below 100% of poverty and for other full Medicaid beneficiaries. Otherwise, federal government pays 100% for all low-income subsidies.	Phased-in federal assumption of state Medicaid drugs costs under new plan for dual eligibles. Otherwise all subsidies 100 percent federal.	Phased-in federal assumption of 50% of state Medicaid drugs costs for dual eligibles. Otherwise all subsidies 100 percent federal.	Federal-state matching rates apply for beneficiaries eligible for full benefits under Medicare and Medicaid, QMBs and SLMB. All other subsidies 100 percent federal.
Collection of premiums and distribution of subsidies	Not applicable.	Premiums collected by Social Security Administration like Part B premiums. Subsidies paid to benefit managers or other contractors administering the coverage.	Premiums collected by sponsors of drug coverage. Subsidies distributed by federal government to plans.	Premiums collected by Social Security Administration like Part B premiums. Subsidies distributed by federal government to plans providing drug coverage.	Premiums collected by Social Security Administration like Part B premiums. Subsidies paid by federal government to contractors administering the coverage.
DRUG BENEFITS					
Standard or variable benefit package	The few outpatient drugs covered by Medicare defined in statute. Medicare+Choice benefit vary by plan.	Standard coverage defined in statute.	Standard coverage defined in statute, or coverage with same actuarial value and stop loss as standard coverage. Plans can also offer additional coverage.	Standard coverage defined in statute or other coverage with same actuarial value and stop loss as standard coverage. Plans can also offer additional drug and other coverage.	Standard coverage defined in statute

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Annual drug deductible	For Medicare covered drugs, Part B cost-sharing rules apply. Medicare+Choice benefits vary by plan.	No deductible.	$250 in 2003	$250 in 2003	$250 in 2003. HHS Secretary can allow contractors administrating the benefit to waive the deductible for generic drugs as part of cost containment program.
Coinsurance/copayment	For Medicare covered drugs, Part B cost-sharing rules apply. Medicare+Choice benefits vary by plan.	50% up to annual cap. Administering entities would be permitted to allow lower cost-sharing for some drugs, provided the Secretary determines total costs would not be increased.	50%	50%	In 2003, 50% of drug expenditures above $250 up to $6,750. ($3,500 out-of-pocket). 25% coinsurance above $6,750 up to $8,750 ($4,000 out-of-pocket). Higher cost-sharing permitted for non-formulary drugs except if non-formulary drug is medically indicated.
Annual benefit limits or cap	Not applicable.	$2000 in 2002,2003 ($1,000 paid each by plan and beneficiary) rising to $3,000 in 2004, 2005, $4,000 in 2006, 2007 & $5,000 in 2008, 2009.	$2,100 in 2003. ($1,050 paid each by plan and beneficiary.) For subsequent years, see Indexing below.	$2,100 in 2003. ($1,050 paid each by plan and beneficiary.) For subsequent years, see Indexing below.	None
Stop-loss (coverage of drug expenditures over a specified threshold)	Not applicable.	Federal government pays 100% for drug expenditures above $5,000 ($4,000 out-of-pocket) in 2002.	Federal government pays 100% for drug expenditures above $7,050 ($6,000 out-of-pocket) in 2003.	Federal government pays 100% for drug expenditures above $7,050 ($6,000 out-of-pocket) in 2003.	Federal government pays 100% for drug expenditures above $8,750 ($4,000 out-of-pocket) in 2003.
Indexing provisions	Not applicable.	Annual cap indexed to consumer price index (CPI). Stop loss indexed to increases in overall drug inflation.	For each calendar year, deductible, annual cap, average beneficiary drug spending thresholds for determining reinsurance payments, and stop loss increases at the rate of growth in per capita Medicare outpatient drug expenditures.	For each calendar year, deductible, annual cap, average beneficiary drug spending thresholds for determining reinsurance payments, and stop loss increases at the rate of growth in per capita Medicare outpatient drug expenditures.	For each calendar year, deductible, cost-sharing thresholds, and stop loss amounts increased by rate of increase in aggregate Medicare outpatient prescription drug expenditures for previous calendar year.

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ACCESS TO DRUGS					
Covered drugs	In general, Medicare does not cover outpatient drugs. Exceptions include immunosuppressive drugs, drugs that cannot be self-administered, and drugs that are "incident" to physician services.	FDA-approved outpatient prescription drugs and biologicals, insulin and related syringes, needles, pumps, and smoking cessation programs.	FDA-approved outpatient prescription drugs and biologicals.	FDA-approved outpatient prescription drugs and biologicals.	FDA-approved outpatient prescription drugs, biologicals, insulin and related syringes, needles, and pumps, and smoking cessation programs.
Formulary rules	Not applicable.	Formularies and other cost containment measures permitted. Formularies must include drugs in all therapeutic classes. Non-formulary coverage required when medically necessary, as determined by a physician.	If sponsor of drug policy uses formularies, pharmaceutical and therapeutic (P&T) committees must develop them. Formularies must include drugs in all therapeutic classes of covered drugs.	Formularies and other cost containment measures permitted. Formularies must include drugs in all therapeutic classes of covered drugs.	Contractors allowed to use formularies. Standards set by DHHS Secretary with advice of new overall Medicare P&T Committee. Formularies must have 2 drugs in each therapeutic class unless the class only contains 1 drug. Non-formulary coverage without required when medically indicated. In other cases, higher cost-sharing permitted for non-formulary drugs.
Appeals process	Regular Medicare coverage and appeals processes apply.	Benefit managers must have an appeals process for denials of coverage.	Plans providing drug coverage must have an appeals process for denials of coverage.	Plans providing drug coverage must have an appeals process for denials of coverage.	Appeals process for denials of coverage including those based on formularies similar to those for Medicare+Choice disputes.
DRUG PRICING					
Drug pricing requirements	For Medicare/Medicaid dual eligibles, Medicaid government receives rebates to assure access to best price available to any private purchaser.	Administering entities negotiate prices and fees with manufacturers, wholesalers, and pharmacies. No Medicaid drug rebates for dual eligibles' drugs paid by Medicare.	Plans negotiate prices and fees with manufacturers, wholesalers, and pharmacies. No Medicaid drug rebates if sponsors have negotiated prices.	Plans negotiate prices and fees with manufacturers, wholesalers, and pharmacies. No Medicaid drug rebates if sponsors have negotiated prices.	Contractors negotiate prices and fees with manufacturers, wholesalers, and pharmacies.
Beneficiary access to price discounts once coverage limits are reached	None	Yes.	Yes.	Yes.	Not applicable.

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PARTICIPATING ENTITIES AND PHARMACY PROVISIONS					
Contracts with private entities	Not applicable except for Medicare+Choice plans that offer outpatient prescription drug benefits.	One administering benefit manager chosen through competitive bidding in each of 15 or more service areas designated by DHHS Secretary for initial contract of 3-5 years. DHHS Secretary could provide incentive payments for efficiency, savings, or risk sharing.	MBA contracts with Medicare+Choice plans, retiree health plans, and any qualified risk bearing entities willing to offer drug coverage as outlined. Entities not licensed as insurers in the state must meet Medicare+Choice solvency standards.	CMA contracts with any Medicare Prescription Plus plans, Medicare+Choice plan, or retiree health plan willing to offer coverage as outlined, assume risk, and meet other qualifying criteria. Entities not licensed as insurers in the state must meet Medicare+Choice solvency standards.	At least two in each region or partial region chosen through competitive bidding administered by DHHS Secretary. One contractor permitted if only one bid is received. Performance-based incentive payments to administering entities for assumption of risk permitted. Such payments may be risk-adjusted.
Requirements for Drug Utilization Review (DUR) & disease/ pharmaceutical management	Not applicable.	Yes.	Yes.	Yes.	Yes.
Pharmacy access rules/reimbursement requirements	Not applicable.	Benefit managers required to secure sufficient numbers of pharmacies to assure convenient access for beneficiaries. Managers are required to include in their network pharmacies that meet defined federal standards.	Plans providing prescription drug coverage required to secure sufficient number of pharmacies to assure convenient access for beneficiaries. Pharmacies not required to participate. Sponsors negotiate dispensing fees with pharmacies.	The Commissioner of the Competitive Medicare Agency would be responsible for ensuring that beneficiaries enrolled in plans offering prescription drug benefits have adequate access to pharmacies.	Administering entities required to secure sufficient numbers of pharmacies to assure reasonable geographic access.
FEDERAL GOVERNMENT AND FINANCING					
Federal financing/Trust funds	Part B's Supplementary Medical Insurance Trust Fund finances use of the few covered outpatient drugs. Medicare+Choice coverage paid out of federal capitated payments to health plans or through additional premiums from beneficiaries.	Benefit payments made from and premiums credited to new Prescription Drug Insurance Account within Part B's Supplementary Medical Insurance Trust Fund.	Payments made from new Medicare Prescription Drug Account within Part B's Supplementary Medical Insurance Trust Fund. Revenues into account include transfer of federal Medicaid costs for dual eligibles' drugs.	Payments made from new Medicare Prescription Drug Account within Part B's Supplementary Medical Insurance Trust Fund. Revenues into account include transfer of federal Medicaid costs for dual eligibles' drugs.	Part B's Supplementary Medical Insurance Trust Fund receives beneficiary premiums and makes all payments to administering entities.

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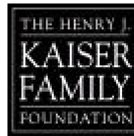
Administration	HCFA , contractors, Medicare+Choice for current limited coverage	DHHS Secretary and HCFA carry out administrative functions as specified in the legislation. SSA collects basic premiums. States determine eligibility for low-income subsidies like for QMB/SLMB	New MBA oversees Medicare+Choice and prescription drug coverage. States determine eligibility for low-income subsidies like for QMB/SLMB.	New CMA oversees Medicare+Choice and prescription drug coverage. States determine eligibility for low-income subsidies like for QMB/SLMB.	DHHS Secretary and HCFA carry out administrative functions as specified in the legislation. SSA collects basic premiums. Department of Treasury administers higher premium payments for upper income beneficiaries. States determine eligibility for low-income subsidies like for QMB/SLMB.
RELATIONSHIP TO EXISTING COVERAGE					
Medicare+Choice	Federal payments to Medicare+Choice plans are for basic Medicare benefits. If payments to plans exceed costs, plans can provide additional benefits. As a result, in 1996, Medicare+Choice plans provided prescription drug coverage for 8% of all Medicare beneficiaries. Prescription drug benefits and cost sharing vary across plans.	Medicare+Choice plans required to provide coverage with deductibles and cost sharing at least as generous as available in traditional FFS Medicare. Plans eligible for same subsidies as other contractors receive.	Medicare+Choice plans can qualify to offer standard or actuarially equivalent coverage and receive reinsurance subsidies.	Medicare+Choice plans can qualify to offer standard or actuarially equivalent coverage and receive reinsurance subsidies.	Medicare+Choice plans required to provide coverage with deductibles and cost sharing at least as generous as available in traditional FFS Medicare. Plans eligible for same subsidies as other contractors receive.
Employer-sponsored retiree coverage	Prescription drug coverage for 31% of Medicare beneficiaries in 1996. Prescription drug benefits and cost sharing variable.	Qualified retiree health plans offering coverage at least actuarially equivalent to the defined Medicare benefit would receive 67% of the premium subsidy that would otherwise be paid, as an incentive to continue coverage.	Retiree health plans can qualify to offer standard or actuarially equivalent coverage and receive reinsurance subsidies.	Retiree health plans can qualify to offer standard or actuarially equivalent coverage and receive reinsurance subsidies.	Qualified retiree health plans offering coverage actuarially equivalent to Medicare's receive 67% of monthly premium amount (instead of Medicare's usual 50% subsidy) as an incentive to continue coverage.

	Current Law	Clinton/Moynihan	House-Passed	Breaux/Frist 2000	Graham/Bryan/Robb
Individually-purchased Medicare supplemental coverage (Medigap)	Policies H and I provide 50% coverage after $250 deductible up to $1,250 in reimbursements. Policy J has same deductible and coinsurance with $3,000 annual cap. Covered 10% of Medicare beneficiaries in 1996. Premiums variable.	Medigap policies revised to reflect new Medicare drug benefit.	Policies H, I, and J (which have drug coverage) eliminated. Beneficiaries already enrolled in these plans could keep them. Those disenrolling have 63 days to purchase another Medigap policy.	Policies H, I, and J (which have drug coverage) eliminated. Beneficiaries already enrolled in these plans could keep them. Those disenrolling have 63 days to purchase another Medigap policy.	Medigap policies revised to reflect new Medicare drug benefit.
Medicaid	Prescription drug coverage is defined as an optional benefit under Medicaid, but is covered by all states. States may impose nominal cost-sharing on beneficiaries other than children. In 1996, 11 percent of all Medicare beneficiaries (i.e., those eligible for full Medicaid benefits) had prescription drug coverage under Medicaid.	States have option of paying for full dual eligible drugs through Medicaid or purchasing Medicare drug coverage and pay cost sharing and other expenses up to the Medicaid benefit.	Medicare becomes primary payer of drug costs covered under the new plan. Phased-in federal assumption of state Medicaid drug costs for dual eligibles.	Medicare would be primary payer of drug costs for dual eligibles. Federal government would assume 50% of costs associated with drug costs for dual eligibles, and for certain qualified Medicare beneficiaries, on phased in basis.	Medicare would be primary payer for full dual eligibles. Medicaid would provide wrap-around drug coverage for full dual eligibles, with regular federal/state match.
CONGRESSIONAL BUDGET OFFICE COST ESTIMATES					
Estimated Federal Costs	Not applicable.	$338 billion in new federal costs over the period between 2001-2010. (CBO July 18, 2000 estimate).	$146 billion in new federal costs 2001-2010. Estimated June 28, 2000.	No CBO estimate.	Preliminary estimate: $241 billion in new federal costs 2001–2010, 7/7/00.[1]

[1] Preliminary CBO estimate provided by sponsor's staff



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