113TH CONGRESS
1ST SESSION

S. 608

To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to improve coverage for colorectal screening tests under Medicare and private health insurance coverage, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 19, 2013

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

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A BILL

To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to improve coverage for colorectal screening tests under Medicare and private health insurance coverage, 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 ''Supporting Colorectal Examination and Education Now Act of 2013'' or the ''SCREEN Act of 2013''.

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

SEC. 2. FINDINGS.

Congress finds the following:

(1) Colon cancer is the third most common cause of cancer-related deaths and the second most common cancer for both men and women.

(2) According to the American Cancer Society, over 50,000 people will die this year from colon cancer.

(3) Colorectal cancer is highly treatable with appropriate screening. According to the American Cancer Society (2010 Facts & Figures), the 5-year survival rate is 90 percent for those individuals who are diagnosed at an early stage of the cancer. However, less than 40 percent of colon cancer cases are diagnosed at an early stage.

(4) The Centers for Disease Control and Prevention recently estimated that approximately 2,000

deaths could be avoided if colonoscopy screening rates rose by just 10 percent.

(5) Colonoscopies allow for simultaneous colorectal cancer screenings and detection and the removal of precancerous polyps, thus preventing cancer from developing.

(6) The U.S. Preventive Services Task Force provides an ''A'' rating for colorectal cancer screenings.

(7) The Centers for Disease Control and Prevention's colorectal cancer control program has set a target of screening 80 percent of eligible adults in certain States by 2014. The American Cancer Society and other patient advocacy groups have a target rate of 75 percent.

(8) Only between 52 and 58 percent of Medicare beneficiaries have had any colorectal cancer screening test, despite Medicare coverage for such tests.

(9) Only 49.3 percent of Medicare beneficiaries who are 50 to 80 years old receive colorectal cancer screenings within recommended intervals.

(10) The Centers for Medicare & Medicaid Services notes that there is ''clearly an opportunity

to improve colorectal cancer screening rates in the Medicare population''.

(11) A January 2011 study by the Colon Cancer Alliance concludes that most Americans over the age of 50—

(A) wish a health care provider was able to sit down with them to discuss a colonoscopy before undergoing the test; and

(B) forgo a colonoscopy due to fear of the procedure.

(12) In February 2010, the National Institutes of Health hosted a conference on colorectal cancer screening and cited patient awareness and fears as barriers to increasing colorectal cancer screening rates.

(13) According to the Medicare Payment Advisory Commission, colonoscopy is one of the most common procedures performed in the ambulatory surgical centers (ASCs) and ''the decline in payment rate for the highest volume procedures is especially a strong concern for ASCs that focus on gastroenterology''.

(14) An Institute of Medicine study on colorectal cancer screening cited the inadequate reimbursement for preventive care services as one of

the constraints limiting colorectal cancer screening rates.

(15) Colorectal cancer screening by colonoscopy has been demonstrated to reduce Medicare costs over the long term.

SEC. 3. TEMPORARY INCREASE IN PAYMENT RATE FOR CERTAIN CANCER SCREENING TESTS.

(a) IN GENERAL.—With respect to a qualifying cancer screening test furnished during the 5-year period beginning on January 1, 2014, by a qualifying provider, the amount otherwise payable under section 1833 or section 1848 of the Social Security Act (42 U.S.C. 1395l, 1395w–4) to such provider for such test shall be increased by 10 percent.

(b) QUALIFYING CANCER SCREENING TEST.—

(1) IN GENERAL.—For purposes of this section, subject to paragraph (2), the term ''qualifying cancer screening test'' means, with respect to a Medicare beneficiary, a cancer screening test that has in effect with respect to such beneficiary a rating of 'A' in the current recommendations of the United States Preventive Services Task Force.

(2) TERMINATION WHEN HIGH UTILIZATION RATE REACHED.—If the Secretary determines that a cancer screening test described in paragraph (1) has

a utilization rate of at least 75 percent of the Medicare beneficiaries for whom such screening has such a recommendation, effective as of the first day of the year after the year in which such determination is made, the cancer screening test shall not be a qualifying cancer screening test.

(c) QUALIFYING PROVIDER DEFINED.—For purposes of this section, the term ''qualifying provider'' means, with respect to a qualifying cancer screening test, an individual or entity—

(1) that is eligible for payment for such test under section 1833 or section 1848 of the Social Security Act; and

(2) that—

(A) participates in a nationally recognized quality improvement registry with respect to such test; and

(B) demonstrates, to the satisfaction of the Secretary, based on the information in such registry, that the tests were provided by such individual or entity in accordance with accepted outcomes-based quality measures.

SEC. 4. WAIVING MEDICARE COST-SHARING FOR COLORECTAL CANCER SCREENING WITH THERAPEUTIC EFFECT.

(a) IN GENERAL.—Section 1833(a)(1)(Y) of the Social Security Act (42 U.S.C. 1395l(a)(1)(Y)) is amended by inserting ", including tests and procedures described in the last sentence of subsection (b)," after "section 1861(ddd)(3)".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to tests and procedures performed on or after January 1, 2014.

SEC. 5. MEDICARE COVERAGE FOR AN OFFICE VISIT OR CONSULTATION PRIOR TO A QUALIFYING SCREENING COLONOSCOPY.

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

(1) in subparagraph (EE), by striking "and" at the end;

(2) in subparagraph (FF), by inserting "and" at the end; and

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

"(GG) prior to a colorectal cancer screening test consisting of a screening colonoscopy or in conjunction with an individual's decision regarding the performance of such a test on the individual, an out-

patient office visit or consultation for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and the sedation of the individual;''.

(b) PAYMENT.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(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 an outpatient office visit or consultation under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount established under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(GG),'' after ''(2)(FF) (including administration of the health risk assessment),''.

(3) REQUIREMENT FOR ESTABLISHMENT OF PAYMENT AMOUNT UNDER PHYSICIAN FEE SCHEDULE.—Section 1834(d) of the Social Security Act

(42 U.S.C. 1395m(d)) is amended by adding at the end the following new paragraph:

''(4) PAYMENT FOR OUTPATIENT OFFICE VISIT OR CONSULTATION PRIOR TO SCREENING COLONOSCOPY.—With respect to an outpatient office visit or consultation under section 1861(s)(2)(GG), payment under section 1848 shall be consistent with the payment amounts for CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, 99214, and 99215 (as in effect as of the date of the enactment of this paragraph or any successors to such codes).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2014.

SEC. 6. BUDGET NEUTRALITY.

(a) ADJUSTMENT OF PHYSICIAN FEE SCHEDULE CONVERSION FACTOR.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall reduce the conversion factor established under subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for each year (beginning with 2014) to the extent necessary to reduce expenditures under such section for items and services furnished during the year in the aggregate by the net offset amount deter-

mined under subsection (c)(5) attributable to such section for the year.

(b) ADJUSTMENT OF HOPD CONVERSION FACTOR.—The Secretary shall reduce the conversion factor established under paragraph (3)(C) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) for each year (beginning with 2014) to the extent necessary to reduce expenditures under such section for items and services furnished during the year in the aggregate by the net offset amount determined under subsection (c)(5) attributable to such section for the year.

(c) DETERMINATIONS RELATING TO EXPENDITURES.—For purposes of this section, before the beginning of each year (beginning with 2014) at the time conversion factors described in subsections (a) and (b) are established for the year, the Secretary shall determine—

(1) the amount of the gross additional expenditures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) estimated to result from the implementation of sections 3, 4, and 5 for items and services furnished during the year;

(2) the amount of any offsetting reductions in expenditures under such title (such as reductions in payments for inpatient hospital services) for such

year attributable to the implementation of such sections;

(3) the amount (if any) by which the amount of the gross additional expenditures determined under paragraph (1) for the year exceeds the amount of offsetting reductions determined under paragraph (2) for the year;

(4) of the gross additional expenditures determined under paragraph (1) for the year that are attributable to expenditures under sections 1848 and 1833(t) of such Act, the ratio of such expenditures that are attributable to each respective section; and

(5) with respect to section 1848 and section 1833(t) of such Act, a net offset amount for the year equal to the product of—

(A) the amount of the net additional expenditures for the year determined under paragraph (3); and

(B) the ratio determined under paragraph (4) attributable to the respective section.

SEC. 7. EXPANSION OF COVERAGE OF ACTIVITIES RELATED TO RECOMMENDED PREVENTIVE HEALTH SERVICES UNDER PRIVATE HEALTH INSURANCE.

(a) IN GENERAL.—Section 2713(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–13(a)(1)) is amended by inserting ''(including related activities occurring as part of the same clinical encounter, such as conducting a biopsy or by removing a lesion or growth)'' after ''Task Force''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2014.

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