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106TH CONGRESS
2D SESSION

H. R. 3887

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 benefits, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 9, 2000

Mr. LEVIN (for himself, Mr. FOLEY, Mr. PALLONE, Mr. LEACH, Mr. MORAN of Virginia, Mr. BONIOR, and Ms. BERKLEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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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 benefits, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Wellness Act of 2000''.

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

SEC. 2. FINDING.

Congress finds that despite significant advancements in general research for health promotion and disease prevention among the elderly, there has been a failure in translating that research into practical intervention.

SEC. 3. DEFINITIONS.

As used in this Act:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

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

(2) COST-SAVING BENEFIT.—The term ''cost-saving benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

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

(3) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

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

(4) MEDICAL EFFICACY; MEDICALLY EFFICACIOUS.—The terms ''medical efficacy'' and ''medically efficacious'' mean, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

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

(5) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

TITLE I—HEALTHY SENIORS PROMOTION PROGRAM

SEC. 101. HEALTHY SENIORS PROMOTION PROGRAM.

(a) DEFINITIONS.—As used in this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity that the Working Group (as defined in paragraph (2)) determines has demonstrated expertise in research regarding health promotion and disease prevention among the elderly.

(2) WORKING GROUP.—The term ''Working Group'' means the Healthy Seniors Working Group established under subsection (d).

(b) PROGRAM AUTHORIZED.—The Secretary, subject to the general policies and criteria established by the Working Group and in accordance with the provisions of this Act, is authorized to make grants to eligible entities to pay for the costs of the activities described in subsection (c).

(c) USE OF FUNDS.—An eligible entity may use payments received under this section in any fiscal year to study—

(1) whether using different types of providers of care who are not physicians and alternative settings (including community-based senior centers) for the implementation of a successful health promotion and

disease prevention strategy, including the implications regarding the payment of such providers, is medically efficacious or medically effective;

(2) the most medically effective means of educating medicare beneficiaries and providers of services regarding the importance of health promotion and disease prevention among the elderly and identification of incentives that would increase the use of new and existing preventive services and healthy behaviors by medicare beneficiaries; and

(3) other topics designated by the Secretary.

(d) HEALTHY SENIORS WORKING GROUP.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Healthy Seniors Working Group.

(2) COMPOSITION.—Subject to paragraph (3), the Working Group established pursuant to subsection (b) shall be composed of 5 members as follows:

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

(B) The Director of the Centers for Disease Control and Prevention.

(C) The Administrator of the Agency for Health Care Policy and Research.

(D) The Assistant Secretary for Aging.

(E) The Director of the National Institute on Aging.

(3) ALTERNATIVE MEMBERSHIP.—

(A) APPOINTMENT.—Any member of the Working Group described in a subparagraph of paragraph (2) may appoint an individual who is an officer or employee of the Federal Government to serve as a member of the Working Group instead of the member described in such subparagraph.

(B) DEADLINE.—If a member described in subparagraph (A) elects to appoint an individual under such subparagraph, such individual shall be appointed not later than December 31, 2001.

(4) GENERAL POLICIES AND CRITERIA.—The Working Group shall establish general policies and criteria with respect to the functions of the Secretary under this section including—

(A) priorities for the approval of applications submitted under subsection (e);

(B) procedures for developing, monitoring, and evaluating research efforts conducted under this section; and

(C) such other matters as are recommended by the Working Group and approved by the Secretary.

(5) CHAIRPERSON.—The Chairperson of the Working Group shall be the Administrator of the Agency for Health Care Policy and Research.

(6) QUORUM.—A majority of the members of the Working Group shall constitute a quorum, but a lesser number of members may hold hearings.

(7) MEETINGS.—The Working Group shall meet at the call of the Chairperson, except that—

(A) it shall meet not less than 4 times each year; and

(B) it shall meet whenever a majority of the appointed members request a meeting in writing.

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

(e) APPLICATION.—

(1) IN GENERAL.—Each eligible entity which desires to receive a grant under this section shall

submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may reasonably require.

(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

(A) describe the activities for which assistance under this section is sought;

(B) describe how the research effort proposed to be conducted will reflect the medical, behavioral, and social aspects of care for the elderly, lead to the development of cost-effective benefits and cost-saving benefits, and impact the quality of life of medicare beneficiaries;

(C) provide evidence that the eligible entity meets the general policies and criteria established by the Working Group pursuant to subsection (d)(4);

(D) provide assurances that the eligible entity will take such steps as may be available to it to continue the activities for which the eligible entity is making application after the period for which assistance is sought; and

(E) provide such additional assurances as the Secretary determines to be essential to en-

sure compliance with the requirements of this Act.

(3) JOINT APPLICATION.—A consortium of eligible entities may file a joint application under the provisions of paragraph (1) of this subsection.

(f) APPROVAL OF APPLICATION.—The Secretary shall approve applications in accordance with the general policies and criteria established by the Working Group under subsection (d)(4).

(g) PAYMENTS.—The Secretary shall pay to each eligible entity having an application approved under subsection (f) the cost of the activities described in the application.

(h) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an annual evaluation of grants made under this section to determine—

(A) the results of the overall applied research conducted under this Act;

(B) the extent to which research assisted under this section has improved or expanded the general research for health promotion and disease prevention among the elderly and identified practical interventions based upon such research;

(C) a list of specific recommendations based upon research conducted under this section which show promise as practical interventions for health promotion and disease prevention among the elderly;

(D) whether or not as a result of the applied research effort certain health promotion and disease prevention benefits or education efforts should be added to the medicare program, including discussions of quality of life, translating the applied research results into a benefit under the medicare program, and whether each additional benefit would be a cost-effective benefit or a cost-saving benefit for each proposed addition;

(E) the utility of, potential for, and issues surrounding health risk appraisals sponsored under the medicare program and targeted followup; and

(F) how best to increase utilization of existing and recommended health promotion and disease prevention services, including an education and public awareness component discussion of financial incentives for providers of services and medicare beneficiaries to improve utili-

zation and other administrative means of increasing utilization.

(2) ANNUAL REPORT.—Not later than December 31, 2002, and each year thereafter through 2005, the Secretary shall submit a report to Congress based on the annual studies made under paragraph (1), which shall contain a detailed statement of the findings and conclusions of the Working Group together with its recommendations for such legislation and administrative actions as it considers appropriate.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $40,000,000 for each of the fiscal years 2001, 2002, 2003, and 2004 to carry out the provisions of this section.

SEC. 102. SENSE OF CONGRESS REGARDING THE RESPONSE OF HCFA TO PREVENTIVE HEALTH ISSUES.

It is the sense of Congress that in administering the medicare program the Secretary should ensure that the Administrator of the Health Care Financing Administration encourages the inclusion of preventive measures as part of all treatments described in such program.

SEC. 103. SENSE OF CONGRESS REGARDING THE EFFORTS OF HCFA TO STUDY HEALTH PROMOTION AND DISEASE PREVENTION FOR MEDICARE BENEFICIARIES.

It is the sense of Congress that the Secretary should ensure that the Administrator of the Health Care Financing Administration expands the study of the most promising behavioral modification of risk factors associated with health promotion and disease prevention for all medicare beneficiaries.

SEC. 104. SENSE OF CONGRESS REGARDING THE ESTABLISHMENT OF A MEDICARE HEALTH PROMOTION AND DISEASE PREVENTION CLEARINGHOUSE.

It is the sense of Congress that the National Library of Medicine should collect information regarding innovative and successful health promotion and disease prevention interventions from both published and unpublished sources, establish a clearinghouse targeting all medicare beneficiaries in a variety of settings for the consolidation and coordination of all such information, and make the clearinghouse available to the public and accessible through the Internet.

TITLE II—MEDICARE COVERAGE OF PREVENTIVE SERVICES

SEC. 201. COUNSELING FOR CESSATION OF TOBACCO USE.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (S), by striking ''and'' at the end;

(2) in subparagraph (T), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(U) counseling for cessation of tobacco use (as defined in subsection (uu)) for individuals who have a history of tobacco use;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Counseling for Cessation of Tobacco Use

''(uu)(1) Except as provided in paragraph (2), the term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for cessation of tobacco use' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and'' before ''(S)''; and

(B) by inserting before the semicolon at the end the following: '', and (T) with respect to counseling for cessation of tobacco use (as defined in section 1861(uu)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)''; and

(B) by inserting before the period the following: '', and (7) such deductible shall not apply with respect to counseling for cessation of tobacco use (as defined in section 1861(uu))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 202. SCREENING FOR HYPERTENSION.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 201(a)) is amended—

(1) in subparagraph (T), by striking ''and'' at the end;

(2) in subparagraph (U), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(V) screening for hypertension (as defined in subsection (vv)) not more frequently than once every 2 years for individuals with normotensive blood pressure measurements and annually for individuals with

blood pressure measurements that are not normotensive;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 201(b)) is amended by adding at the end the following new subsection:

''Screening for Hypertension

''(vv) The term 'screening for hypertension' means diagnostic services for hypertension which are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 201(c)(1)) is amended—

(A) by striking ''and'' before ''(T)''; and

(B) by inserting before the semicolon at the end the following: '', and (U) with respect

to screening for hypertension (as defined in section 1861(vv)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 201(c)(2)) is amended—

(A) by striking ''and'' before ''(7)''; and

(B) by inserting before the period the following: '', and (8) such deductible shall not apply with respect to screening for hypertension (as defined in section 1861(vv))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 203. COUNSELING FOR HORMONE REPLACEMENT THERAPY.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 202(a)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) counseling for hormone replacement therapy (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 202(b)) is amended by adding at the end the following new subsection:

''Counseling for Hormone Replacement Therapy

''(ww)(1) Except as provided in paragraph (2), the term 'counseling for hormone replacement therapy' means diagnostic, therapy, and counseling services for hormone replacement which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for hormone replacement therapy' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 202(c)(1)) is amended—

(A) by striking ''and'' before ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to counseling for hormone replacement therapy (as defined in section 1861(ww)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 202(c)(2)) is amended—

(A) by striking ''and'' before ''(8)''; and

(B) by inserting before the period the following: '', and (9) such deductible shall not apply with respect to counseling for hormone

replacement therapy (as defined in section 1861(ww))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 204. SCREENING FOR GLAUCOMA.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 203(a)) is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(X) screening for glaucoma (as defined in subsection (xx)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma, and individuals with diabetes or myopia;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 203(b)) is amended by adding at the end the following new subsection:

''Screening for Glaucoma

''(xx) The term 'screening for glaucoma' means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 203(c)(1)) is amended—

(A) by striking ''and'' before ''(V)''; and

(B) by inserting before the semicolon at the end the following: '', and (W) with respect to screening for glaucoma (as defined in section 1861(xx)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 203(c)(2)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to screening for glaucoma (as defined in section 1861(xx))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 205. SCREENING FOR DIMINISHED VISUAL ACUITY.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 204(a)) is amended—

(1) in subparagraph (W), by striking ''and'' at the end;

(2) in subparagraph (X), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(Y) screening for diminished visual acuity (as defined in subsection (yy));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 204(b)) is amended by adding at the end the following new subsection:

''Screening for Diminished Visual Acuity

''(yy) The term 'screening for diminished visual acuity' means diagnostic services for screening for diminished visual acuity which are furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 204(c)(1)) is amended—

(A) by striking ''and'' before ''(W)''; and

(B) by inserting before the semicolon at the end the following: '', and (X) with respect to screening for diminished visual acuity (as defined in section 1861(yy)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount deter-

mined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 204(c)(2)) is amended—

(A) by striking ''and'' before ''(10)''; and

(B) by inserting before the period the following: '', and (11) such deductible shall not apply with respect to screening for diminished visual acuity (as defined in section 1861(yy))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 206. SCREENING FOR HEARING IMPAIRMENT.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 205(a)) is amended—

(1) in subparagraph (X), by striking ''and'' at the end;

(2) in subparagraph (Y), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(Z) screening for hearing impairment (as defined in subsection (zz));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 205(b)) is amended by adding at the end the following new subsection:

''Screening for Hearing Impairment

''(zz) The term 'screening for hearing impairment' means diagnostic services for hearing impairment by use of periodic questions, otoscopic examination and audio metric testing if such questions indicate potential hearing impairment, and counseling about hearing aid devices which are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 205(c)(1)) is amended—

(A) by striking ''and'' before ''(X)''; and

(B) by inserting before the semicolon at the end the following: '', and (Y) with respect to screening for hearing impairment (as defined in section 1861(zz)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 205(c)(2)) is amended—

(A) by striking ''and'' before ''(11)''; and

(B) by inserting before the period the following: '', and (12) such deductible shall not apply with respect to screening for hearing impairment (as defined in section 1861(zz))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 207. SCREENING AND COUNSELING FOR OSTEOPOROSIS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 206(a)) is amended—

(1) in subparagraph (Y), by striking ''and'' at the end;

(2) in subparagraph (Z), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(AA) screening and counseling for osteoporosis (as defined in subsection (aaa)) for—

''(i) women; and

''(ii) men with fractures;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 206(b)) is amended by adding at the end the following new subsection:

''Screening and Counseling for Osteoporosis

''(aaa) The term 'screening and counseling for osteoporosis' means diagnostic and counseling services for osteoporosis in addition to a bone mass measurement (as defined in subsection (rr)) which are furnished in accordance with methods approved by the Food and Drug Administration—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 206(c)(1)) is amended—

(A) by striking ''and'' before ''(Y)''; and

(B) by inserting before the semicolon at the end and inserting the following: '', and (Z) with respect to screening and counseling for osteoporosis (as defined in section 1861(aaa)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C.

1395l(b)) (as amended by section 206(c)(2)) is amended—

(A) by striking ''and'' before ''(12)''; and

(B) by inserting before the period the following: '', and (13) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(aaa))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 208. SCREENING FOR CHOLESTEROL.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 207(a)) is amended—

(1) in subparagraph (Z), by striking ''and'' at the end;

(2) in subparagraph (AA), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(BB) screening for cholesterol (as defined in subsection (bbb)) for individuals between the ages of 65 and 75 that exhibit major risk factors for coro-

nary heart disease, including smoking, hypertension, and diabetes;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 207(b)) is amended by adding at the end the following new subsection:

''Screening for Cholesterol

''(bbb) The term 'screening for cholesterol' means diagnostic services for cholesterol that are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 207(c)(1)) is amended—

(A) by striking ''and'' before ''(Z)''; and

(B) by inserting before the semicolon at the end the following: '', and (AA) with respect

to screening for cholesterol (as defined in section 1861(bbb)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 207(c)(2)) is amended—

(A) by striking ''and'' before ''(13)''; and

(B) by inserting before the period the following: '', and (14) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(bbb))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 209. MEDICAL NUTRITION THERAPY SERVICES FOR BENEFICIARIES WITH DIABETES, A CARDIOVASCULAR DISEASE, OR A RENAL DISEASE.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 208(a)) is amended—

(1) in subparagraph (AA) by striking ''and'' at the end;

(2) in subparagraph (BB) by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(CC) medical nutrition therapy services (as defined in subsection (ccc)(1)) in the case of a beneficiary with diabetes, a cardiovascular disease (including congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia), or a renal disease;''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) (as amended by section 208(b)) is amended by adding at the end the following new subsection:

''Medical Nutrition Therapy Services; Registered Dietitian or Nutrition Professional

''(ccc)(1) The term 'medical nutrition therapy services' means nutritional diagnostic, therapy, and counseling services which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician.

''(2) Subject to paragraph (3), the term 'registered dietitian or nutrition professional' means an individual who—

''(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

''(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

''(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

''(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

''(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of the date of enactment of this subsection, is licensed or certified as a dietitian or nutrition professional by the State

in which medical nutrition therapy services are performed.''.

(c) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 208(c)(1)) is amended—

(1) by striking ''and'' before ''(AA)''; and

(2) by inserting before the semicolon at the end the following: '', and (BB) with respect to medical nutrition therapy services (as defined in section 1861(ccc)), the amount paid shall be 85 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

SEC. 210. ELIMINATION OF COST-SHARING FOR CURRENT PREVENTIVE BENEFITS.

(a) WAIVER OF COINSURANCE AND DEDUCTIBLES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(m) WAIVER OF COINSURANCE AND DEDUCTIBLE FOR PREVENTIVE SERVICES.—

''(1) COINSURANCE.—

''(A) IN GENERAL.—Notwithstanding any other provision of this part—

''(i) the Secretary shall waive any co-insurance applicable to services described in subparagraph (B); and

''(ii) with respect to payment for such services, any reference to a percent that is less than 100 percent shall be deemed to be a reference to 100 percent.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph are the following services:

''(i) Screening mammography (as defined in section 1861(jj)).

''(ii) Screening pelvic exam (as defined in section 1861(nn)(2)).

''(iii) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

''(iv) Colorectal cancer screening test (as defined in section 1861(pp)).

''(v) Bone mass measurement (as defined in section 1861(rr)).

"(vi) Prostate cancer screening test (as defined in section 1861(oo)).

"(vii) Diabetes outpatient self-management training services (as defined in section 1861(qq)).

"(2) DEDUCTIBLE.—

"(A) IN GENERAL.—Notwithstanding any other provision of this part, the deductible described in section 1833(b) shall not apply with respect to services described in subparagraph (B).

"(B) SERVICES DESCRIBED.—The services described in this subparagraph are the following services:

"(i) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

"(ii) Colorectal cancer screening test (as defined in section 1861(pp)).

"(iii) Bone mass measurement (as defined in section 1861(rr)).

"(iv) Prostate cancer screening test (as defined in section 1861(oo)).

"(v) Diabetes outpatient self-management training services (as defined in section 1861(qq))."

(2) CONFORMING AMENDMENT.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by striking "section 1876" and inserting "sections 1834 and 1876" in the matter preceding paragraph (1).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 211. NATIONAL FALLS PREVENTION EDUCATION AND AWARENESS CAMPAIGN.

The Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall conduct a national falls prevention and awareness campaign to reduce fall-related injuries among medicare beneficiaries.

SEC. 212. PROGRAM INTEGRITY.

The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall integrate the benefits described in sections 201 through 208 with existing program integrity measures.

TITLE III—MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

SEC. 301. MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

''SEC. 1897. (a) ESTABLISHMENT.—The Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, the Administrator of the Agency for Health Care Policy and Research, and the Administrator of the Health Care Financing Administration, shall establish a health education and risk appraisal program to inform the target individuals described in subsection (b) of the major behavioral risk factors described in subsection (c) through the self-assessment described in subsection (d) and shall conduct the periodic followup described in subsection (e).

''(b) TARGET INDIVIDUALS.—The target individuals described in this subsection are the following:

''(1) MEDICARE BENEFICIARIES.—Individuals that are beneficiaries under this title.

''(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—Individuals between the ages of 50 and 64.

''(c) MAJOR BEHAVIORAL RISK FACTORS.—The major behavioral risk factors described in this subsection include—

''(1) the lack of proper nutrition;

''(2) the use of alcohol;

''(3) the lack of regular exercise;

''(4) the use of tobacco;

''(5) depression; and

''(6) other risk factors identified by the Secretary.

''(d) SELF-ASSESSMENT.—

''(1) IN GENERAL.—The self-assessment described in this subsection is a form delivered by the Secretary to each target individual that—

''(A) includes questions regarding major behavioral risk factors;

''(B) requests that such individual answer the questions and return the form to the Secretary; and

''(C) is then assessed using—

''(i) knowledge coupling computer software that assesses overall health risks

and then provides options for management of identified risk factors;

"(ii) nurse hotlines; and

"(iii) case managers as the Secretary determines appropriate.

"(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—With respect to the target individuals described in subsection (b)(2), the Secretary shall coordinate the delivery of the self-assessment form with the issuance of the statement described in section 1143(c)(2).

"(e) PERIODIC FOLLOWUP.—

"(1) MEDICARE BENEFICIARIES.—Not less frequently than once every 2 years, the Secretary shall conduct periodic followup appraisals with respect to the target individuals described in subsection (b)(1) to reduce major behavioral risk factors described in subsection (c)—

"(A) by providing such individuals with—

"(i) information regarding the results of the self-administered risk appraisal;

"(ii) recommendations regarding behavior modifications based on such appraisal; and

''(iii) information regarding any need for further assessment or treatment; and

''(B) by providing the information described in subparagraph (A) to the provider designated by such individual to receive such information.

''(2) INDIVIDUALS BETWEEN THE AGES OF 50 AND 64.—The Secretary shall conduct such periodic followup appraisals with respect to the target individuals described in subsection (b)(2) as the Secretary determines appropriate.''.

TITLE IV—DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS

SEC. 401. DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall conduct demonstration projects for the purpose of promoting disease self-management for conditions identified by the working group established under paragraph (2) for target individuals (as defined in paragraph (3)).

(2) DISEASE SELF-MANAGEMENT WORKING GROUP.—

(A) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Disease Self-Management Working Group.

(B) COMPOSITION.—The Disease Self-Management Working Group established under subparagraph (A) shall be composed of 4 members as follows:

(i) The Administrator of the Health Care Financing Administration.

(ii) The Director of the Centers for Disease Control and Prevention.

(iii) The Administrator of the Agency for Health Care Policy and Research.

(iv) The Director of the Administration on Aging.

(C) GENERAL POLICIES AND CRITERIA.—The Disease Self-Management Working Group established under paragraph (1) shall establish general policies and criteria with respect to the functions of the Secretary under this section including—

(i) the identification of conditions for which a demonstration project may be implemented;

(ii) the prioritization of the conditions identified under clause (i) based on potential of self-management of such condition to be medically effective and for such self-management to be a cost-effective benefit or cost-saving benefit, as those terms are defined in section 3 of this Act;

(iii) the identification of target individuals;

(iv) the development of procedures for selecting areas in which a demonstration project may be implemented; and

(v) such other matters as are recommended by the Disease Self-Management Working Group and approved by the Secretary.

(3) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that is at risk for or has a condition identified by the working group described under paragraph (2) and is eligible for benefits under the fee-for-service program under parts A and B of title XVIII of the

Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.) or is enrolled under the Medicare+Choice program under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.).

(b) NUMBER, PROJECT AREAS, AND DURATION.—

(1) NUMBER.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement a series of demonstration projects.

(2) PROJECT AREAS.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas.

(3) DURATION.—The demonstration projects under this section shall be conducted for a period of 3 years, beginning on the date on which the Secretary implements the initial demonstration project.

(c) REPORTS TO CONGRESS.—

(1) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the Secretary implements the initial demonstration project under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(B) CONTENTS OF REPORT.—The report in subparagraph (A) shall include the following:

(i) A description of the demonstration projects conducted under this section.

(ii) An evaluation of—

(I) whether each benefit provided under the demonstration project is a cost-effective benefit or a cost-saving benefit;

(II) the level of the disease self-management attained by target individuals under the demonstration projects; and

(III) the satisfaction of target individuals under the demonstration project.

(iii) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(2) FINAL REPORT.—Not later than 1 year after the conclusion of the demonstration projects under this section, the Secretary shall submit a final report to Congress on the demonstration projects conducted under this section containing the rec-

ommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out the demonstration projects under this section, establishing the Disease Self-Management Working Group under subsection (a)(2), and submitting the reports to Congress under subsection (c).

TITLE V—STUDIES AND REPORTS ADVANCING ORIGINAL RESEARCH IN THE FIELD OF DISEASE PREVENTION AND THE ELDERLY

SEC. 501. MEDPAC BIANNUAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period and inserting ''; and''; and

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

''(E) by not later than January 1, 2002, and biannually thereafter, submit the report to Congress described in paragraph (7).''; and

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

''(7) EVALUATION OF ACTUARIAL EQUIVALENCE OF MEDICARE AND PRIVATE SECTOR BENEFIT PACKAGES.—

''(A) EVALUATION.—The Commission shall—

''(i) evaluate the benefit package offered under the medicare program under this title; and

''(ii) determine the degree to which such benefit package is actuarially equivalent to that offered by health benefit programs available in the private sector to individuals over age 65.

''(B) REPORT.—The Commission shall submit a report to Congress that shall contain—

"(i) a detailed statement of the findings and conclusions of the Commission regarding the evaluation conducted under subparagraph (A);

"(ii) the recommendations of the Commission regarding changes in the benefit package offered under the medicare program under this title that would keep the program modern and competitive in relation to health benefit programs available in the private sector; and

"(iii) the recommendations of the Commission for such legislation and administrative actions as it considers appropriate.".

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

SEC. 502. NATIONAL INSTITUTE ON AGING STUDY AND REPORT.

(a) STUDIES.—The Director of the National Institute on Aging shall conduct 1 or more studies focusing on ways to—

(1) improve quality of life for the elderly;

(2) develop better ways to prevent or delay the onset of age-related functional decline and disease and disability among the elderly; and

(3) develop means of assessing the long-term development of cost-effective benefits and cost-savings benefits for health promotion and disease prevention among the elderly.

(b) REPORT.—Not later than January 1, 2006, the Director of the National Institute on Aging shall submit a report to the Secretary regarding each study conducted under subsection (a) and containing a detailed statement of research findings and conclusions that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly.

(c) TRANSMISSION TO INSTITUTE OF MEDICINE.—Upon receipt of each report described in subsection (b), the Secretary shall transmit such report to the Institute of Medicine of the National Academy of Sciences for consideration in its effort to conduct the comprehensive study of current literature and best practices in the field of health promotion and disease prevention among the medicare beneficiaries described in section 503.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for fiscal years 2001

through 2006 to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until September 30, 2005.

SEC. 503. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

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

(A) whether each covered benefit is—

(i) medically effective; and

(ii) a cost-effective benefit or a cost-saving benefit;

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed statement of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

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

(B) modify preventive benefits offered under the medicare program based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

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

(B) to the Clerk of the House of Representatives if the House is not in session; and

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

SEC. 504. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

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

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 503(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such re-

port shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

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

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or

more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

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

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 503(b)(2), transmitted by the President to the House of Representatives and the Senate under subsection 503(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

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

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

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

TITLE VI—CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS

SEC. 601. CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall conduct demonstration projects for the purpose of evaluating the efficacy of providing annual screenings for clinical depression as a benefit under the medicare program.

(2) ANNUAL SCREENING FOR CLINICAL DEPRESSION DEFINED.—For purposes of this section, the term ''annual screening for clinical depression'' means the following, conducted with respect to a medicare beneficiary no more frequently than annually:

(A) A self-administered written screening test (using an instrument to be chosen and distributed by the Secretary at least 3 months before date that benefits are first provided under

demonstration projects under this section) which asks questions to establish a beneficiary's risk of clinical depression.

(B) After administering such a test, a consultation as a followup to such a test with a physician, nurse practitioner, or mental health professional licensed under State law to determine whether the beneficiary has or is at high risk of developing clinical depression.

(C) If the health care professional determines that the beneficiary is at high risk, a referral of the beneficiary to a physician or mental health professional for a full diagnostic evaluation.

(3) PAYMENT LEVEL.—The reimbursement level for health care professionals will be set by the Secretary in accordance with generally accepted payment levels for the type of service involved and shall not require payment of any deductibles or coinsurance.

(b) NUMBER, PROJECT AREAS, AND DURATION.—

(1) NUMBER.—Not later than 1 year after the date of enactment of this Act, the Secretary shall implement no fewer than 6, and no more than 10, demonstration projects under this section.

(2) PROJECT AREAS.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas. Areas are to be chosen in a manner that fosters geographic diversity and a mix of screening sites (including doctors' offices, mental health clinics, and nursing homes) and that gives preference to areas with a high concentration of medicare beneficiaries.

(3) DURATION.—The demonstration projects under this section shall be conducted for a period of 3 years, beginning on the date on which the Secretary implements the initial demonstration project.

(c) REPORTS TO CONGRESS.—

(1) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the Secretary implements the initial demonstration project under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(B) CONTENTS OF REPORT.—The report in subparagraph (A) shall include the following:

(i) A description of the demonstration projects conducted under this section.

(ii) An evaluation of—

(I) whether each benefit provided under the demonstration project is a cost-effective benefit or a cost-saving benefit; and

(II) the satisfaction of medicare beneficiaries under the demonstration project.

(iii) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(2) FINAL REPORT.—Not later than 1 year after the conclusion of the demonstration projects under this section, the Secretary shall submit a final report to Congress on the demonstration projects conducted under this section containing the recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out the demonstration projects under this section and submitting the reports to Congress under subsection (c).

○