106TH CONGRESS
1ST SESSION

S. 1204

To promote general and applied research for health promotion and disease prevention among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 10, 1999

Mr. GRAHAM introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To promote general and applied research for health promotion and disease prevention 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 ''Healthy Seniors Promotion Act of 1999''.

(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) 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.

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

(3) 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 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) the effectiveness of using different types of providers of care who are not physicians and the use of alternative settings (including community based senior centers) for the implementation of a successful health promotion and disease prevention strategy, including implications regarding the payment of such providers;

(2) the most 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 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, 1999.

(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;

(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.

(d) 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 el-

derly, including cost-effectiveness and quality of life impacts stemming from any initiative;

(C) provide evidence that the eligible entity meets the general policies 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 ensure 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 established by the Working Group under subsection (d).

(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 and cost-effectiveness for each proposed addition;

(E) the utility of, potential for, and issues surrounding health risk appraisals sponsored

under the medicare program and targeted follow up; 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 utilization and other administrative means of increasing utilization.

(2) REPORT.—Not later than December 31, 2002, 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 $25,000,000 for fiscal years 1999, 2000, 2001, and 2002 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. MEDICARE COVERAGE OF 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 striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(U) counseling for cessation of tobacco use (as defined in subsection (uu)).''.

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

''Counseling for Cessation of Tobacco Use

''(uu) The term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished by or under the supervision of a physician or other health care profes-

sional 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) PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (S)'' and inserting ''(S)''; and

(2) by striking the semicolon at the end and inserting 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;''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 202. MEDICARE COVERAGE OF 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 striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(V) screening for hypertension (as defined in subsection (vv)).''.

(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:

''Screening for Hypertension

''(vv) The term 'screening for hypertension' means diagnostic services for hypertension which are furnished by or under the supervision of a physician or 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) PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 201(c)) is amended—

(1) by striking ''and (T)'' and inserting ''(T)''; and

(2) by striking the semicolon at the end and inserting 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;''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 203. MEDICARE COVERAGE OF 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 striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(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:

''Counseling for Hormone Replacement Therapy

''(ww) The term 'counseling for hormone replacement therapy' means diagnostic, therapy, and counseling services for hormone replacement which are furnished by or under the supervision of a physician or 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) PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 201(c)) is amended—

(1) by striking ''and (U)'' and inserting ''(U)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (V) with respect to counseling for hormone replacement therapy (as de-

fined 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;''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 204. MEDICARE COVERAGE OF 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 striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(X) screening for glaucoma (as defined in subsection (xx)).''.

(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:

''Screening for Glaucoma

''(xx) The term 'screening for glaucoma' means diagnostic services for early detection of glaucoma which are furnished by or under the supervision of a physician or 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) PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 201(c)) is amended—

(1) by striking ''and (V)'' and inserting ''(V)''; and

(2) by striking the semicolon at the end and inserting 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 the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 205. 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. 206. 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, 202, 203, and 204 with existing program integrity measures.

TITLE III—PREVENTIVE OUTPATIENT PRESCRIPTION DRUG BENEFIT

SEC. 301. MEDICARE COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS.

(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) by striking the period at the end of subparagraph (X) and inserting ''; and''; and

(3) by adding at the end the following:

''(Y) preventive outpatient prescription drugs (as defined in section 1849(h)(1)) pursuant to the procedures established under such section;''.

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

(1) by striking ''and (W)'' and inserting ''(W)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (X) with respect to preventive outpatient prescription drugs (as defined in section 1849(h)(1)), the amounts paid shall be the amounts established by the Secretary pursuant to such section;''.

SEC. 302. SELECTION OF ENTITIES TO PROVIDE PREVENTIVE OUTPATIENT DRUG BENEFIT.

Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) is amended by adding at the end the following:

"SEC. 1849. SELECTION OF ENTITIES TO PROVIDE PREVENTIVE OUTPATIENT DRUG BENEFIT.

"(a) ESTABLISHMENT OF BIDDING PROCESS.—

"(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary accepts bids from eligible entities and awards contracts to such entities in order to provide preventive outpatient prescription drugs to eligible beneficiaries in an area. Such contracts may be awarded based on shared risk, capitation, or performance.

"(2) AREA.—

"(A) REGIONAL BASIS.—The contract entered into between the Secretary and an eligible entity shall require the eligible entity to provide preventive outpatient prescription drugs on a regional basis.

"(B) DETERMINATION.—In determining coverage areas under this section, the Secretary shall take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities.

"(3) SUBMISSION OF BIDS.—Each eligible entity desiring to provide preventive outpatient prescription drugs under this section shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may

reasonably require. Such bids shall include the amount the eligible entity will charge eligible beneficiaries under subsection (e)(2) for preventive outpatient prescription drugs under the contract.

''(4) ACCESS.—The Secretary shall ensure that—

''(A) an eligible entity complies with the access requirements described in subsection (f)(4); and

''(B) an eligible entity makes available to each beneficiary covered under the contract the full scope of benefits required under paragraph (5).

''(5) SCOPE OF BENEFITS.—The Secretary shall ensure that all preventive outpatient prescription drugs that are reasonable and necessary to prevent or slow the deterioration of, and improve or maintain, the health of eligible beneficiaries are offered under a contract entered into under this section.

''(6) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this section and the goal of containing medicare program costs, award at least 2 contracts in an area, unless only 1 bidding entity meets the minimum standards specified under this section and by the Secretary.

''(7) DURATION OF CONTRACTS.—Each contract under this section shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary shall make an election to enroll with any eligible entity that has been awarded a contract under this section and serves the geographic area in which the beneficiary resides. In establishing such process, the Secretary shall use rules similar to the rules for enrollment and disenrollment with a Medicare+Choice plan under section 1851.

''(2) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary not enrolled in a Medicare+Choice plan under part C must enroll with an eligible entity under this section in order to be eligible to receive preventive outpatient prescription drugs under this title.

''(3) ENROLLMENT IN ABSENCE OF ELECTION BY ELIGIBLE BENEFICIARY.—In the case of an eligible beneficiary that fails to make an election pursuant to paragraph (1), the Secretary shall provide, pursuant to procedures developed by the Secretary,

for the enrollment of such beneficiary with an eligible entity that has a contract under this section that covers the area in which such beneficiary resides.

''(4) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of preventive outpatient prescription drugs under this title to eligible beneficiaries that reside in an area that is not covered by any contract under this section.

''(5) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that an eligible beneficiary that resides in different regions in a year is provided benefits under this section throughout the entire year.

''(c) PROVIDING INFORMATION TO BENEFICIARIES.—The Secretary shall provide for activities under this section to broadly disseminate information to medicare beneficiaries on the coverage provided under this section. Such activities shall be similar to the activities performed by the Secretary under section 1851(d).

''(d) PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to an eligible entity under a contract.

''(e) COST-SHARING.—

''(1) DEDUCTIBLE.—Benefits under this section shall not begin until an eligible beneficiary has met a $50 deductible.

''(2) COINSURANCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), an eligible beneficiary shall be responsible for making payments in an amount not greater than 20 percent of the cost (as stated in the contract) of any preventive outpatient prescription drug that is provided to the beneficiary. Pursuant to subsection (a)(4)(B), an eligible entity may reduce the payment amount that an eligible beneficiary is responsible for making to the entity.

''(B) BASIC BENEFIT.—If the aggregate amount of preventive outpatient prescription drugs provided to an eligible beneficiary under this section for any calendar year (based on the cost of preventive outpatient prescription drugs stated in the contract) exceeds $750—

''(i) the beneficiary may continue to purchase preventive outpatient prescription drugs under the contract based on the contract price, but

"(ii) the copayment under subparagraph (A) shall be 100 percent.

"(C) INFLATION ADJUSTMENT.—

"(i) IN GENERAL.—In the case of any calendar year beginning after 2000, each of the dollar amounts in subparagraph (B) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) an adjustment, as determined by the Secretary, for changes in the per capita cost of prescription drugs for beneficiaries under this title.

"(ii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10.

"(3) COPAYMENT.—Each time a prescription is filled, the eligible beneficiary shall be responsible for making payments in an amount equal to the lesser of—

"(A) the cost (as stated in the contract) of any preventive outpatient prescription drug that is provided to the beneficiary minus the deduct-

ible described in paragraph (1) and the coinsurance described in paragraph (2); or

"(B) $5.

"(f) CONDITIONS FOR AWARDING CONTRACT.—The Secretary shall not award a contract to an eligible entity under subsection (a) unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify, including the following:

"(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets quality and financial standards specified by the Secretary.

"(2) INFORMATION.—The eligible entity provides the Secretary with information that the Secretary determines is necessary in order to carry out the bidding process under this section.

"(3) PROCEDURES TO ENSURE PROPER UTILIZATION AND TO AVOID ADVERSE DRUG REACTIONS.—The eligible entity has in place procedures to ensure the—

"(A) appropriate utilization by eligible beneficiaries of the benefits to be provided under the contract; and

''(B) avoidance of adverse drug reactions among eligible beneficiaries enrolled with the entity.

''(4) ACCESS.—The eligible entity ensures that the preventive outpatient prescription drugs are accessible and convenient to eligible beneficiaries covered under the contract, including by offering the services in the following manner:

''(A) SERVICES DURING EMERGENCIES.—The offering of services 24 hours a day and 7 days a week for emergencies.

''(B) CONTRACTS WITH RETAIL PHARMACIES.—The offering of services—

''(i) at a sufficient number (as determined by the Secretary) of retail pharmacies; and

''(ii) to the extent feasible, at retail pharmacies located throughout the eligible entity's service area.

''(5) RULES RELATING TO PROVISION OF BENEFITS.—

''(A) PROVISION OF BENEFITS.—In providing benefits under a contract under this section, an eligible entity may—

"(i) employ mechanisms to provide benefits economically, including the use of—

"(I) formularies;

"(II) alternative methods of distribution; and

"(III) generic drug substitution; and

"(ii) use incentives to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs which are of equal clinical effectiveness.

"(6) PROCEDURES REGARDING DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

"(A) the timely review and resolution of denials of care and complaints (including those regarding the use of formularies under paragraph (5)) by eligible beneficiaries, or providers, pharmacists, and other individuals acting on behalf of each such beneficiary (with the beneficiary's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for

Medicare+Choice organizations under part C; and

''(B) that beneficiaries are provided with information regarding the appeals procedures under this section at the time of enrollment.

''(g) PROTECTION OF PATIENT CONFIDENTIALITY.—Insofar as an eligible organization maintains individually identifiable medical records or other health information regarding eligible beneficiaries under a contract entered into under this section, the organization shall—

''(1) safeguard the privacy of any individually identifiable beneficiary information;

''(2) maintain such records and information in a manner that is accurate and timely; and

''(3) assure timely access of such beneficiaries to such records and information.

''(h) DEFINITIONS.—In this section:

''(1) PREVENTIVE OUTPATIENT PRESCRIPTION DRUG.—The term 'preventive outpatient prescription drug' means any drug or biological not otherwise covered under this title that may be dispensed only upon prescription and as a direct result of the individual's participation in—

''(A) a screening mammography (as defined in section 1861(jj));

"(B) a screening pap smear or a screening pelvic exam (as defined in section 1861(nn));

"(C) a prostate cancer screening test (as defined in section 1861(oo));

"(D) a colorectal cancer screening test (as defined in section 1861(pp));

"(E) a diabetes outpatient self-management training service (as defined in section 1861(qq);

"(F) a bone mass measurement (as defined in section 1861(rr));

"(G) a cessation of tobacco use program (as defined in section 1861(uu));

"(H) a screening for hypertension (as defined in section 1861(vv));

"(I) counseling for hormone replacement therapy (as defined in section 1861(ww));

"(J) a screening for glaucoma (as defined in section 1861(xx)); or

"(K) any other preventive service (as defined by the Secretary).

"(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is enrolled under part B of this title.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate, including—

''(A) any pharmaceutical benefit management company;

''(B) any wholesale or retail pharmacist delivery system;

''(C) any insurer; or

''(D) any combination of the entities described in subparagraphs (A) through (C).''.

SEC. 303. ACCESS OF LOW-INCOME BENEFICIARIES TO PREVENTIVE OUTPATIENT PRESCRIPTION DRUGS.

(a) ELIGIBILITY.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) in subparagraph (E)(iv)(II), by striking ''and'' at the end;

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

(3) by inserting after subparagraph (F), the following:

''(G) for making medical assistance available (but only for preventive outpatient prescription drugs (as defined in section 1849(h)(1)) in the same amount, duration, and

scope as such assistance for such drugs is made available to any individual described in subparagraph (A)(i)) for any individual who—

"(i) is a qualified medicare beneficiary described in section 1905(p)(1);

"(ii) would be a qualified medicare beneficiary described in section 1905(p)(1) except for the fact that the income of such individual exceeds the income level established by the State under section 1905(p)(2) but is less than 135 percent of the official poverty line (referred to in such section) for a family of the size involved, and who is not otherwise eligible for medical assistance for preventive outpatient prescription drugs under the State plan; and

"(iii) would otherwise satisfy the requirements of clause (i) or (ii) except for the fact that they are entitled to hospital insurance benefits under part A of title XVIII only pursuant to an enrollment under section 1818A;".

(b) PAYMENTS TO STATES.—

(1) IN GENERAL.—Section 1903 of such Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(x)(1) Subject to paragraph (2), with respect to medical assistance that is attributable to the enactment of section 1902(a)(10)(G), including an estimate of medical assistance provided to additional individuals who enroll in the State plan under this title due to such enactment, the Federal medical assistance percentage for such medical assistance is equal to 100 percent.

''(2) No payment shall be made to a State for medical assistance described in paragraph (1) unless the State demonstrates to the satisfaction of the Secretary that, with respect to a fiscal year, State expenditures for any State-funded prescription drug program is not less than the level of such expenditures for fiscal year 1999.''.

(2) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended in the first sentence by inserting ''and 1903(x)'' after ''1933(d)''.

SEC. 304. ALLOCATION OF FEDERAL PROCEEDS FROM GLOBAL TOBACCO SETTLEMENT TO ENHANCE PREVENTIVE OUTPATIENT PRESCRIPTION DRUG BENEFIT.

(a) TRANSFER OF FEDERAL PROCEEDS FROM GLOBAL TOBACCO SETTLEMENT.—The Secretary of the Treasury shall transfer to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) an amount equal to 50 percent of any amount received by the Federal Government as a result of any legislation providing for a global tobacco settlement. Such transfer shall occur not later than 60 days after each date on which the Federal Government receives such amount.

(b) USE OF AMOUNT TRANSFERRED.—Any amount transferred pursuant to subsection (a) shall be available to enhance the drug benefit described in section 1849 of the Social Security Act (as added by section 302) in a manner that is consistent with the recommendations of the Institute of Medicine of the National Academy of Sciences developed under section 305.

SEC. 305. MEDICARE DRUG BENEFIT STUDY.

(a) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to conduct the study described in subsection (b) and submit the report described in subsection (c).

(b) STUDY.—The Institute of Medicine of the National Academy of Sciences shall—

(1) conduct a study of the feasibility and issues involved in the developing, administering, and financing of a comprehensive outpatient prescription drug benefit under the medicare program; and

(2) develop a prioritized list of drug categories that could be added to the benefit based on the availability of funding.

(c) REPORT.—Not later than June 30, 2001, the Institute of Medicine of the National Academy of Sciences shall submit a report to the Secretary which contains—

(1) a detailed statement of the findings and conclusions of the study conducted under subsection (b)(1);

(2) the list developed under subsection (b)(2); and

(3) the recommendations of the Secretary for such legislative and administrative actions as it considers appropriate.

(d) SUBMISSION TO CONGRESS.—Not later than 30 days after the Secretary receives the report described in subsection (c), the Secretary shall transmit the report to Congress.

SEC. 306. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this title shall apply to items and services furnished on or after January 1, 2001.

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

SEC. 401. 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:

''(E) by not later than January 1, 2001, and biannually thereafter, submit the report to Congress described in paragraph (7).''; and

(2) by adding at the end the following:

''(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. 402. 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 new means of assessing the long-term cost-effectiveness of health promotion and disease prevention efforts among the elderly.

(b) REPORT.—Not later than January 1, 2005, 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 403.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for fiscal years 2000 through 2005 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, 2004.

SEC. 403. 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) clinical and cost-effectiveness issues;

(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 or outpatient prescription drugs 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, including outpatient prescription drugs; 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. 404. 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 man-

ner 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 403(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House, by the majority leader of the House, for himself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House.

(ii) SENATE.—In the Senate, by the majority leader of the Senate, for himself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate.

(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

403(b)(2), transmitted by the President to the House of Representatives and the Senate under subsection 403(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.

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