

107TH CONGRESS
1ST SESSION

S. 982

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive health benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 5, 2001

Mr. GRAHAM (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. LUGAR, Mr. BINGAMAN, Mr. CHAFEE, Mr. ROCKEFELLER, Mrs. MURRAY, Mr. HOLLINGS, Mr. LEVIN, Mr. CORZINE, and Mrs. LINCOLN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive health benefits, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Wellness Act of 2001”.

1 (b) TABLE OF CONTENTS.—The table of contents of
 2 this Act is as follows:

- Sec. 1. Short title; table of contents.
 Sec. 2. Definitions.

TITLE I—HEALTHY SENIORS PROMOTION PROGRAM

- Sec. 101. Definitions.
 Sec. 102. Working Group on Disease Self-Management and Health Promotion.
 Sec. 103. Healthy seniors promotion grants.
 Sec. 104. Disease self-management demonstration projects.

TITLE II—MEDICARE COVERAGE OF PREVENTIVE HEALTH
 BENEFITS

- Sec. 201. Therapy and counseling for cessation of tobacco use.
 Sec. 202. Counseling for post-menopausal women.
 Sec. 203. Screening for diminished visual acuity.
 Sec. 204. Screening for hearing impairment.
 Sec. 205. Screening for cholesterol.
 Sec. 206. Screening for hypertension.
 Sec. 207. Expansion of eligibility for bone mass measurement.
 Sec. 208. Coverage of medical nutrition therapy services for beneficiaries with
 cardiovascular diseases.
 Sec. 209. Elimination of deductibles and coinsurance for existing preventive
 health benefits.
 Sec. 210. Program integrity.
 Sec. 211. Promotion of preventive health benefits.

TITLE III—NATIONAL FALLS PREVENTION EDUCATION AND
 AWARENESS CAMPAIGN

- Sec. 301. National falls prevention education and awareness campaign.

TITLE IV—CLINICAL DEPRESSION SCREENING DEMONSTRATION
 PROJECTS

- Sec. 401. Clinical depression screening demonstration projects.

TITLE V—MEDICARE HEALTH EDUCATION AND RISK APPRAISAL
 PROGRAM

- Sec. 501. Medicare health education and risk appraisal program.

TITLE VI—STUDIES, EVALUATIONS, AND REPORTS IN THE FIELD
 OF DISEASE PREVENTION AND THE ELDERLY

- Sec. 601. MedPAC evaluation and report on medicare benefit package in rela-
 tion to private sector benefit packages.
 Sec. 602. National Institute on Aging study and report on ways to improve the
 quality of life of elderly.
 Sec. 603. Institute of Medicine medicare prevention benefit study and report.
 Sec. 604. Fast-track consideration of prevention benefit legislation.

1 **SEC. 2. DEFINITIONS.**

2 In this Act:

3 (1) **MEDICARE BENEFICIARY.**—The term
 4 “medicare beneficiary” means any individual who is
 5 entitled to benefits under part A or enrolled under
 6 part B of the medicare program, including any indi-
 7 vidual enrolled in a Medicare+Choice plan offered
 8 by a Medicare+Choice organization under part C of
 9 such program.

10 (2) **MEDICARE PROGRAM.**—The term “medicare
 11 program” means the health benefits program under
 12 title XVIII of the Social Security Act (42 U.S.C.
 13 1395 et seq.).

14 (3) **SECRETARY.**—The term “Secretary” means
 15 the Secretary of Health and Human Services.

16 **TITLE I—HEALTHY SENIORS**
 17 **PROMOTION PROGRAM**

18 **SEC. 101. DEFINITIONS.**

19 In this title:

20 (1) **COST-EFFECTIVE BENEFIT.**—The term
 21 “cost-effective benefit” means a benefit or technique
 22 that has—

23 (A) been subject to peer review;

24 (B) been described in scientific journals;

25 and

1 (C) demonstrated value as measured by
2 unit costs relative to health outcomes achieved.

3 (2) COST-SAVING BENEFIT.—The term “cost-
4 saving benefit” means a benefit or technique that
5 has—

6 (A) been subject to peer review;

7 (B) been described in scientific journals;

8 and

9 (C) caused a net reduction in health care
10 costs for medicare beneficiaries.

11 (3) ELIGIBLE ENTITY.—The term “eligible enti-
12 ty” means an entity that the Working Group (as de-
13 fined in paragraph (6)) determines has dem-
14 onstrated expertise regarding health promotion and
15 disease prevention among medicare beneficiaries.

16 (4) MEDICALLY EFFECTIVE.—The term “medi-
17 cally effective” means, with respect to a benefit or
18 technique, that the benefit or technique has been—

19 (A) subject to peer review;

20 (B) described in scientific journals; and

21 (C) determined to achieve an intended goal
22 under normal programmatic conditions.

23 (5) MEDICALLY EFFICACIOUS.—The term
24 “medically efficacious” means, with respect to a ben-

1 efit or technique, that the benefit or technique has
2 been—

3 (A) subject to peer review;

4 (B) described in scientific journals; and

5 (C) determined to achieve an intended goal
6 under controlled conditions.

7 (6) WORKING GROUP.—The term “Working
8 Group” means the Working Group on Disease Self-
9 Management and Health Promotion established
10 under section 102.

11 **SEC. 102. WORKING GROUP ON DISEASE SELF-MANAGE-**
12 **MENT AND HEALTH PROMOTION.**

13 (a) ESTABLISHMENT.—There is established within
14 the Department of Health and Human Services a Working
15 Group on Disease Self-Management and Health Pro-
16 motion.

17 (b) COMPOSITION.—

18 (1) IN GENERAL.—Subject to paragraph (2),
19 the Working Group shall be composed of 5 members
20 as follows:

21 (A) The Administrator of the Health Care
22 Financing Administration.

23 (B) The Director of the Centers for Dis-
24 ease Control and Prevention.

1 (C) The Director of the Agency for
2 Healthcare Research and Quality.

3 (D) The Assistant Secretary for Aging.

4 (E) The Director of the National Institutes
5 of Health.

6 (2) ALTERNATIVE MEMBERSHIP.—Any member
7 of the Working Group described in a subparagraph
8 of paragraph (1) may appoint an individual who is
9 an officer or employee of the Federal Government to
10 serve as a member of the Working Group instead of
11 the member described in such subparagraph.

12 (c) DUTIES.—The duties of the Working Group are
13 as follows:

14 (1) HEALTHY SENIORS PROMOTION GRANTS.—
15 The Working Group shall establish general policies
16 and criteria with respect to the functions of the Sec-
17 retary under section 103, including—

18 (A) priorities for the approval of applica-
19 tions submitted under subsection (c) of such
20 section;

21 (B) procedures for monitoring and evalu-
22 ating research efforts conducted under such
23 section; and

24 (C) such other matters relating to the
25 grant program established under such section

1 as are recommended by the Working Group and
2 approved by the Secretary.

3 (2) DISEASE SELF-MANAGEMENT DEMONSTRA-
4 TION PROJECTS.—The Working Group shall estab-
5 lish general policies and criteria with respect to the
6 functions of the Secretary under section 104,
7 including—

8 (A) the identification of medical conditions
9 for which a demonstration project under such
10 section may be implemented;

11 (B) the prioritization of the conditions
12 identified under subparagraph (A) based on the
13 potential for the self-management of such con-
14 dition to be medically effective and for such
15 self-management to be a cost-effective benefit
16 or cost-saving benefit;

17 (C) the identification of target individuals
18 (as defined in section 104(a)(2));

19 (D) the development of procedures for se-
20 lecting areas in which such a demonstration
21 project may be implemented; and

22 (E) such other matters relating to such
23 demonstration projects as are recommended by
24 the Working Group and approved by the Sec-
25 retary.

1 (d) CHAIRPERSON.—The Secretary shall designate 1
2 of the members of the Working Group to be the chair-
3 person of the Group.

4 (e) QUORUM.—A majority of the members of the
5 Working Group shall constitute a quorum, but, subject to
6 subsection (f), a lesser number of members may hold
7 meetings.

8 (f) MEETINGS.—The Working Group shall meet at
9 the call of the chairperson, except that—

10 (1) it shall meet not less than 4 times each
11 year; and

12 (2) it shall meet upon the written request of a
13 majority of the members.

14 (g) COMPENSATION OF MEMBERS.—Each member of
15 the Working Group shall serve without compensation in
16 addition to that received for their service as an officer or
17 employee of the Federal Government.

18 (h) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated such sums as may be
20 necessary for the purpose of carrying out this section.

21 **SEC. 103. HEALTHY SENIORS PROMOTION GRANTS.**

22 (a) PROGRAM AUTHORIZED.—The Secretary, using
23 the general policies and criteria established by the Work-
24 ing Group under section 102(c)(1) and in accordance with
25 the provisions of this section, is authorized to make grants

1 to eligible entities (as defined in section 101(3)) to pay
2 for the costs of the activities described in subsection (b).

3 (b) USE OF FUNDS.—An eligible entity may use pay-
4 ments received under this section in any fiscal year to con-
5 duct a program to—

6 (1) study whether using different types of pro-
7 viders of care and alternative settings (including
8 community-based senior centers) for the implemen-
9 tation of a successful health promotion and disease
10 prevention strategy, including the implications re-
11 garding the payment of such providers, is medically
12 efficacious or medically effective;

13 (2) determine the most effective means of edu-
14 cating medicare beneficiaries, either directly or
15 through providers of care, regarding the importance
16 of health promotion and disease prevention among
17 such beneficiaries;

18 (3) identify incentives that would increase the
19 use of new and existing preventive health benefits
20 and healthy behaviors by medicare beneficiaries;

21 (4) promote—

22 (A) the use of preventive health benefits by
23 medicare beneficiaries, including such services
24 that are covered under the medicare program;

1 (B) the proper use by medicare bene-
2 ficiaries of prescription and over-the-counter
3 drugs in order to reduce the number of hospital
4 stays and physician visits that are a result of
5 improper use of such drugs; and

6 (C) the utilization by medicare bene-
7 ficiaries of the steps (including exercise, mainte-
8 nance of a proper diet, and the utilization of ac-
9 cident prevention techniques) that research has
10 shown to promote and safeguard individual
11 health; and

12 (5) address other topics designated by the Sec-
13 retary.

14 (c) APPLICATION.—

15 (1) IN GENERAL.—Each eligible entity that de-
16 sires to receive a grant under this section shall sub-
17 mit an application to the Secretary, at such time, in
18 such manner, and accompanied by such additional
19 information as the Secretary may reasonably re-
20 quire.

21 (2) CONTENTS.—Each application submitted
22 under paragraph (1) shall—

23 (A) describe the activities for which assist-
24 ance under this section is sought;

25 (B) describe how such activities will—

1 (i) reflect the medical, behavioral, and
2 social aspects of care for medicare bene-
3 ficiaries;

4 (ii) lead to the development of cost-ef-
5 fective benefits and cost-saving benefits;
6 and

7 (iii) impact the quality of life of medi-
8 care beneficiaries;

9 (C) provide assurances that such activities
10 will focus on broad medicare populations rather
11 than unique local medicare populations;

12 (D) provide evidence that the eligible entity
13 meets the general policies and criteria estab-
14 lished by the Working Group under section
15 102(c)(1);

16 (E) provide assurances that the eligible en-
17 tity will take such steps as may be available to
18 the entity in order to continue the activities for
19 which the entity is making application after the
20 period for which assistance is sought; and

21 (F) provide such additional assurances as
22 the Secretary determines to be essential to en-
23 sure compliance with the requirements of this
24 title.

1 (3) JOINT APPLICATION.—A consortium of eli-
2 gible entities may file a joint application under the
3 provisions of paragraph (1).

4 (d) APPROVAL OF APPLICATION.—The Secretary
5 shall approve applications in accordance with the general
6 policies and criteria established by the Working Group
7 under section 102(c)(1).

8 (e) PAYMENTS.—Subject to amounts appropriated
9 under subsection (g), the Secretary shall pay to each eligi-
10 ble entity having an application approved under subsection
11 (d) the cost of the activities described in the application.

12 (f) EVALUATION AND REPORT.—

13 (1) EVALUATION.—The Secretary shall conduct
14 an annual evaluation of grants made under this sec-
15 tion to determine—

16 (A) the results of the activities conducted
17 under the programs for which grants were
18 made under this section;

19 (B) the extent to which research assisted
20 under this section has improved or expanded
21 the general research for health promotion and
22 disease prevention among medicare beneficiaries
23 and identified practical interventions based
24 upon such research;

1 (C) a list of specific recommendations
2 based upon the activities conducted under the
3 programs for which grants were made under
4 this section which show promise as practical
5 interventions for health promotion and disease
6 prevention among medicare beneficiaries;

7 (D) whether or not, as a result of the ac-
8 tivities conducted under the programs for which
9 grants were made under this section, certain
10 health promotion and disease prevention bene-
11 fits or education efforts should be added to the
12 medicare program, including discussions of
13 quality of life, translating the applied research
14 results into a benefit under the medicare pro-
15 gram, and whether each additional benefit
16 would be a cost-effective benefit or a cost-saving
17 benefit for each proposed addition; and

18 (E) how best to increase utilization of ex-
19 isting and recommended health promotion and
20 disease prevention services, such as an edu-
21 cation and public awareness campaign, pro-
22 viding financial incentives for providers of care
23 and medicare beneficiaries, or utilizing other
24 administrative means.

1 (2) ANNUAL REPORT.—Not later than Decem-
2 ber 31, 2003, and annually thereafter through 2005,
3 the Secretary, in consultation with the Working
4 Group, shall submit a report to Congress on the
5 evaluation conducted under paragraph (1), together
6 with such recommendations for such legislation and
7 administrative actions as the Secretary considers ap-
8 propriate.

9 (g) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated for the purpose of car-
11 rying out this section \$50,000,000 for each of fiscal years
12 2002, 2003, 2004, and 2005.

13 **SEC. 104. DISEASE SELF-MANAGEMENT DEMONSTRATION**
14 **PROJECTS.**

15 (a) DEMONSTRATION PROJECTS.—

16 (1) IN GENERAL.—The Secretary shall conduct
17 demonstration projects for the purpose of promoting
18 disease self-management for conditions identified by
19 the Working Group under section 102(c)(2) for tar-
20 get individuals (as defined in paragraph (2)).

21 (2) TARGET INDIVIDUAL DEFINED.—In this
22 section, the term “target individual” means an indi-
23 vidual who—

1 (A) is at risk for, or has, 1 or more of the
2 conditions identified by the Working Group
3 under section 102(c)(2); and

4 (B) is enrolled under the original medicare
5 fee-for-service program under parts A and B of
6 title XVIII of the Social Security Act (42
7 U.S.C. 1395c et seq.; 1395j et seq.) or is en-
8 rolled under the Medicare+Choice program
9 under part C of title XVIII of such Act (42
10 U.S.C. 1395w-21 et seq.).

11 (b) NUMBER; PROJECT AREAS; DURATION.—

12 (1) NUMBER.—Not later than 2 years after the
13 date of enactment of this Act, the Secretary shall
14 implement a series of demonstration projects to
15 carry out the purpose described in subsection (a)(1).

16 (2) PROJECT AREAS.—The Secretary shall im-
17 plement the demonstration projects described in
18 paragraph (1) in urban, suburban, and rural areas.

19 (3) DURATION.—The demonstration projects
20 under this section shall be conducted during the 3-
21 year period beginning on the date on which the ini-
22 tial demonstration project is implemented.

23 (c) REPORT TO CONGRESS.—

24 (1) IN GENERAL.—Not later than 18 months
25 after the conclusion of the demonstration projects

1 under this section, the Secretary shall submit a re-
2 port to Congress on such projects.

3 (2) CONTENTS OF REPORT.—The report re-
4 quired under paragraph (1) shall include the fol-
5 lowing:

6 (A) A description of the demonstration
7 projects.

8 (B) An evaluation of—

9 (i) whether each benefit provided
10 under the demonstration projects is a cost-
11 effective benefit or a cost-saving benefit;

12 (ii) the level of the disease self-man-
13 agement attained by target individuals
14 under the demonstration projects; and

15 (iii) the satisfaction of target individ-
16 uals under the demonstration projects.

17 (C) Recommendations of the Secretary re-
18 garding whether to conduct the demonstration
19 projects on a permanent basis.

20 (D) Such recommendations for legislation
21 and administrative action as the Secretary de-
22 termines to be appropriate.

23 (E) Any other information regarding the
24 demonstration projects that the Secretary de-
25 termines to be appropriate.

1 (d) FUNDING.—The Secretary shall provide for the
2 transfer from the Federal Hospital Insurance Trust Fund
3 under section 1817 of the Social Security Act (42 U.S.C.
4 1395i) an amount not to exceed \$30,000,000 for the costs
5 of carrying out this section.

6 **TITLE II—MEDICARE COVERAGE**
7 **OF PREVENTIVE HEALTH**
8 **BENEFITS**

9 **SEC. 201. THERAPY AND COUNSELING FOR CESSATION OF**
10 **TOBACCO USE.**

11 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
12 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
13 105(a) of the Medicare, Medicaid, and SCHIP Benefits
14 Improvement and Protection Act of 2000 (114 Stat.
15 2763A–471), as enacted into law by section 1(a)(6) of
16 Public Law 106–554, is amended—

17 (1) in subparagraph (U), by striking “and” at
18 the end;

19 (2) in subparagraph (V), by inserting “and” at
20 the end; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(W) supplemental preventive health services
24 (as defined in subsection (ww));”.

1 (b) SERVICES DESCRIBED.—Section 1861 of the So-
 2 cial Security Act (42 U.S.C. 1395x), as amended by sec-
 3 tion 105(b) of the Medicare, Medicaid, and SCHIP Bene-
 4 fits Improvement and Protection Act of 2000 (114 Stat.
 5 2763A–471), as enacted into law by section 1(a)(6) of
 6 Public Law 106–554, is amended by adding at the end
 7 the following new subsection:

8 “Supplemental Preventive Health Services

9 “(ww) The term ‘supplemental preventive health serv-
 10 ices’ means the following:

11 “(1)(A) Therapy and counseling for cessation of
 12 tobacco use for individuals who use tobacco products
 13 or who are being treated for tobacco use that is
 14 furnished—

15 “(i) by or under the supervision of a physi-
 16 cian; or

17 “(ii) by any other health care professional
 18 who—

19 “(I) is legally authorized to furnish
 20 such services under State law (or the State
 21 regulatory mechanism provided by State
 22 law) of the State in which the services are
 23 furnished; and

1 “(II) is authorized to receive payment
2 for other services under this title or is des-
3 ignated by the Secretary for this purpose.

4 “(B) Subject to subparagraph (C), such term is
5 limited to—

6 “(i) therapy and counseling services rec-
7 ommended in ‘Treating Tobacco Use and De-
8 pendence: A Clinical Practice Guideline’, pub-
9 lished by the Public Health Service in June
10 2000, or any subsequent modification of such
11 Guideline; and

12 “(ii) such other therapy and counseling
13 services that the Secretary recognizes to be ef-
14 fective.

15 “(C) Such term shall not include coverage for
16 drugs or biologicals that are not otherwise covered
17 under this title.”.

18 (c) PAYMENT AND ELIMINATION OF COST-SHARING
19 FOR ALL SUPPLEMENTAL PREVENTIVE HEALTH SERV-
20 ICES.—

21 (1) PAYMENT AND ELIMINATION OF COINSUR-
22 ANCE.—Section 1833(a)(1) of the Social Security
23 Act (42 U.S.C. 1395l(a)(1)), as amended by section
24 223(c) of the Medicare, Medicaid, and SCHIP Bene-
25 fits Improvement and Protection Act of 2000 (114

1 Stat. 2763A–489), as enacted into law by section
2 1(a)(6) of Public Law 106–554, is amended—

3 (A) in subparagraph (N), by inserting
4 “other than supplemental preventive health
5 services (as defined in section 1861(ww))” after
6 “(as defined in section 1848(j)(3))”

7 (B) by striking “and” before “(U)”; and

8 (C) by inserting before the semicolon at
9 the end the following: “, and (V) with respect
10 to supplemental preventive health services (as
11 defined in section 1861(ww)), the amount paid
12 shall be 100 percent of the lesser of the actual
13 charge for the services or the amount deter-
14 mined under the payment basis determined
15 under section 1848 by the Secretary for the
16 particular supplemental preventive health serv-
17 ice involved”.

18 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-
19 ULE.—Section 1848(j)(3) (42 U.S.C. 1395w-
20 4(j)(3)) is amended by inserting “(2)(W),” after
21 “(2)(S),”.

22 (3) ELIMINATION OF COINSURANCE IN OUT-
23 PATIENT HOSPITAL SETTINGS.—The third sentence
24 of section 1866(a)(2)(A) of the Social Security Act
25 (42 U.S.C. 1395cc(a)(2)(A)) is amended by insert-

1 ing after “1861(s)(10)(A)” the following: “, with re-
2 spect to supplemental preventive health services (as
3 defined in section 1861(ww)),”.

4 (4) ELIMINATION OF DEDUCTIBLE.—The first
5 sentence of section 1833(b) of the Social Security
6 Act (42 U.S.C. 1395l(b)) is amended—

7 (A) by striking “and” before “(6)”; and

8 (B) by inserting before the period the fol-
9 lowing: “, and (7) such deductible shall not
10 apply with respect to supplemental preventive
11 health services (as defined in section
12 1861(ww))”.

13 (d) APPLICATION OF LIMITS ON BILLING.—Section
14 1842(b)(18)(C) of the Social Security Act (42 U.S.C.
15 1395u(b)(18)(C)), as amended by section 105(d) of the
16 Medicare, Medicaid, and SCHIP Benefits Improvement
17 and Protection Act of 2000 (114 Stat. 2763A–472), as
18 enacted into law by section 1(a)(6) of Public Law 106–
19 554, is amended by adding at the end the following new
20 clause:

21 “(vii) Any health care professional designated
22 under section 1861(ww)(1)(A)(ii)(II) to perform
23 therapy and counseling for cessation of tobacco
24 use.”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 the day that is 1 year after the date of enactment of this
4 Act.

5 **SEC. 202. COUNSELING FOR POST-MENOPAUSAL WOMEN.**

6 (a) COVERAGE.—Section 1861(ww) of the Social Se-
7 curity Act (42 U.S.C. 1395x(s)(2)), as added by section
8 201(b), is amended by adding at the end the following new
9 paragraph:

10 “(2)(A) Counseling for post-menopausal
11 women.

12 “(B) For purposes of subparagraph (A), the
13 term ‘counseling for post-menopausal women’ means
14 counseling provided to a post-menopausal woman
15 regarding—

16 “(i) the symptoms, risk factors, and condi-
17 tions associated with menopause;

18 “(ii) appropriate treatment options for
19 post-menopausal women, including hormone re-
20 placement therapy; and

21 “(iii) other interventions that can be imple-
22 mented to prevent or delay the onset of health
23 risks associated with menopause.

1 “(C) Such term does not include coverage for
2 drugs or biologicals that are not otherwise covered
3 under this title.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 this section shall apply to services furnished on or after
6 the day that is 1 year after the date of enactment of this
7 Act.

8 **SEC. 203. SCREENING FOR DIMINISHED VISUAL ACUITY.**

9 (a) COVERAGE.—Section 1861(ww) of the Social Se-
10 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
11 202(a), is amended by adding at the end the following new
12 paragraph:

13 “(3)(A) Screening for diminished visual acuity.

14 “(B) For purposes of subparagraph (A), the
15 term ‘screening for diminished visual acuity’ means
16 a screening for diminished visual acuity that is fur-
17 nished by or under the supervision of an optometrist
18 or ophthalmologist who is legally authorized to fur-
19 nish such services under State law (or the State reg-
20 ulatory mechanism provided by State law) of the
21 State in which the services are furnished.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 this section shall apply to services furnished on or after
24 the day that is 1 year after the date of enactment of this
25 Act.

1 **SEC. 204. SCREENING FOR HEARING IMPAIRMENT.**

2 (a) **COVERAGE.**—Section 1861(ww) of the Social Se-
3 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
4 203(a), is amended by adding at the end the following new
5 paragraph:

6 “(4)(A) Screening for hearing impairment.

7 “(B) For purposes of subparagraph (A), the
8 term ‘screening for hearing impairment’ means the
9 following services:

10 “(i) A screening for hearing impairment
11 using periodic questions that is furnished by—

12 “(I) a physician, including an
13 otolaryngologist;

14 “(II) a qualified audiologist (as de-
15 fined in subsection (l)(3)(B)); or

16 “(III) any other health care profes-
17 sional who is legally authorized to furnish
18 such screening under State law (or the
19 State regulatory mechanism provided by
20 State law) of the State in which the
21 screening is furnished.

22 “(ii) If the answers to such questions indi-
23 cate potential hearing impairment, an otoscopic
24 examination and an audiometric screening test
25 that are furnished by an otolaryngologist or a
26 qualified audiologist (as so defined).

1 “(iii) If the results of such examination or
2 test indicate a need for assistive listening de-
3 vices (whether or not such examination or test
4 was based on a screening or was diagnostic),
5 counseling about such devices that is furnished
6 by an otolaryngologist or a qualified audiologist
7 (as so defined).”.

8 (b) **EFFECTIVE DATE.**—The amendment made by
9 this section shall apply to services furnished on or after
10 the day that is 1 year after the date of enactment of this
11 Act.

12 **SEC. 205. SCREENING FOR CHOLESTEROL.**

13 (a) **COVERAGE.**—Section 1861(ww) of the Social Se-
14 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
15 204(a), is amended by adding at the end the following new
16 paragraph:

17 “(5)(A) Screening for cholesterol if the indi-
18 vidual involved has not had such a screening during
19 the preceding 5 years.

20 “(B) Notwithstanding subparagraph (A), pay-
21 ment may be made under this part for a screening
22 for cholesterol with respect to an individual even if
23 the individual has had such a screening during the
24 preceding 5 years if the individual exhibits major
25 risk factors for coronary heart disease or a stroke,

1 including, but not limited to, smoking, hypertension,
2 and diabetes.”.

3 (b) CONFORMING AMENDMENT.—Section 1862(a)(1)
4 of the Social Security Act (42 U.S.C. 1395y(a)(1)) is
5 amended—

6 (1) in subparagraph (H), by striking “and” at
7 the end;

8 (2) in subparagraph (I), by striking the semi-
9 colon at the end and inserting “, and”; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(J) in the case of a screening for choles-
13 terol, which is performed more frequently than
14 is covered under section 1861(w)(5);”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to services furnished on or after
17 the day that is 1 year after the date of enactment of this
18 Act.

19 **SEC. 206. SCREENING FOR HYPERTENSION.**

20 (a) COVERAGE.—Section 1861(w) of the Social Se-
21 curity Act (42 U.S.C. 1395x(s)(2)), as amended by section
22 205(a), is amended by adding at the end the following new
23 paragraph:

1 “(6)(A) Screening for hypertension if the indi-
2 vidual involved has not had such a screening during
3 the preceding 2 years.

4 “(B) Notwithstanding subparagraph (A), pay-
5 ment may be made under this part for a screening
6 for hypertension with respect to an individual even
7 if the individual has had such a screening during the
8 preceding 2 years if the individual has a history of,
9 or is at risk for, hypertension.”.

10 (b) CONFORMING AMENDMENT.—Section 1862(a)(1)
11 of the Social Security Act (42 U.S.C. 1395y(a)(1)), as
12 amended by section 205(b), is amended—

13 (1) in subparagraph (I), by striking “and” at
14 the end;

15 (2) in subparagraph (J), by striking the semi-
16 colon at the end and inserting “, and”; and

17 (3) by adding at the end the following new sub-
18 paragraph:

19 “(K) in the case of a screening for hyper-
20 tension, which is performed more frequently
21 than is covered under section 1861(w)(6);”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to services furnished on or after
24 the day that is 1 year after the date of enactment of this
25 Act.

1 **SEC. 207. EXPANSION OF ELIGIBILITY FOR BONE MASS**
2 **MEASUREMENT.**

3 (a) EXPANSION.—Section 1861(rr)(2) of the Social
4 Security Act (42 U.S.C. 1395x(rr)(2)) is amended to read
5 as follows:

6 “(2) For purposes of this subsection, the term ‘quali-
7 fied individual’ means an individual who is (in accordance
8 with regulations prescribed by the Secretary)—

9 “(A) an estrogen-deficient woman (including
10 those receiving hormone replacement therapy);

11 “(B) an individual with low trauma or fragility
12 fractures (including vertebral abnormalities and hip,
13 rib, wrist, pelvic, or proximal humeral fractures);

14 “(C) an individual receiving long-term medica-
15 tions that have associations to bone loss or
16 osteoporosis (including glucocorticoid therapy and
17 androgen deprivation therapy);

18 “(D) an individual with a long-term medical
19 condition that has association to osteoporosis (in-
20 cluding primary hyperparathyroidism);

21 “(E) a man with risk factors for osteoporosis
22 such as hypogonadism; and

23 “(F) an individual being monitored to assess
24 the response to, or efficacy of, an approved
25 osteoporosis therapy.”.

1 (b) REFERENCE TO ELIMINATION OF COINSURANCE
 2 AND WAIVER OF APPLICATION OF DEDUCTIBLE.—For
 3 the elimination of the coinsurance for bone mass measure-
 4 ment and for the waiver of the application of the part B
 5 deductible for such measurement, see section 209.

6 (c) EFFECTIVE DATE.—The amendment made by
 7 subsection (a) shall apply to services furnished on or after
 8 the day that is 1 year after the date of enactment of this
 9 Act.

10 **SEC. 208. COVERAGE OF MEDICAL NUTRITION THERAPY**
 11 **SERVICES FOR BENEFICIARIES WITH CAR-**
 12 **DIOVASCULAR DISEASES.**

13 (a) IN GENERAL.—Section 1861(s)(2)(V) of the So-
 14 cial Security Act (42 U.S.C. 1395x(s)(2)(V)), as added by
 15 subsection (a) of section 105 of the Medicare, Medicaid,
 16 and SCHIP Benefits Improvement and Protection Act of
 17 2000 (114 Stat. 2763A–471), as enacted into law by sec-
 18 tion 1(a)(6) of Public Law 106–554, is amended to read
 19 as follows:

20 “(V) medical nutrition therapy services (as de-
 21 fined in subsection (vv)(1)) in the case of a
 22 beneficiary—

23 “(i) with a cardiovascular disease (includ-
 24 ing congestive heart failure, arteriosclerosis,
 25 hyperlipidemia, hypertension, and

1 hypercholesterolemia), diabetes, or a renal dis-
2 ease (or a combination of such conditions)
3 who—

4 “(I) has not received diabetes out-
5 patient self-management training services
6 within a time period determined by the
7 Secretary;

8 “(II) is not receiving maintenance di-
9 alysis for which payment is made under
10 section 1881; and

11 “(III) meets such other criteria deter-
12 mined by the Secretary after consideration
13 of protocols established by dietitian or nu-
14 trition professional organizations; or

15 “(ii) with a combination of such conditions
16 who—

17 “(I) is not described in clause (i) be-
18 cause of the application of subclause (I) or
19 (II) of such clause;

20 “(II) receives such medical nutrition
21 therapy services in a coordinated manner
22 (as determined appropriate by the Sec-
23 retary) with any services described in such
24 subclauses that the beneficiary is receiving;
25 and

1 “(III) meets such other criteria deter-
2 mined by the Secretary after consideration
3 of protocols established by dietitian or nu-
4 trition professional organizations;”.

5 (b) ELIMINATION OF COINSURANCE.—Section
6 1833(a)(1)(T) of the Social Security Act (42 U.S.C.
7 1395l(a)(1)(T)), as added by section 105(c)(2) of the
8 Medicare, Medicaid, and SCHIP Benefits Improvement
9 and Protection Act of 2000 (114 Stat. 2763A–472), as
10 enacted into law by section 1(a)(6) of Public Law 106–
11 554, is amended by striking “80 percent” and inserting
12 “100 percent”.

13 (c) REFERENCE TO WAIVER OF APPLICATION OF DE-
14 DUCTIBLE.—For the waiver of the application of the part
15 B deductible for medical nutrition therapy services, see
16 section 209.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect as if included in the enact-
19 ment of section 105 of the Medicare, Medicaid, and
20 SCHIP Benefits Improvement and Protection Act of 2000
21 (114 Stat. 2763A–471), as enacted into law by section
22 1(a)(6) of Public Law 106–554.

1 **SEC. 209. ELIMINATION OF DEDUCTIBLES AND COINSUR-**
2 **ANCE FOR EXISTING PREVENTIVE HEALTH**
3 **BENEFITS.**

4 (a) IN GENERAL.—Section 1833 of the Social Secu-
5 rity Act (42 U.S.C. 1395l) is amended by inserting after
6 subsection (o) the following new subsection:

7 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR
8 PREVENTIVE HEALTH ITEMS AND SERVICES.—The Sec-
9 retary may not require the payment of any deductible or
10 coinsurance under subsection (a) or (b), respectively, of
11 any individual enrolled for coverage under this part for
12 any of the following preventive health items and services:

13 “(1) Blood-testing strips, lancets, and blood
14 glucose monitors for individuals with diabetes de-
15 scribed in section 1861(n).

16 “(2) Diabetes outpatient self-management
17 training services (as defined in section 1861(qq)(1)).

18 “(3) Pneumococcal, influenza, and hepatitis B
19 vaccines and administration described in section
20 1861(s)(10).

21 “(4) Screening mammography (as defined in
22 section 1861(jj)).

23 “(5) Screening pap smear and screening pelvic
24 exam (as defined in paragraphs (1) and (2) of sec-
25 tion 1861(nn), respectively).

1 “(6) Bone mass measurement (as defined in
2 section 1861(rr)(1)).

3 “(7) Prostate cancer screening test (as defined
4 in section 1861(oo)(1)).

5 “(8) Colorectal cancer screening test (as de-
6 fined in section 1861(pp)(1)).

7 “(9) Screening for glaucoma (as defined in sec-
8 tion 1861(uu)).

9 “(10) Medical nutrition therapy services (as de-
10 fined in section 1861(vv)(1)).”.

11 (b) WAIVER OF COINSURANCE.—

12 (1) IN GENERAL.—Section 1833(a)(1)(B) of the
13 Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is
14 amended to read as follows: “(B) with respect to
15 preventive health items and services described in
16 subsection (p), the amounts paid shall be 100 per-
17 cent of the fee schedule or other basis of payment
18 under this title for the particular item or service,”.

19 (2) ELIMINATION OF COINSURANCE IN OUT-
20 PATIENT HOSPITAL SETTINGS.—The third sentence
21 of section 1866(a)(2)(A) of the Social Security Act
22 (42 U.S.C. 1395cc(a)(2)(A)), as amended by section
23 201(c)(3), is amended by inserting after “section
24 1861(ww)” the following: “and preventive health
25 items and services described in section 1833(p)”.

1 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—
2 Section 1833(b)(1) of the Social Security Act (42 U.S.C.
3 1395l(b)(1)) is amended to read as follows: “(1) such de-
4 ductible shall not apply with respect to preventive health
5 items and services described in subsection (p),”.

6 (d) ADDING “LANCET” TO DEFINITION OF DME.—
7 Section 1861(n) of the Social Security Act (42 U.S.C.
8 1395x(n)) is amended by striking “blood-testing strips
9 and blood glucose monitors” and inserting “blood-testing
10 strips, lancets, and blood glucose monitors”.

11 (e) CONFORMING AMENDMENTS.—

12 (1) ELIMINATION OF COINSURANCE FOR CLIN-
13 ICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs
14 (1)(D)(i) and (2)(D)(i) of section 1833(a) of the So-
15 cial Security Act (42 U.S.C. 1395l(a)), as amended
16 by section 201(b)(1) of the Medicare, Medicaid, and
17 SCHIP Benefits Improvement and Protection Act of
18 2000 (114 Stat. 2763A–481), as enacted into law by
19 section 1(a)(6) of Public Law 106–554, are each
20 amended by inserting “or which are described in
21 subsection (p)” after “assignment-related basis”.

22 (2) ELIMINATION OF COINSURANCE FOR CER-
23 TAIN DME.—Section 1834(a)(1)(A) of the Social Se-
24 curity Act (42 U.S.C. 1395m(a)(1)(A)) is amended
25 by inserting “(or 100 percent, in the case of such an

1 item described in section 1833(p))” after “80 per-
 2 cent”.

3 (3) ELIMINATION OF DEDUCTIBLES AND COIN-
 4 SURANCE FOR COLORECTAL CANCER SCREENING
 5 TESTS.—Section 1834(d) of the Social Security Act
 6 (42 U.S.C. 1395m(d)) is amended—

7 (A) in paragraph (2)(C)—

8 (i) by striking “(C) FACILITY PAY-
 9 MENT LIMIT.—” and all that follows
 10 through “Notwithstanding subsections”
 11 and inserting the following:

12 “(C) FACILITY PAYMENT LIMIT.—Notwith-
 13 standing subsections”;

14 (ii) by striking “(I) in accordance”
 15 and inserting the following:

16 “(i) in accordance”;

17 (iii) by striking “(II) are performed”
 18 and all that follows through “payment
 19 under” and inserting the following:

20 “(ii) are performed in an ambulatory
 21 surgical center or hospital outpatient de-
 22 partment,

23 payment under”; and

24 (iv) by striking clause (ii); and

25 (B) in paragraph (3)(C)—

1 (i) by striking “(C) FACILITY PAY-
2 MENT LIMIT.—” and all that follows
3 through “Notwithstanding subsections”
4 and inserting the following:

5 “(C) FACILITY PAYMENT LIMIT.—Notwith-
6 standing subsections”; and

7 (ii) by striking clause (ii).

8 (f) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to services furnished on or after
10 the day that is 1 year after the date of enactment of this
11 Act.

12 **SEC. 210. PROGRAM INTEGRITY.**

13 The Secretary, in consultation with the Inspector
14 General of the Department of Health and Human Serv-
15 ices, shall integrate supplemental preventive health serv-
16 ices (as defined in section 1861(wv) of the Social Security
17 Act (as added by the preceding provisions of this title))
18 with existing program integrity measures.

19 **SEC. 211. PROMOTION OF PREVENTIVE HEALTH BENEFITS.**

20 In order to promote the use by medicare beneficiaries
21 of preventive health benefits, including preventive health
22 services (as defined in section 1861(wv) of the Social Se-
23 curity Act (as added by the preceding provisions of this
24 title)) and preventive health items and services described

1 in section 1833(p) of such Act (as added by section 209),
2 the Secretary shall do the following:

3 (1) MEDICARE HANDBOOK AND OTHER ANNUAL
4 NOTICES.—Include in any medicare handbook and
5 any other annual notice provided to medicare bene-
6 ficiaries a detailed description of—

7 (A) the preventive health benefits that are
8 covered under the medicare program; and

9 (B) the importance of using such benefits.

10 (2) FISCAL INTERMEDIARIES AND CARRIERS.—
11 Require that fiscal intermediaries with a contract
12 under section 1816 of the Social Security Act (42
13 U.S.C. 1395h) and carriers with a contract under
14 section 1842 of such Act (42 U.S.C. 1395u) include
15 preventive health benefits messages on Medicare
16 Summary Notice Statements and Explanations of
17 Medicare Benefits distributed by such entities.

18 (3) MEDICARE PART B STATEMENT.—Regularly
19 include preventive health benefits messages on the
20 medicare part B statement.

21 (4) MEDICARE+CHOICE PLANS.—Require that
22 Medicare+Choice organizations offering a
23 Medicare+Choice plan disclose under section
24 1852(c)(1)(B) of the Social Security Act (42 U.S.C.
25 1395w–22(c)(1)(B)) information regarding the pre-

1 ventive health benefits that are covered under the
2 plan.

3 (5) OTHER ACTIVITIES.—Conduct activities in
4 addition to those described in paragraphs (1)
5 through (4) that the Secretary determines to be use-
6 ful in disseminating information to medicare bene-
7 ficiaries regarding—

8 (A) the preventive health benefits that are
9 covered under the medicare program;

10 (B) the importance of using such benefits;

11 and

12 (C) general health promotion.

13 **TITLE III—NATIONAL FALLS**
14 **PREVENTION EDUCATION**
15 **AND AWARENESS CAMPAIGN**

16 **SEC. 301. NATIONAL FALLS PREVENTION EDUCATION AND**
17 **AWARENESS CAMPAIGN.**

18 (a) IN GENERAL.—The Director of the Centers for
19 Disease Control and Prevention, in consultation with the
20 Administrator of the Health Care Financing Administra-
21 tion, shall conduct a national falls prevention and aware-
22 ness campaign to reduce fall-related injuries among medi-
23 care beneficiaries.

24 (b) REPORT TO CONGRESS.—

1 (1) IN GENERAL.—The Director of the Centers
2 for Disease Control and Prevention, in consultation
3 with the Administrator of the Health Care Financ-
4 ing Administration, shall submit to Congress a re-
5 port on the campaign conducted under this section.

6 (2) DEADLINE FOR REPORT.—The report re-
7 quired under paragraph (1) shall be submitted not
8 later than the earlier of—

9 (A) 6 months after the campaign is com-
10 pleted; or

11 (B) 3 years after the campaign is imple-
12 mented.

13 (3) CONTENTS OF REPORT.—The report re-
14 quired under paragraph (1) shall include the fol-
15 lowing:

16 (A) A description of the campaign.

17 (B) An evaluation of—

18 (i) whether the campaign has effec-
19 tively reached its target population; and

20 (ii) the cost-effectiveness of the cam-
21 paign.

22 (C) An assessment of whether the cam-
23 paign has been effective, as measured by
24 whether—

1 (i) the target population has adopted
 2 the interventions suggested in the cam-
 3 paign, and if not, the reasons why such
 4 interventions have not been adopted; and

5 (ii) the fall rates among the target
 6 population have decreased since the cam-
 7 paign was implemented, and if not, the
 8 reasons why such fall rates have not de-
 9 creased.

10 (D) Any other information regarding the
 11 campaign that the Director of the Centers for
 12 Disease Control and Prevention determines to
 13 be appropriate.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—There
 15 are authorized to be appropriated such sums as may be
 16 necessary for the purpose of carrying out this section.

17 **TITLE IV—CLINICAL DEPRES-**
 18 **SION SCREENING DEM-**
 19 **ONSTRATION PROJECTS**

20 **SEC. 401. CLINICAL DEPRESSION SCREENING DEMONSTRA-**
 21 **TION PROJECTS.**

22 (a) DEFINITIONS.—In this section:

23 (1) DEMONSTRATION PROJECT.—The term
 24 “demonstration project” means a demonstration
 25 project established under subsection (b)(1).

1 (2) ELIGIBLE BENEFICIARY.—The term “eligi-
2 ble beneficiary” means an individual enrolled for
3 benefits under part B who is not enrolled in any of
4 the following:

5 (A) A Medicare+Choice plan under part C
6 of title XVIII of the Social Security Act (42
7 U.S.C. 1395w–21 et seq.).

8 (B) A plan offered by an eligible organiza-
9 tion under section 1876 of such Act (42 U.S.C.
10 1395mm).

11 (C) A program of all-inclusive care for the
12 elderly (PACE) under section 1894 of such Act
13 (42 U.S.C. 1395eee).

14 (D) A social health maintenance organiza-
15 tion (SHMO) demonstration project established
16 under section 4018(b) of the Omnibus Budget
17 Reconciliation Act of 1987 (Public Law 100–
18 203).

19 (E) A health care prepayment plan under
20 section 1833(a)(1)(A) of the Social Security Act
21 (42 U.S.C. 1395l(a)(1)(A)).

22 (3) PART B.—The term “part B” means part
23 B of the original medicare fee-for-service program
24 under title XVIII of the Social Security Act (42
25 U.S.C. 1395j et seq.).

1 (4) QUALIFIED HEALTH PROFESSIONAL.—The
2 term “qualified health professional” means an indi-
3 vidual that—

4 (A) is—

5 (i) a physician (as defined in section
6 1861(r)(1) of the Social Security Act (42
7 U.S.C. 1395x(r)(1)));

8 (ii) a nurse practitioner (as defined in
9 section 1861(aa)(5) of such Act (42 U.S.C.
10 1395x(aa)(5))); or

11 (iii) a mental health care professional
12 (including a clinical social worker, as de-
13 fined in section 1861(hh) of such Act (42
14 U.S.C. 1395x(hh))) that is licensed to per-
15 form mental health services by the State in
16 which a screening for clinical depression is
17 furnished under a demonstration project;
18 and

19 (B) has an agreement in effect with the
20 Secretary under which the professional agrees
21 to accept the amount determined by the Sec-
22 retary under subsection (b)(4) as full payment
23 for such screening and to accept an assignment
24 described in section 1842(b)(3)(B)(ii) of the So-
25 cial Security Act (42 U.S.C.

1 1395u(b)(3)(B)(ii)) with respect to payment for
2 each screening furnished by the professional to
3 an eligible beneficiary participating in a dem-
4 onstration project.

5 (5) SCREENING FOR CLINICAL DEPRESSION.—

6 (A) IN GENERAL.—The term “screening
7 for clinical depression” means a consultation
8 during which—

9 (i) a self-administered written screen-
10 ing test (or an alternative format for such
11 test pursuant to subsection (b)(3)(B)) is
12 made available to an eligible beneficiary;
13 and

14 (ii) a qualified health professional—
15 (I) interprets the results of such
16 test;
17 (II) discusses the beneficiary’s
18 responses to the questions on the test
19 with the beneficiary;

20 (III) assesses the beneficiary’s
21 risk of clinical depression; and

22 (IV) if the qualified health pro-
23 fessional determines that the bene-
24 ficiary is at high risk for clinical de-
25 pression, refers the eligible beneficiary

1 for a full diagnostic evaluation and
2 such additional treatment as may be
3 required.

4 (B) CONSTRUCTION.—Nothing in subpara-
5 graph (A)(ii)(IV) shall be construed as prohib-
6 iting a qualified health professional performing
7 the screening for clinical depression with re-
8 spect to an individual from directly providing
9 the diagnostic evaluation and additional treat-
10 ment described in such subparagraph to such
11 individual if legally authorized under State law
12 to do so.

13 (6) SELF-ADMINISTERED WRITTEN SCREENING
14 TEST.—The term “self-administered written screen-
15 ing test” means an instrument on which an eligible
16 beneficiary writes answers to questions designed to
17 enable a qualified health professional to establish the
18 level of risk of such eligible beneficiary for clinical
19 depression.

20 (b) DEMONSTRATION PROJECTS.—

21 (1) IN GENERAL.—The Secretary shall establish
22 and conduct demonstration projects for the purpose
23 of evaluating the efficacy of providing screenings for
24 clinical depression as a benefit under part B to eligi-
25 ble beneficiaries through qualified health profes-

1 sionals in accordance with the requirements of this
2 section.

3 (2) NUMBER, PROJECT AREAS, DURATION.—

4 (A) NUMBER.—The Secretary shall estab-
5 lish no fewer than 6 and no more than 10 dem-
6 onstration projects.

7 (B) PROJECT AREAS.—

8 (i) IN GENERAL.—The Secretary shall
9 conduct demonstration projects in geo-
10 graphic areas that include urban, subur-
11 ban, and rural areas.

12 (ii) SELECTION.—The Secretary shall
13 select the geographic areas described in
14 clause (i) in a manner that—

15 (I) ensures geographic diversity
16 and a mix of screening sites (includ-
17 ing physicians' offices, hospital out-
18 patient departments, community men-
19 tal health centers, and skilled nursing
20 facilities); and

21 (II) gives preference to areas
22 with a high concentration of eligible
23 beneficiaries.

24 (C) DURATION.—The demonstration
25 projects under this section shall be conducted

1 during the 3-year period beginning on the date
2 on which the initial demonstration project is
3 implemented.

4 (3) IDENTIFICATION AND DISTRIBUTION OF
5 SELF-ADMINISTERED TESTS.—

6 (A) IN GENERAL.—The Secretary, in con-
7 sultation with professionals experienced in con-
8 ducting large-scale depression screening
9 projects, shall—

10 (i) establish or identify a self-adminis-
11 tered written screening test to be used in
12 conducting the demonstration projects; and

13 (ii) not later than the date that is 3
14 months before the date on which a dem-
15 onstration project is implemented in a geo-
16 graphic area, distribute such test to each
17 qualified health professional that provides
18 services in such area in which the Sec-
19 retary conducts a demonstration project,
20 together with guidelines for making the
21 test available to eligible beneficiaries.

22 (B) ALTERNATIVE FORMATS FOR TEST.—
23 The Secretary shall also establish and distribute
24 alternative formats for the self-administered
25 written screening test under subparagraph (A)

1 which shall be available for use when cir-
2 cumstances do not permit an individual to com-
3 plete the self-administered written screening
4 test.

5 (4) PAYMENT FOR SCREENINGS FOR CLINICAL
6 DEPRESSION.—

7 (A) IN GENERAL.—Subject to subpara-
8 graph (C), the Secretary shall provide for pay-
9 ment of the reasonable charges for each screen-
10 ing for clinical depression furnished to an eligi-
11 ble beneficiary by a qualified health professional
12 from the amounts transferred under subsection
13 (d).

14 (B) WAIVER OF COINSURANCE AND
15 DEDUCTIBLES.—The Secretary may not require
16 the payment of any deductible or coinsurance
17 by any eligible beneficiary for a screening for
18 clinical depression furnished under a dem-
19 onstration project.

20 (C) FREQUENCY LIMITATION.—No pay-
21 ment may be made under this section for a
22 screening for clinical depression if such a
23 screening is performed with respect to an eligi-
24 ble beneficiary within the year after a previous
25 screening of such beneficiary.

1 (5) WAIVER AUTHORITY.—The Secretary may
2 waive such requirements under title XVIII of the So-
3 cial Security Act (42 U.S.C. 1395 et seq.) as the
4 Secretary determines necessary to carry out the
5 demonstration projects under this section.

6 (c) REPORTS TO CONGRESS.—

7 (1) INTERIM REPORT.—

8 (A) IN GENERAL.—Not later than 2 years
9 after the Secretary implements the initial dem-
10 onstration project, the Secretary shall submit to
11 Congress a report regarding the demonstration
12 projects conducted under this section.

13 (B) CONTENTS OF REPORT.—The report
14 submitted under subparagraph (A) shall
15 contain—

16 (i) a description of the demonstration
17 projects conducted under this section;

18 (ii) an evaluation of—

19 (I) whether screening for clinical
20 depression is a cost-effective benefit or
21 a cost-saving benefit; and

22 (II) the level of satisfaction of el-
23 igible beneficiaries to whom such a
24 screening is furnished under the dem-
25 onstration project; and

1 (iii) any other information regarding
2 the demonstration projects that the Sec-
3 retary determines to be appropriate.

4 (2) FINAL REPORT.—Not later than 1 year
5 after the conclusion of the demonstration projects,
6 the Secretary shall submit a final report to Congress
7 on the demonstration projects containing the rec-
8 ommendations of the Secretary regarding whether to
9 conduct the demonstration projects on a permanent
10 basis, together with such recommendations for legis-
11 lation and administrative action as the Secretary
12 considers appropriate.

13 (d) FUNDING.—The Secretary shall provide for the
14 transfer from the Federal Hospital Insurance Trust Fund
15 under section 1817 of the Social Security Act (42 U.S.C.
16 1395i) an amount not to exceed \$30,000,000 for the costs
17 of carrying out the demonstration projects under this sec-
18 tion.

1 **TITLE V—MEDICARE HEALTH**
2 **EDUCATION AND RISK AP-**
3 **PRAISAL PROGRAM**

4 **SEC. 501. MEDICARE HEALTH EDUCATION AND RISK AP-**
5 **PRAISAL PROGRAM.**

6 Title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.) is amended by adding at the end the fol-
8 lowing new section:

9 “MEDICARE HEALTH EDUCATION AND RISK APPRAISAL
10 PROGRAM

11 “SEC. 1897. (a) ESTABLISHMENT.—Not later than
12 18 months after the date of the conclusion of the dem-
13 onstration projects conducted under subsection (b)(1), the
14 Secretary shall implement the demonstration project that
15 the Secretary identifies as being the most effective project
16 under subsection (c)(2)(C) on a nationwide and perma-
17 nent basis.

18 “(b) DEMONSTRATION PROJECTS.—

19 “(1) ESTABLISHMENT.—Not later than 1 year
20 after the date of enactment of this Act, the Sec-
21 retary, in consultation with the Health Care Financ-
22 ing Administration, the Centers for Disease Control
23 and Prevention, and the Agency for Healthcare Re-
24 search and Quality, shall conduct a demonstration
25 project for the purpose of developing a comprehen-

1 sive and systematic model for delivering health pro-
2 motion and disease prevention services that—

3 “(A) through self-assessment identifies—

4 “(i) behavioral risk factors, such as
5 tobacco use, physical inactivity, alcohol
6 use, and depression, among target individ-
7 uals;

8 “(ii) needed medicare clinical preven-
9 tive and screening health benefits among
10 target individuals; and

11 “(iii) functional and self-management
12 information the Secretary determines to be
13 appropriate;

14 “(B) provides ongoing followup to reduce
15 risk factors and promote the appropriate use of
16 preventive and screening health benefits;

17 “(C) improves clinical outcomes, satisfac-
18 tion, quality of life, and appropriate use by tar-
19 get individuals of items and services covered
20 under the medicare program; and

21 “(D) provides target individuals with infor-
22 mation regarding the adoption of healthy behav-
23 iors.

24 “(2) SELF-ASSESSMENT AND PROVISION OF IN-
25 FORMATION.—The Secretary shall conduct the dem-

1 demonstration projects established under paragraph (1)
2 in the following manner:

3 “(A) SELF-ASSESSMENT.—

4 “(i) IN GENERAL.—The Secretary
5 shall test different—

6 “(I) methods of making self-as-
7 sessments available to each target in-
8 dividual;

9 “(II) methods of encouraging
10 each target individual to participate in
11 the self-assessment; and

12 “(III) methods for processing re-
13 sponses to the self-assessment.

14 “(ii) CONTENTS.—A self-assessment
15 made available under clause (i) shall
16 include—

17 “(I) questions regarding behav-
18 ioral risk factors;

19 “(II) questions regarding needed
20 preventive screening health services;

21 “(III) questions regarding the
22 target individual’s preferences for re-
23 ceiving follow-up information; and

24 “(IV) other information that the
25 Secretary determines appropriate.

1 “(B) PROVISION OF INFORMATION.—After
2 each target individual completes the self-assess-
3 ment, the Secretary shall ensure that the target
4 individual is provided with such information as
5 the Secretary determines appropriate, which
6 may include—

7 “(i) information regarding the results
8 of the self-assessment;

9 “(ii) recommendations regarding any
10 appropriate behavior modification based on
11 the self-assessment;

12 “(iii) information regarding how to
13 access behavior modification assistance
14 that promotes healthy behavior, including
15 information on nurse hotlines, counseling
16 services, provider services, and case-man-
17 agement services;

18 “(iv) information, feedback, support,
19 and recommendations regarding any need
20 for clinical preventive and screening health
21 services or treatment; and

22 “(v) referrals to available community
23 resources in order to assist the target indi-
24 vidual in reducing health risks.

25 “(3) PROJECT AREAS AND DURATION.—

1 “(A) PROJECT AREAS.—The Secretary
2 shall implement the demonstration projects in
3 geographic areas that include urban, suburban,
4 and rural areas.

5 “(B) DURATION.—The Secretary shall
6 conduct the demonstration projects during the
7 3-year period beginning on the date on which
8 the first demonstration project is implemented.

9 “(c) REPORT TO CONGRESS.—

10 “(1) IN GENERAL.—Not later than 1 year after
11 the date on which the demonstration projects con-
12 clude, the Secretary shall submit to Congress a re-
13 port on such projects.

14 “(2) CONTENTS OF REPORT.—The report sub-
15 mitted under paragraph (1) shall—

16 “(A) describe the demonstration projects
17 conducted under this section;

18 “(B) identify the demonstration project
19 that is the most effective; and

20 “(C) contain such other information re-
21 garding the demonstration projects as the Sec-
22 retary determines appropriate.

23 “(3) MEASUREMENT OF EFFECTIVENESS.—For
24 purposes of paragraph (2)(B), in identifying the

1 demonstration project that is the most effective, the
2 Secretary shall consider—

3 “(A) how successful the project was at—

4 “(i) reaching target individuals and
5 engaging them in an assessment of the risk
6 factors of such individuals;

7 “(ii) educating target individuals on
8 healthy behaviors and getting such individ-
9 uals to modify their behaviors in order to
10 diminish the risk of chronic disease; and

11 “(iii) ensuring that target individuals
12 were provided with necessary information;

13 “(B) the cost-effectiveness of the dem-
14 onstration project; and

15 “(C) the degree of beneficiary satisfaction
16 under the demonstration projects.

17 “(d) WAIVER AUTHORITY.—The Secretary may
18 waive such requirements under this title as the Secretary
19 determines necessary to carry out the demonstration
20 projects under this section.

21 “(e) FUNDING.—There are authorized to be appro-
22 priated \$25,000,000 for carrying out the demonstration
23 project under this section.

24 “(f) DEFINITIONS.—In this section:

1 “(1) TARGET INDIVIDUAL.—The term ‘target
2 individual’ means each individual that is—

3 “(A) entitled to benefits under part A or
4 enrolled under part B, including an individual
5 enrolled under the Medicare+Choice program
6 under part C; or

7 “(B) between the ages of 50 and 64 who
8 is not a beneficiary under this title.

9 “(2) MAJOR BEHAVIORAL RISK FACTOR.—The
10 term ‘major behavioral risk factor’ includes—

11 “(A) the lack of proper nutrition;

12 “(B) the use of alcohol;

13 “(C) the lack of regular exercise;

14 “(D) the use of tobacco;

15 “(E) depression; and

16 “(F) any other risk factor identified by the
17 Secretary.”.

1 **TITLE VI—STUDIES, EVALUA-**
 2 **TIONS, AND REPORTS IN THE**
 3 **FIELD OF DISEASE PREVEN-**
 4 **TION AND THE ELDERLY**

5 **SEC. 601. MEDPAC EVALUATION AND REPORT ON MEDI-**
 6 **CARE BENEFIT PACKAGE IN RELATION TO**
 7 **PRIVATE SECTOR BENEFIT PACKAGES.**

8 (a) IN GENERAL.—Section 1805(b) of the Social Se-
 9 curity Act (42 U.S.C. 1395b–6(b)), as amended by section
 10 544(b) of the Medicare, Medicaid, and SCHIP Benefits
 11 Improvement and Protection Act of 2000 (114 Stat.
 12 2763A–551), as enacted into law by section 1(a)(6) of
 13 Public Law 106–554, is amended—

14 (1) in paragraph (1)—

15 (A) in subparagraph (C), by striking
 16 “and” at the end;

17 (B) in subparagraph (D), by striking the
 18 period and inserting “; and”; and

19 (C) by adding at the end the following new
 20 subparagraph:

21 “(E) on the date that is 3 years after the
 22 date of enactment of the Medicare Wellness Act
 23 of 2001, and each successive 3-year anniversary
 24 thereafter, submit the report described in para-
 25 graph (8)(C) to Congress.”; and

1 (2) by adding at the end the following new
2 paragraph:

3 “(8) EVALUATION OF MEDICARE BENEFIT
4 PACKAGE IN RELATION TO PRIVATE SECTOR BEN-
5 EFIT PACKAGES.—

6 “(A) EVALUATION.—The Commission shall
7 evaluate—

8 “(i) the benefit package offered under
9 the medicare program under this title; and

10 “(ii) the degree to which such benefit
11 package compares to the benefit packages
12 offered by health benefit programs avail-
13 able in the private sector to individuals
14 over age 55.

15 “(B) ISSUES.—In conducting the evalua-
16 tion under subparagraph (A)(ii), the Commis-
17 sion shall address the following issues:

18 “(i) Whether the benefit packages
19 available under the programs are—

20 “(I) similar;

21 “(II) appropriate for the enroll-
22 ees of the programs (based on what
23 experts recommend for such enroll-
24 ees);

25 “(III) actuarially equivalent; and

1 “(IV) comprehensive.

2 “(ii) The financial liabilities of enroll-
3 ees of the programs and whether such li-
4 abilities are appropriate.

5 “(iii) The ability of enrollees of the
6 programs to take advantage of benefits
7 under the programs.

8 “(C) REPORT.—The Commission shall
9 submit a report to Congress that shall
10 contain—

11 “(i) a detailed statement of the find-
12 ings and conclusions of the Commission re-
13 garding the evaluation conducted under
14 subparagraph (A);

15 “(ii) the recommendations of the
16 Commission regarding changes in the ben-
17 efit package offered under the medicare
18 program under this title that would keep
19 the program modern and competitive in re-
20 lation to health benefit packages offered by
21 health benefit programs available in the
22 private sector to individuals over age 55;
23 and

24 “(iii) the recommendations of the
25 Commission for such legislation and ad-

1 ministrative actions as it considers appro-
2 priate.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect on the date of enactment of
5 this Act.

6 **SEC. 602. NATIONAL INSTITUTE ON AGING STUDY AND RE-**
7 **PORT ON WAYS TO IMPROVE THE QUALITY**
8 **OF LIFE OF ELDERLY.**

9 (a) STUDIES.—The Director of the National Institute
10 on Aging, in consultation with the Working Group on Dis-
11 ease Self-Management and Health Promotion (established
12 in section 102) and the United States Preventive Services
13 Task Force, shall conduct 1 or more studies focusing on
14 ways to—

- 15 (1) improve quality of life for the elderly; and
16 (2) develop better ways to prevent or delay the
17 onset of age-related functional decline and disease
18 and disability among the elderly.

19 (b) REPORTS.—

20 (1) REPORT FOR EACH STUDY.—The Director
21 of the National Institute on Aging, in consultation
22 with the Working Group on Disease Self-Manage-
23 ment and Health Promotion and the United States
24 Preventive Services Task Force, shall submit a re-
25 port to the Secretary regarding each study con-

1 ducted under subsection (a), together with a detailed
2 statement of research findings and conclusions that
3 are scientifically valid and are demonstrated to pre-
4 vent or delay the onset of chronic illness or disability
5 among the elderly.

6 (2) TIMING FOR SUBMITTING REPORTS.—Each
7 report regarding a study that is required to be sub-
8 mitted pursuant to paragraph (1) shall be submitted
9 by not later than the earlier of—

10 (A) the date that is 18 months after the
11 completion of the study involved; or

12 (B) January 1, 2008.

13 (c) TRANSMISSION TO INSTITUTE OF MEDICINE.—
14 Upon receipt of each report described in subsection (b),
15 the Secretary shall transmit such report to the Institute
16 of Medicine of the National Academy of Sciences for con-
17 sideration in its effort to conduct the comprehensive study
18 of current literature and best practices in the field of
19 health promotion and disease prevention among the medi-
20 care beneficiaries described in section 603.

21 (d) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There are authorized to be
23 appropriated for the purpose of carrying out this
24 section such sums as may be necessary for the pe-
25 riod of fiscal years 2002 through 2008.

1 (2) AVAILABILITY.—Any sums appropriated
2 under the authorization contained in this subsection
3 shall remain available, without fiscal year limitation,
4 until September 30, 2008.

5 **SEC. 603. INSTITUTE OF MEDICINE MEDICARE PREVEN-**
6 **TION BENEFIT STUDY AND REPORT.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Secretary shall contract
9 with the Institute of Medicine of the National Acad-
10 emy of Sciences to—

11 (A) conduct a comprehensive study of cur-
12 rent literature and best practices in the field of
13 health promotion and disease prevention among
14 medicare beneficiaries, including the issues de-
15 scribed in paragraph (2); and

16 (B) submit the report described in sub-
17 section (b).

18 (2) ISSUES STUDIED.—The study required
19 under paragraph (1) shall include an assessment
20 of—

21 (A) whether each health promotion and
22 disease prevention benefit covered under the
23 medicare program is—

24 (i) medically effective (as defined in
25 section 101(4)); and

1 (ii) a cost-effective benefit (as defined
2 in section 101(2)) or a cost-saving benefit
3 (as defined in section 101(3));

4 (B) utilization by medicare beneficiaries of
5 such benefits (including any barriers to or in-
6 centives to increase utilization);

7 (C) quality of life issues associated with
8 such benefits; and

9 (D) health promotion and disease preven-
10 tion benefits that are not covered under the
11 medicare program that would affect all medi-
12 care beneficiaries.

13 (b) REPORTS.—

14 (1) THREE-YEAR REPORT.—On the date that is
15 3 years after the date of enactment of this Act, and
16 each successive 3-year anniversary thereafter, the
17 Institute of Medicine of the National Academy of
18 Sciences shall submit to the President a report that
19 contains—

20 (A) a detailed statement of the findings
21 and conclusions of the study conducted under
22 subsection (a); and

23 (B) the recommendations for legislation
24 described in paragraph (3).

1 (2) INTERIM REPORT BASED ON NEW GUIDE-
2 LINES.—If the United States Preventive Services
3 Task Force or the Task Force on Community Pre-
4 ventive Services establishes new guidelines regarding
5 preventive health benefits for medicare beneficiaries
6 more than 1 year prior to the date that a report de-
7 scribed in paragraph (1) is due to be submitted to
8 the President, then not later than 6 months after
9 the date such new guidelines are established, the In-
10 stitute of Medicine of the National Academy of
11 Sciences shall submit to the President a report that
12 contains a detailed description of such new guide-
13 lines. Such report may also contain recommenda-
14 tions for legislation described in paragraph (3).

15 (3) RECOMMENDATIONS FOR LEGISLATION.—
16 The Institute of Medicine of the National Academy
17 of Sciences, in consultation with the United States
18 Preventive Services Task Force and the Task Force
19 on Community Preventive Services, shall develop
20 recommendations in legislative form that—

21 (A) prioritize the preventive health benefits
22 under the medicare program; and

23 (B) modify such benefits, including adding
24 new benefits under such program, based on the
25 study conducted under subsection (a).

1 (c) TRANSMISSION TO CONGRESS.—

2 (1) IN GENERAL.—On the day on which the re-
3 port described in paragraph (1) of subsection (b) (or
4 paragraph (2) of such subsection if the report con-
5 tains recommendations in legislative form described
6 in subsection (b)(3)) is submitted to the President,
7 the President shall transmit the report and rec-
8 ommendations to Congress.

9 (2) DELIVERY.—Copies of the report and rec-
10 ommendations in legislative form required to be
11 transmitted to Congress under paragraph (1) shall
12 be delivered—

13 (A) to both Houses of Congress on the
14 same day;

15 (B) to the Clerk of the House of Rep-
16 resentatives if the House is not in session; and

17 (C) to the Secretary of the Senate if the
18 Senate is not in session.

19 **SEC. 604. FAST-TRACK CONSIDERATION OF PREVENTION**
20 **BENEFIT LEGISLATION.**

21 (a) RULES OF HOUSE OF REPRESENTATIVES AND
22 SENATE.—This section is enacted by Congress—

23 (1) as an exercise of the rulemaking power of
24 the House of Representatives and the Senate, re-

1 spectively, and is deemed a part of the rules of each
2 House of Congress, but—

3 (A) is applicable only with respect to the
4 procedure to be followed in that House of Con-
5 gress in the case of an implementing bill (as de-
6 fined in subsection (d)); and

7 (B) supersedes other rules only to the ex-
8 tent that such rules are inconsistent with this
9 section; and

10 (2) with full recognition of the constitutional
11 right of either House of Congress to change the
12 rules (so far as relating to the procedure of that
13 House of Congress) at any time, in the same man-
14 ner and to the same extent as in the case of any
15 other rule of that House of Congress.

16 (b) INTRODUCTION AND REFERRAL.—

17 (1) INTRODUCTION.—

18 (A) IN GENERAL.—Subject to paragraph
19 (2), on the day on which the President trans-
20 mits the report pursuant to section 603(c) to
21 the House of Representatives and the Senate,
22 the recommendations in legislative form trans-
23 mitted by the President with respect to such re-
24 port shall be introduced as a bill (by request)
25 in the following manner:

1 (i) HOUSE OF REPRESENTATIVES.—In
2 the House of Representatives, by the Ma-
3 jority Leader, for himself and the Minority
4 Leader, or by Members of the House of
5 Representatives designated by the Majority
6 Leader and Minority Leader.

7 (ii) SENATE.—In the Senate, by the
8 Majority Leader, for himself and the Mi-
9 nority Leader, or by Members of the Sen-
10 ate designated by the Majority Leader and
11 Minority Leader.

12 (B) SPECIAL RULE.—If either House of
13 Congress is not in session on the day on which
14 such recommendations in legislative form are
15 transmitted, the recommendations in legislative
16 form shall be introduced as a bill in that House
17 of Congress, as provided in subparagraph (A),
18 on the first day thereafter on which that House
19 of Congress is in session.

20 (2) REFERRAL.—Such bills shall be referred by
21 the presiding officers of the respective Houses to the
22 appropriate committee, or, in the case of a bill con-
23 taining provisions within the jurisdiction of 2 or
24 more committees, jointly to such committees for con-

1 sideration of those provisions within their respective
2 jurisdictions.

3 (c) CONSIDERATION.—After the recommendations in
4 legislative form have been introduced as a bill and referred
5 under subsection (b), such implementing bill shall be con-
6 sidered in the same manner as an implementing bill is con-
7 sidered under subsections (d), (e), (f), and (g) of section
8 151 of the Trade Act of 1974 (19 U.S.C. 2191).

9 (d) IMPLEMENTING BILL DEFINED.—In this section,
10 the term “implementing bill” means only the recommenda-
11 tions in legislative form of the Institute of Medicine of the
12 National Academy of Sciences described in section
13 603(b)(3), transmitted by the President to the House of
14 Representatives and the Senate under subsection 603(c),
15 and introduced and referred as provided in subsection (b)
16 as a bill of either House of Congress.

17 (e) COUNTING OF DAYS.—For purposes of this sec-
18 tion, any period of days referred to in section 151 of the
19 Trade Act of 1974 shall be computed by excluding—

20 (1) the days on which either House of Congress
21 is not in session because of an adjournment of more
22 than 3 days to a day certain or an adjournment of
23 Congress sine die; and

1 (2) any Saturday and Sunday, not excluded
2 under paragraph (1), when either House is not in
3 session.

○