help reduce substance abuse among teenagers.

As many of you know, I am a proud father of three wonderful sons. My wife, Ingrid, and I have always made it a priority for our family to sit down together for dinner. During our dinner conversations, Ingrid and I would inquire as to what each of our children accomplished or struggled with that day. We offered words of wisdom and support to our children throughout their formidable years and fostered the notion we would always be there for them in times of need. It is my belief that these consistent family times also served to make our children confident and responsible decision-makers.

The idea for this resolution grew out of research done by the National Center on Addiction and Substance abuse at Columbia University (CASA). In its latest survey, CASA found the more often a child eats dinner with his or her parents, the less likely that child is to smoke, drink, or use illegal drugs. The result was consistent throughout the five years of the CASA survey, but never in as striking a manner as in the most recent survey.

The survey showed that teens from families who almost never eat dinner together are 72 percent more likely than the average teen to use illegal drugs, cigarettes, and alcohol, while those from families who almost always eat dinner together are 31 percent less likely than the average teen to engage in these activities. In an effort to raise awareness about the powerful impact parents can have on their children's decisions about the drug use, Congressman RANGEL and I felt compelled to introduce this resolution to show the nation cares about our youth. We want America's children to know we will stand behind them as they deal with the growing pressures prevalent as an adolescent.

I thank Congressman RANGEL for his efforts in bringing this measure to the floor. I enthusiastically support H. Con. Res. 343, the National Eat Dinner With Your Children Day, and encourage my colleagues to vote in support of this important resolution.

Mr. LARSON. Mr. Speaker, I rise today in support of H. Con. Resolution 343, regarding the importance of families eating together. I would like to commend my colleague Mr. RANGEL for bringing this important piece of legislation to my attention and the attention of the American people. Families eating together have long been a pillar of American Family Life and should be part future generations as well. Family Dinners are a dying commodity or infrequent at best. Having dinner as a family opens up communication lines between parents and their children. One will know more and have more influence on their child if they spend time talking to them. What better time to talk and communicate, then sitting around the dinner table sharing a meal. We need to spend more time with our children to influence them to do their best in school, to avoid tobacco, alcohol, illegal drugs and to make them productive, healthy citizens.

One of my constituents, Chris Lenihan, who is now an intern in my office, a nice young gentleman, told me that he had dinner as a family every night when he lived at home. He has benefited greatly from the discussion at the dinner table and feels that his parents David and Midge had a great impact on him as result of eating dinner every night as a family.

We need to make sure that the Youth of America grow up to become healthy productive citizens. We can start by having more dinners with our families. I realize that parents can not immediately have dinner every night with their children, but establishing a National ''Eat Dinner with Your Children Day'' is a step in the right direction. I fully support this resolution and urge the rest of my colleagues to do the same.

Mr. RANGEL. Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 343

Whereas the use and abuse of illegal drugs, nicotine, and alcohol are the greatest threat to the health and well-being of American children;

Whereas parental influence is one of the most crucial factors in determining the likelihood of teenage substance abuse;

Whereas family dinners have long been a pillar of American family life;

Whereas the correlation between the frequency of family dinners and the risk of substance abuse is well documented;

Whereas surveys conducted by the National Center on Addiction and Substance Abuse at Columbia University have found, for each of the past 4 years, that children and teenagers who routinely eat dinner with their families are far less likely to use illegal drugs, cigarettes, and alcohol;

Whereas, according to these surveys, teenagers from families that seldom eat dinner together are 72 percent more likely than the average teenager to use illegal drugs, cigarettes, and alcohol, and teenagers from families that eat dinner together are 31 percent less likely than the average teenager to use illegal drugs, cigarettes, and alcohol;

Whereas one method for families to eat dinner together more often would be for them to select a recurring occasion for doing so, such as the third Monday of each month; and

Whereas a National Eat-Dinner-With-Your-Children Day on Monday, June 19, 2000, would encourage families to eat together: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That it is the sense of the Congress that—

(1) eating dinner together is a critical step for a family in raising healthy, drug-free children; and

(2) a National Eat-Dinner-With-Your-Children Day should be established in order to encourage families to eat together as often as possible.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

RYAN WHITE CARE ACT AMENDMENTS OF 2000

Mr. COBURN. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4807) to amend the Public Health Service Act to revise and extend programs established under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, and for other purposes, as amended.

The Clerk read as follows:

H.R. 4807

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Ryan White CARE Act Amendments of 2000''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—EMERGENCY RELIEF FOR AREAS WITH SUBSTANTIAL NEED FOR SERVICES

Subtitle A—HIV Health Services Planning Councils

Sec. 101. Membership of councils.
Sec. 102. Duties of councils.
Sec. 103. Open meetings; other additional provisions.

Subtitle B—Type and Distribution of Grants

Sec. 111. Formula grants.
Sec. 112. Supplemental grants.

Subtitle C—Other Provisions

Sec. 121. Use of amounts.
Sec. 122. Application.
Sec. 123. Review of administrative costs and compensation.

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

Sec. 201. Priority for women, infants, and children.
Sec. 202. Use of grants.
Sec. 203. Grants to establish HIV care consortia.
Sec. 204. Provision of treatments.
Sec. 205. State application.
Sec. 206. Distribution of funds.
Sec. 207. Supplemental grants for certain States.

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

Sec. 211. Repeals.
Sec. 212. Grants.
Sec. 213. Study by Institute of Medicine.

Subtitle C—Certain Partner Notification Programs

Sec. 221. Grants for compliant partner notification programs.

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

Sec. 301. Repeal of program.

Subtitle B—Categorical Grants

Sec. 311. Preferences in making grants.
Sec. 312. Planning and development grants.
Sec. 313. Authorization of appropriations.

Subtitle C—General Provisions

Sec. 321. Provision of certain counseling services.
Sec. 322. Additional required agreements.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

Subtitle A—Certain Programs for Research, Demonstrations, or Training

Sec. 401. Grants for coordinated services and access to research for women, infants, children, and youth.
Sec. 402. AIDS education and training centers.

Subtitle B—General Provisions in Title XXVI

Sec. 411. Evaluations and reports.
Sec. 412. Data collection through Centers for Disease Control and Prevention.
Sec. 413. Coordination.
Sec. 414. Plan regarding release of prisoners with HIV disease.
Sec. 415. Audits.
Sec. 416. Administrative simplification.
Sec. 417. Authorization of appropriations for parts A and B.

TITLE V—GENERAL PROVISIONS

Sec. 501. Studies by Institute of Medicine.
Sec. 502. Development of rapid HIV test.

TITLE VI—EFFECTIVE DATE

Sec. 601. Effective date.

TITLE I—EMERGENCY RELIEF FOR AREAS WITH SUBSTANTIAL NEED FOR SERVICES

Subtitle A—HIV Health Services Planning Councils

SEC. 101. MEMBERSHIP OF COUNCILS.

(a) IN GENERAL.—Section 2602(b) of the Public Health Service Act (42 U.S.C. 300ff–12(b)) is amended—

(1) in paragraph (1), by striking ''demographics of the epidemic in the eligible area involved,'' and inserting ''demographics of the population of individuals with HIV disease in the eligible area involved,''; and

(2) in paragraph (2)—

(A) in subparagraph (G), by striking ''or AIDS'';

(B) in subparagraph (K), by striking ''and'' at the end;

(C) in subparagraph (L), by striking the period and inserting the following: '', including but not limited to providers of HIV prevention services; and''; and

(D) by adding at the end the following subparagraph:

''(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding three years, and had HIV disease as of the date on which the individuals were so released.''.

(b) CONFLICTS OF INTERESTS.—Section 2602(b)(5) of the Public Health Service Act (42 U.S.C. 300ff–12(b)(5)) is amended by adding at the end the following subparagraph:

''(C) COMPOSITION OF COUNCIL.—The following applies regarding the membership of a planning council under paragraph (1):

''(i) Not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant under section 2601(a), are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV disease as determined under paragraph (4)(A). For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

''(ii) With respect to membership on the planning council, clause (i) may not be construed as having any effect on entities that receive funds from grants under any of parts B through F but do not receive funds from grants under section 2601(a), on officers or employees of such entities, or on individuals who represent such entities.''.

SEC. 102. DUTIES OF COUNCILS.

(a) IN GENERAL.—Section 2602(b)(4) of the Public Health Service Act (42 U.S.C. 300ff–12(b)(4)) is amended—

(1) by redesignating subparagraphs (A) through (E) as subparagraphs (C) through (G), respectively;

(2) by inserting before subparagraph (C) (as so redesignated) the following subparagraphs:

''(A) determine the size and demographics of the population of individuals with HIV disease;

''(B) determine the needs of such population, with particular attention to—

''(i) individuals with HIV disease who are not receiving HIV-related services; and

''(ii) disparities in access and services among affected subpopulations and historically underserved communities;'';

(3) in subparagraph (C) (as so redesignated), by striking clauses (i) through (iv) and inserting the following:

''(i) size and demographics of the population of individuals with HIV disease (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));

''(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;

''(iii) priorities of the communities with HIV disease for whom the services are intended;

''(iv) availability of other governmental and nongovernmental resources to provide HIV-related services to individuals and families with HIV disease, including the State plan under title XIX of the Social Security Act (relating to the Medicaid program) and the program under title XXI of such Act (relating to the program for State children's health insurance); and

''(v) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;'';

(4) in subparagraph (D) (as so redesignated), by amending the subparagraph to read as follows:

''(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 2604 that—

''(i) includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

''(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse; and

''(iii) is compatible with any State or local plan for the provision of services to individuals with HIV disease;'';

(5) in subparagraph (F) (as so redesignated), by striking ''and'' at the end;

(6) in subparagraph (G) (as so redesignated)—

(A) by striking ''public meetings,'' and inserting ''public meetings (in accordance with paragraph (7)),''; and

(B) by striking the period and inserting ''; and''; and

(7) by adding at the end the following subparagraph:

''(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.''.

(b) PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.—Section 2602 of the Public Health Service Act (42 U.S.C. 300ff–12) is amended by adding at the end the following subsection:

''(d) PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.—Promptly after the date of the submission of the report required in section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the Secretary, in consultation with entities that receive amounts from grants under section 2601(a) or 2611, shall develop epidemiologic measures—

''(1) for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services; and

''(2) for carrying out the duties under subsection (b)(4) and section 2617(b).''.

(c) TRAINING.—Section 2602 of the Public Health Service Act (42 U.S.C. 300ff–12), as amended by subsection (b) of this section, is amended by adding at the end the following subsection:

''(e) TRAINING GUIDANCE AND MATERIALS.—The Secretary shall provide to each chief elected official receiving a grant under 2601(a) guidelines and materials for training members of the planning council under paragraph (1) regarding the duties of the council.''.

SEC. 103. OPEN MEETINGS; OTHER ADDITIONAL PROVISIONS.

Section 2602(b) of the Public Health Service Act (42 U.S.C. 300ff–12(b)) is amended—

(1) in paragraph (3), by striking subparagraph (C); and

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

''(7) PUBLIC DELIBERATIONS.—With respect to a planning council under paragraph (1), the following applies:

''(A) The council may not be chaired solely by an employee of the grantee under section 2601(a).

''(B) In accordance with criteria established by the Secretary:

''(i) The meetings of the council shall be open to the public and shall be held only after adequate notice to the public.

''(ii) The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location.

''(iii) Detailed minutes of each meeting of the council shall be kept. The accuracy of all minutes shall be certified to by the chair of the council.

''(iv) This subparagraph does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters.''.

Subtitle B—Type and Distribution of Grants

SEC. 111. FORMULA GRANTS.

(a) EXPEDITED DISTRIBUTION.—Section 2603(a)(2) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(2)) is amended in the first sentence by striking ''for each of the fiscal years 1996 through 2000'' and inserting ''for a fiscal year''.

(b) AMOUNT OF GRANT; ESTIMATE OF LIVING CASES.—

(1) IN GENERAL.—Section 2603(a)(3)) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(3)) is amended—

(A) in subparagraph (C)(i), by inserting before the semicolon the following: '', except that (subject to subparagraph (D)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome''; and

(B) in subparagraph (C), in the matter after and below clause (ii)(X)—

(i) in the first sentence, by inserting before the period the following: '', and shall be reported to the congressional committees of jurisdiction''; and

(ii) by adding at the end the following sentence: ''Updates shall as applicable take into account the counting of cases of HIV disease pursuant to clause (i).''

(2) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—Section 2603(a)(3)) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(3)) is amended—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following subparagraph:

''(D) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—

''(i) IN GENERAL.—Not later than July 1, 2004, the Secretary shall determine whether there is data on cases of HIV disease from all eligible areas (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) sufficiently accurate and reliable for use for purposes of subparagraph (C)(i). In making such a determination, the Secretary shall take into consideration the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the fiscal impact of the use of such data,

the impact of the use of such data on the organization and delivery of HIV-related services in eligible areas, and the fiscal impact of not using such data.

''(ii) EFFECT OF ADVERSE DETERMINATION.—If under clause (i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable for use for purposes of subparagraph (C)(i), then notwithstanding such subparagraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.

''(iii) GRANTS AND TECHNICAL ASSISTANCE REGARDING COUNTING OF HIV CASES.—Of the amounts appropriated under section 2675 for a fiscal year, the Secretary shall reserve amounts to make grants and provide technical assistance to States and eligible areas with respect to obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as is practicable but not later than the beginning of fiscal year 2007.''.

(c) INCREASES IN GRANT.—Section 2603(a)(4)) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(4)) is amended to read as follows:

''(4) INCREASES IN GRANT.—

''(A) IN GENERAL.—For each fiscal year in a protection period for an eligible area, the Secretary shall increase the amount of the grant made pursuant to paragraph (2) for the area to ensure that—

''(i) for the first fiscal year in the protection period, the grant is not less than 98 percent of the amount of the grant made for the eligible area pursuant to such paragraph for the base year for the protection period;

''(ii) for any second fiscal year in such period, the grant is not less than 95.7 percent of the amount of such base year grant;

''(iii) for any third fiscal year in such period, the grant is not less than 91.1 percent of the amount of the base year grant;

''(iv) for any fourth fiscal year in such period, the grant is not less than 84.2 percent of the amount of the base year grant; and

''(v) for any fifth or subsequent fiscal year in such period, the grant is not less than 75 percent of the amount of the base year grant.

''(B) BASE YEAR; PROTECTION PERIOD.—With respect to grants made pursuant to paragraph (2) for an eligible area:

''(i) The base year for a protection period is the fiscal year preceding the trigger grant-reduction year.

''(ii) The first trigger grant-reduction year is the first fiscal year (after fiscal year 2000) for which the grant for the area is less than the grant for the area for the preceding fiscal year.

''(iii) A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the amount of the grant for the area equals or exceeds the amount of the grant for the base year for the period.

''(iv) Any subsequent trigger grant-reduction year is the first fiscal year, after the end of the preceding protection period, for which the amount of the grant is less than the amount of the grant for the preceding fiscal year.''.

SEC. 112. SUPPLEMENTAL GRANTS.

(a) IN GENERAL.—Section 2603(b)(2) of the Public Health Service Act (42 U.S.C. 300ff–13(b)(2)) is amended—

(1) in the heading for the paragraph, by striking ''DEFINITION'' and inserting ''AMOUNT OF GRANT'';

(2) by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively;

(3) by inserting before subparagraph (B) (as so redesignated) the following subparagraph:

''(A) IN GENERAL.—The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on a weighting of factors under paragraph (1), with severe need under subparagraph (B) of such paragraph counting one-third.'';

(4) in subparagraph (B) (as so redesignated)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following clauses:

''(iv) the current prevalence of HIV disease;

''(v) an increasing need for HIV-related services, including relative rates of increase in the number of cases of HIV disease; and

''(vi) unmet need for such services, as determined under section 2602(b)(4).'';

(5) in subparagraph (C) (as so redesignated)—

(A) by striking ''subparagraph (A)'' each place such term appears and inserting ''subparagraph (B)'';

(B) in the second sentence, by striking ''2 years after the date of enactment of this paragraph'' and inserting ''18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000''; and

(C) by inserting after the second sentence the following sentence: ''Such a mechanism shall be modified to reflect the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease).''; and

(6) in subparagraph (D) (as so redesignated), by striking ''subparagraph (B)'' and inserting ''subparagraph (C)''.

(b) REQUIREMENTS FOR APPLICATION.—Section 2603(b)(1)(E) of the Public Health Service Act (42 U.S.C. 300ff–13(b)(1)(E)) is amended by inserting ''youth,'' after ''children,''.

(c) CONFORMING AMENDMENT.—Section 2603(b) of the Public Health Service Act (42 U.S.C. 300ff–13(b)) is amended—

(1) by striking paragraph (4); and

(2) by redesignating paragraph (5) as paragraph (4).

Subtitle C—Other Provisions

SEC. 121. USE OF AMOUNTS.

(a) PRIMARY PURPOSES.—Section 2604(b)(1) of the Public Health Service Act (42 U.S.C. 300ff–14(b)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''HIV-related—'' and inserting ''HIV-related services, as follows:'';

(2) in subparagraph (A)—

(A) by striking ''outpatient'' and all that follows through ''substance abuse treatment and'' and inserting the following: ''Outpatient and ambulatory health services, including substance abuse treatment,''; and

(B) by striking ''; and'' and inserting a period;

(3) in subparagraph (B), by striking ''(B) inpatient case management'' and inserting ''(C) Inpatient case management'';

(4) by inserting after subparagraph (A) the following subparagraph:

''(B) Outpatient and ambulatory support services (including case management), to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.''; and

(5) by adding at the end the following:

''(D) Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—

''(i) necessary to implement the strategy under section 2602(b)(4)(D), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in paragraph (3);

''(ii) conducted in a manner consistent with the requirements under sections 2605(a)(3) and 2651(b)(2); and

''(iii) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.''.

(b) ADDITIONAL PURPOSES.—Section 2604(b) (42 U.S.C. 300ff–14(b)) of the Public Health Service Act is amended—

(1) by redesignating paragraph (3) as paragraph (4);

(2) by inserting after paragraph (2) the following:

''(3) EARLY INTERVENTION SERVICES.—

''(A) IN GENERAL.—The purposes for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to subparagraph (B). The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

''(B) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

''(i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

''(ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.''; and

(3) in paragraph (4) (as so redesignated), by inserting ''youth,'' after ''children,'' each place such term appears;

(c) QUALITY MANAGEMENT.—Section 2604 of the Public Health Service Act (42 U.S.C. 300ff–14) is amended—

(1) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively; and

(2) by inserting after subsection (b) the following:

''(c) QUALITY MANAGEMENT.—

''(1) REQUIREMENT.—The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

''(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the chief elected official of an eligible area may (in addition to amounts to which subsection (f)(1) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

''(A) 5 percent of amounts received under the grant; or

''(B) $3,000,000.''.

SEC. 122. APPLICATION.

Section 2605(a) of the Public Health Service Act (42 U.S.C. 300ff–15(a)) is amended—

(1) by redesignating paragraphs (3) through (6) as paragraphs (4) through (7), respectively; and

(2) by inserting after paragraph (2) the following paragraph:

''(3) that entities within the eligible area that receive funds under a grant under section 2601(a) will maintain relationships with appropriate entities in the area, including entities described in section 2604(b)(3);''.

SEC. 123. REVIEW OF ADMINISTRATIVE COSTS AND COMPENSATION.

Each chief elected official of an eligible area (as defined in section 2607 of the Public Health

Service Act) shall ensure that, not later than one year after the date of the enactment of this Act, the planning council for the eligible area—

(1) conducts a review of the existing, available data on the extent to which entities in the area that receive amounts from a grant under section 2601(a) of the Public Health Service Act have from their overall budget expended amounts for administrative costs (including financial compensation and benefits), expressed as a proportion and indicating the growth in such expenditures, including a statement of the average amount expended for such costs per client served and the average amount expended for such costs per client served in providing HIV-related services; and

(2) makes a determination of whether the financial compensation of any officers or employees of such entities exceeds that of the chief elected official of the eligible area.

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

SEC. 201. PRIORITY FOR WOMEN, INFANTS, AND CHILDREN.

Section 2611(b) of the Public Health Service Act (42 U.S.C. 300ff–21(b)) is amended by inserting ''youth,'' after ''children,'' each place such term appears.

SEC. 202. USE OF GRANTS.

Section 2612 of the Public Health Service Act (42 U.S.C. 300ff–22) is amended—

(1) by striking ''A State may use'' and inserting ''(a) IN GENERAL.—A State may use''; and

(2) by adding at the end the following subsections:

''(b) SUPPORT SERVICES; OUTREACH.—The purposes for which a grant under this part may be used include delivering or enhancing the following:

''(1) Support services under section 2611(a) (including case management) to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.

''(2) Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—

''(A) necessary to implement the strategy under section 2617(b)(4)(B);

''(B) conducted in a manner consistent with the requirement under section 2617(b)(6)(G); and

''(C) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.

''(c) EARLY INTERVENTION SERVICES.—

''(1) IN GENERAL.—The purposes for which a grant under this part may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to paragraph (2). The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

''(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph applies only if the entity demonstrates to the satisfaction of the State involved that—

''(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

''(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

''(d) QUALITY MANAGEMENT.—

''(1) REQUIREMENT.—Each State that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

''(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the State may (in addition to amounts to which section 2618(c)(5) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

''(A) 5 percent of amounts received under the grant; or

''(B) $3,000,000.''.

SEC. 203. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

Section 2613 of the Public Health Service Act (42 U.S.C. 300ff–23) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A), by inserting before the semicolon the following: '', particularly those experiencing disparities in access and services and those who reside in historically underserved communities''; and

(B) in subparagraph (B), by inserting after ''by such consortium'' the following: ''is consistent with the comprehensive plan under 2617(b)(4) and'';

(2) in subsection (c)(1)—

(A) in subparagraph (D), by striking ''and'' after the semicolon at the end;

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

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

''(F) demonstrates that adequate planning occurred to address disparities in access and services and historically underserved communities.''; and

(3) in subsection (c)(2)—

(A) in subparagraph (B), by striking ''and'' after the semicolon;

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

(C) by inserting after subparagraph (C) the following subparagraph:

''(D) entities described in section 2602(b)(2).''.

SEC. 204. PROVISION OF TREATMENTS.

Section 2616 of the Public Health Service Act (42 U.S.C. 300ff–26) is amended by adding at the end the following subsection:

''(e) USE OF HEALTH INSURANCE AND PLANS.—In carrying out subsection (a), a State may expend a grant under this part to provide the therapeutics described in such subsection by paying on behalf of individuals with HIV disease the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.''.

SEC. 205. STATE APPLICATION.

(a) DETERMINATION OF SIZE AND NEEDS OF POPULATION; COMPREHENSIVE PLAN.—Section 2617(b) of the Public Health Service Act (42 U.S.C. 300ff–27(b)) is amended—

(1) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6), respectively;

(2) by inserting after paragraph (1) the following paragraphs:

''(2) a determination of the size and demographics of the population of individuals with HIV disease in the State;

''(3) a determination of the needs of such population, with particular attention to—

''(A) individuals with HIV disease who are not receiving HIV-related services; and

''(B) disparities in access and services among affected subpopulations and historically underserved communities;''; and

(3) in paragraph (4) (as so redesignated)—

(A) by striking ''comprehensive plan for the organization'' and inserting ''comprehensive plan that describes the organization'';

(B) by striking '', including—'' and inserting '', and that—'';

(C) by redesignating subparagraphs (A) through (C) as subparagraphs (D) through (F), respectively;

(D) by inserting before subparagraph (C) the following subparagraphs:

''(A) establishes priorities for the allocation of funds within the State based on—

''(i) size and demographics of the population of individuals with HIV disease (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));

''(ii) availability of other governmental and nongovernmental resources to provide HIV-related services to individuals and families with HIV disease;

''(iii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and

''(iv) the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;

''(B) includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

''(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse;'';

(E) in subparagraph (D) (as redesignated by subparagraph (C) of this paragraph), by inserting ''describes'' before ''the services and activities'';

(F) in subparagraph (E) (as so redesignated), by inserting ''provides'' before ''a description''; and

(G) in subparagraph (F) (as so redesignated), by inserting ''provides'' before ''a description''.

(b) PUBLIC PARTICIPATION.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended—

(1) in paragraph (5), by striking ''HIV'' and inserting ''HIV disease''; and

(2) in paragraph (6), by amending subparagraph (A) to read as follows:

''(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (5), and entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (4) and commenting on the implementation of such plan;''.

(c) HEALTH CARE RELATIONSHIPS.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended in paragraph (6)—

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

(2) in subparagraph (F), by striking the period and inserting ''; and''; and

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

''(G) entities within areas in which activities under the grant are carried out will maintain relationships with appropriate entities in the area, including entities described in section 2612(c);''.

SEC. 206. DISTRIBUTION OF FUNDS.

(a) MINIMUM ALLOTMENT.— Section 2618(b)(1)(A)(i) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(1)(A)(i)) is amended—

(1) in subclause (I), by striking ''$100,000'' and inserting ''$200,000''; and

(2) in subclause (II), by striking ''$250,000'' and inserting ''$500,000''.

(b) AMOUNT OF GRANT; ESTIMATE OF LIVING CASES.—Section 2618(b)(2) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(2)) is amended—

(1) in subparagraph (D)(i), by inserting before the semicolon the following: '', except that (subject to subparagraph (E)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome'';

(2) by redesignating subparagraphs (E) through (H) as subparagraphs (F) through (I), respectively; and

(3) by inserting after subparagraph (D) the following subparagraph:

''(E) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—If under 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable, then notwithstanding subparagraph (D) of this paragraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.''.

(c) INCREASES IN FORMULA AMOUNT.—Section 2618(b) of the Public Health Service Act (42 U.S.C. 300ff–28(b)) is amended—

(1) in paragraph (1)(A)(ii), by inserting before the semicolon the following: ''and then, as applicable, increased under paragraph (2)(H)''; and

(2) in paragraph (2)—

(A) in subparagraph (A)(i), by striking ''subparagraph (H)'' and inserting ''subparagraphs (H) and (I)''; and

(B) in subparagraph (H) (as redesignated by subsection (b)(2) of this section), by amending the subparagraph to read as follows:

''(H) LIMITATION.—

''(i) IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory under section 2611 for a fiscal year is not less than—

''(I) with respect to fiscal year 2001, 99 percent;

''(II) with respect to fiscal year 2002, 98 percent;

''(III) with respect to fiscal year 2003, 97 percent;

''(IV) with respect to fiscal year 2004, 96 percent; and

''(V) with respect to fiscal year 2005, 95 percent;

of the amount such State or territory received for fiscal year 2000 under such section. In administering this subparagraph, the Secretary shall, with respect to States or territories that will under such section receive grants in amounts that exceed the amounts that such States received under such section for fiscal year 2000, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 2000.

''(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 for a fiscal year and available for grants under section 2611 is less than the amount appropriated and available under such section for fiscal year 2000, the limitation contained in clause (i) shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.''.

(d) TERRITORIES.—Section 2618(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(1)(B)) is amended by inserting ''the greater of $50,000 or'' after ''shall be''.

(e) SEPARATE TREATMENT DRUG GRANTS.—Section 2618(b)(2) of the Public Health Service Act, as amended by subsection (b)(3) of this section, is amended in subparagraph (I)—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;

(2) by striking ''(I) APPROPRIATIONS'' and all that follows through ''With respect to'' and inserting the following:

''(I) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

''(i) FORMULA GRANTS.—With respect to'';

(3) in subclause (I) of clause (i) (as designated by paragraphs (1) and (2)), by striking ''100 percent'' and inserting ''98 percent''; and

(4) by adding at the end the following clause:

''(ii) SUPPLEMENTAL TREATMENT DRUG GRANTS.—

''(I) IN GENERAL.—With respect to the fiscal year involved, if under section 2677 an appropriations Act provides an amount exclusively for carrying out section 2616, and such amount is not less than the amount so provided for the preceding fiscal year, the Secretary shall reserve 2 percent of such amount for making grants to States whose population of individuals with HIV disease has, as determined by the Secretary, a need for quantities of therapeutics described in section 2616(a) greater than the quantities available pursuant to clause (i). Such a grant is available for purposes of obtaining such therapeutics. The Secretary shall carry out this clause as a program of discretionary grants, and not as a program of formula grants.

''(II) DISTRIBUTION OF GRANTS.—The Secretary shall disburse all amounts under grants under subclause (I) for a fiscal year not later than 240 days after the date on which the amount referred to in such subclause with respect to section 2616 becomes available.

''(III) REQUIREMENT OF MATCHING FUNDS.—A condition for receiving a grant under subclause (I) is that the State agree to make available (directly or through donations from public or private entities) non-Federal contributions toward the costs of obtaining the therapeutics involved in an amount that is not less than 25 percent of such costs (determined in the same manner as under 2617(d)(2)(A)).''.

(f) TECHNICAL AMENDMENT.—Section 2618(b)(3)(B) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(3)(B)) is amended by striking ''and the Republic of the Marshall Islands'' and inserting ''the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, and only for purposes of paragraph (1) the Commonwealth of Puerto Rico''.

SEC. 207. SUPPLEMENTAL GRANTS FOR CERTAIN STATES.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.) is amended—

(1) by striking section 2621; and

(2) by inserting after section 2620 the following section:

''SEC. 2621. SUPPLEMENTAL GRANTS.

''(a) IN GENERAL.—From amounts available pursuant to subsection (d) for a fiscal year, the Secretary shall make grants to States that meet the conditions to receive grants under section 2611, and that have one or more eligible communities, for the purpose of providing in such communities comprehensive services of the type described in section 2612(a) to supplement the development and care activities, primary care, and support services otherwise provided in such communities by the State under a grant under section 2611.

''(b) ELIGIBLE COMMUNITY.—For purposes of this section, the term 'eligible community' means a geographic area that—

''(1) is not within any eligible area as defined in section 2607; and

''(2) has a severe need for supplemental financial assistance to combat the HIV epidemic, according to criteria developed by the Secretary in consultation with the States, including evidence of underserved or rural areas or both.

''(c) APPLICATION.—A grant under subsection (a) may be made to a State if the State submits to the Secretary, as part of the State application submitted under section 2617, such information as required to apply for funds under this section as determined by the Secretary in consultation with the States.

''(d) FUNDING.—

''(1) IN GENERAL.—For the purpose of making grants under subsection (a) for a fiscal year, the Secretary shall reserve 50 percent of the amount specified in paragraph (2).

''(2) INCREASES IN PART B FUNDING.—

''(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph is the amount by which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase over the amount so appropriated and available for the preceding fiscal year, subject to subparagraphs (B) and (C).

''(B) INITIAL ALLOCATION YEAR.—The allocation under paragraph (1) shall not be made until the first fiscal year for which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase of not less than $20,000,000 over the amount so appropriated and available for fiscal year 2000, subject to subparagraph (C).

''(C) EXCLUSION REGARDING SEPARATE TREATMENT DRUG GRANTS.—Each determination under subparagraph (A) or (B) of the amount appropriated under section 2677 for a fiscal year and available for carrying out part B shall be made without regard to any amount to which section 2618(b)(2)(I)(i) applies.''.

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

SEC. 211. REPEALS.

Subpart II of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–33 et seq.) is amended—

(1) in section 2626, by striking each of subsections (d) through (f); and

(2) by striking section 2627.

SEC. 212. GRANTS.

(a) IN GENERAL.—Section 2625(c) of the Public Health Service Act (42 U.S.C. 300ff–33) is amended—

(1) in paragraph (1), by inserting at the end the following subparagraph:

''(F) Making available to pregnant women with HIV disease, and to the infants of women with such disease, treatment services for such disease in accordance with applicable recommendations of the Secretary.'';

(2) by amending paragraph (2) to read as follows:

''(2) FUNDING.—

''(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated $30,000,000 for each of the fiscal years 2001 through 2005. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.

''(B) ALLOCATIONS FOR CERTAIN STATES.—

''(i) IN GENERAL.—Of the amounts appropriated under subparagraph (A) for a fiscal year in excess of $10,000,000, the Secretary shall reserve the applicable percentage under clause (ii) for making grants under paragraph (1) to States that under law (including under regulations or the discretion of State officials) have—

''(I) a requirement that all newborn infants born in the State be tested for HIV disease; or

''(II) a requirement that newborn infants born in the State be tested for HIV disease in circumstances in which the attending obstetrician for the birth does not know the HIV status of the mother of the infant.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable amount for a fiscal year is as follows:

''(I) For fiscal year 2001, 25 percent.

''(II) For fiscal year 2002, 50 percent.

''(III) For fiscal year 2003, 50 percent.

''(IV) For fiscal year 2004, 75 percent.

''(V) For fiscal year 2005, 75 percent.

''(C) CERTAIN PROVISIONS.—With respect to grants under paragraph (1) that are made with amounts reserved under subparagraph (B) of this paragraph:

''(i) Such a grant may not be made in an amount exceeding $4,000,000.

''(ii) If pursuant to clause (i) or pursuant to an insufficient number of qualifying applications for such grants (or both), the full amount reserved under subparagraph (B) for a fiscal year is not obligated, the requirement under such subparagraph to reserve amounts ceases to apply.''; and

(3) by adding at the end the following paragraph:

''(4) MAINTENANCE OF EFFORT.—A condition for the receipt of a grant under paragraph (1) is that the State involved agree that the grant will be used to supplement and not supplant other funds available to the State to carry out the purposes of the grant.''.

(b) SPECIAL FUNDING RULE FOR FISCAL YEAR 2001.—

(1) IN GENERAL.—If for fiscal year 2001 the amount appropriated under paragraph (2)(A) of section 2625(c) of the Public Health Service Act is less than $14,000,000—

(A) the Secretary of Health and Human Services shall, for the purpose of making grants under paragraph (1) of such section, reserve from the amount specified in paragraph (2) of this subsection an amount equal to the difference between $14,000,000 and the amount appropriated under paragraph (2)(A) of such section for such fiscal year;

(B) the amount so reserved shall, for purposes of paragraph (2)(B)(i) of such section, be considered to have been appropriated under paragraph (2)(A) of such section; and

(C) the percentage specified in paragraph (2)(B)(ii)(I) of such section is deemed to be 50 percent.

(2) ALLOCATION FROM INCREASES IN FUNDING FOR PART B.—For purposes of paragraph (1), the amount specified in this paragraph is the amount by which the amount appropriated under section 2677 of the Public Health Service Act for fiscal year 2001 and available for grants under section 2611 of such Act is an increase over the amount so appropriated and available for fiscal year 2000.

SEC. 213. STUDY BY INSTITUTE OF MEDICINE.

Subpart II of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–33 et seq.) is amended by adding at the end the following section:

''SEC. 2630. RECOMMENDATIONS FOR REDUCING INCIDENCE OF PERINATAL TRANSMISSION.

''(a) STUDY BY INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—The Secretary shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study to provide the following:

''(A) For the most recent fiscal year for which the information is available, a determination of the number of newborn infants with HIV born in the United States with respect to whom the attending obstetrician for the birth did not know the HIV status of the mother.

''(B) A determination for each State of any barriers, including legal barriers, that prevent or discourage an obstetrician from making it a routine practice to offer pregnant women an HIV test and a routine practice to test newborn infants for HIV disease in circumstances in which the obstetrician does not know the HIV status of the mother of the infant.

''(C) Recommendations for each State for reducing the incidence of cases of the perinatal transmission of HIV, including recommendations on removing the barriers identified under subparagraph (B).

If such Institute declines to conduct the study, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

''(2) REPORT.—The Secretary shall ensure that, not later than 18 months after the effective date of this section, the study required in paragraph (1) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress, the Secretary, and the chief public health official of each of the States.

''(b) PROGRESS TOWARD RECOMMENDATIONS.—Each State shall comply with the following (as applicable to the fiscal year involved):

''(1) For fiscal year 2004, the State shall submit to the Secretary a report describing the actions taken by the State toward meeting the recommendations specified for the State under subsection (a)(1)(C).

''(2) For fiscal year 2005 and each subsequent fiscal year—

''(A) the State shall make reasonable progress toward meeting such recommendations; or

''(B) if the State has not made such progress—

''(i) the State shall cooperate with the Director of the Centers for Disease Control and Prevention in carrying out activities toward meeting the recommendations; and

''(ii) the State shall submit to the Secretary a report containing a description of any barriers identified under subsection (a)(1)(B) that continue to exist in the State; as applicable, the factors underlying the continued existence of such barriers; and a description of how the State intends to reduce the incidence of cases of the perinatal transmission of HIV.

''(c) SUBMISSION OF REPORTS TO CONGRESS.—The Secretary shall submit to the appropriate committees of the Congress each report received by the Secretary under subsection (b)(2)(B)(ii).''.

Subtitle C—Certain Partner Notification Programs

SEC. 221. GRANTS FOR COMPLIANT PARTNER NOTIFICATION PROGRAMS.

Part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–21 et seq.) is amended by adding at the end the following subpart:

''Subpart III—Certain Partner Notification Programs

''SEC. 2631. GRANTS FOR PARTNER NOTIFICATION PROGRAMS.

''(a) IN GENERAL.—In the case of States whose laws or regulations are in accordance with subsection (b), the Secretary, subject to subsection (c)(2), may make grants to the States for carrying out programs to provide partner counseling and referral services.

''(b) DESCRIPTION OF COMPLIANT STATE PROGRAMS.—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if under such laws or regulations (including programs carried out pursuant to the discretion of State officials) the following policies are in effect:

''(1) The State requires that the public health officer of the State carry out a program of partner notification to inform partners of individuals with HIV disease that the partners may have been exposed to the disease.

''(2)(A) In the case of a health entity that provides for the performance on an individual of a test for HIV disease, or that treats the individual for the disease, the State requires, subject to subparagraph (B), that the entity confidentially report the positive test results to the State public health officer in a manner recommended and approved by the Director of the Centers for Disease Control and Prevention, together with such additional information as may be necessary for carrying out such program.

''(B) The State may provide that the requirement of subparagraph (A) does not apply to the testing of an individual for HIV disease if the individual underwent the testing through a program designed to perform the test and provide the results to the individual without the individual disclosing his or her identity to the program. This subparagraph may not be construed as affecting the requirement of subparagraph (A) with respect to a health entity that treats an individual for HIV disease.

''(3) The program under paragraph (1) is carried out in accordance with the following:

''(A) Partners are provided with an appropriate opportunity to learn that the partners have been exposed to HIV disease, subject to subparagraph (B).

''(B) The State does not inform partners of the identity of the infected individuals involved.

''(C) Counseling and testing for HIV disease are made available to the partners and to infected individuals, and such counseling includes information on modes of transmission for the disease, including information on prenatal and perinatal transmission and preventing transmission.

''(D) Counseling of infected individuals and their partners includes the provision of information regarding therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from the disease, and the provision of other prevention-related information.

''(E) Referrals for appropriate services are provided to partners and infected individuals, including referrals for support services and legal aid.

''(F) Notifications under subparagraph (A) are provided in person, unless doing so is an unreasonable burden on the State.

''(G) There is no criminal or civil penalty on, or civil liability for, an infected individual if the individual chooses not to identify the partners of the individual, or the individual does not otherwise cooperate with such program.

''(H) The failure of the State to notify partners is not a basis for the civil liability of any health entity who under the program reported to the State the identity of the infected individual involved.

''(I) The State provides that the provisions of the program may not be construed as prohibiting the State from providing a notification under subparagraph (A) without the consent of the infected individual involved.

''(4) The State annually reports to the Director of the Centers for Disease Control and Prevention the number of individuals from whom the names of partners have been sought under the program under paragraph (1), the number of such individuals who provided the names of partners, and the number of partners so named who were notified under the program.

''(5) The State cooperates with such Director in carrying out a national program of partner notification, including the sharing of information between the public health officers of the States.

''(c) REPORTING SYSTEM FOR CASES OF HIV DISEASE.—

''(1) PREFERENCE IN MAKING GRANTS THROUGH FISCAL YEAR 2003.—In making grants under subsection (a) for each of the fiscal years 2001 through 2003, the Secretary shall give preference to States whose reporting systems for cases of HIV disease produce data on such cases that is sufficiently accurate and reliable for use for purposes of section 2618(b)(2)(D)(i).

''(2) ELIGIBILITY CONDITION AFTER FISCAL YEAR 2003.—For fiscal year 2004 and subsequent fiscal years, a State may not receive a grant under subsection (a) unless the reporting system of the State for cases of HIV disease produces data on such cases that is sufficiently accurate and reliable for purposes of section 2618(b)(2)(D)(i).

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $30,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.''.

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

SEC. 301. REPEAL OF PROGRAM.

Subpart I of part C of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–41 et seq.) is repealed.

Subtitle B—Categorical Grants

SEC. 311. PREFERENCES IN MAKING GRANTS.

Section 2653 of the Public Health Service Act (42 U.S.C. 300ff–53) is amended by adding at the end the following subsection:

''(d) UNDERSERVED AND RURAL AREAS.—Of the applicants who qualify for preference under this section, the Secretary shall give preference to applicants that will expend the grant under section 2651 to provide early intervention under such section in rural areas or in areas that are underserved with respect to such services.''.

SEC. 312. PLANNING AND DEVELOPMENT GRANTS.

(a) IN GENERAL.—Section 2654(c)(1) of the Public Health Service Act (42 U.S.C. 300ff–54(c)(1)) is amended by striking ''planning grants'' and all that follows and inserting the following: ''planning grants to public and nonprofit private entities for purposes of—

''(A) enabling such entities to provide HIV early intervention services; and

''(B) assisting the entities in expanding their capacity to provide HIV-related health services, including early intervention services, in low-income communities and affected subpopulations that are underserved with respect to such services (subject to the condition that a grant pursuant to this subparagraph may not be expended to purchase or improve land, or to purchase, construct, or permanently improve, other than minor remodeling, any building or other facility).''.

(b) AMOUNT; DURATION.—Section 2654(c) of the Public Health Service Act (42 U.S.C. 300ff–54(c)) is further amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following:

''(4) AMOUNT AND DURATION OF GRANTS.—

''(A) EARLY INTERVENTION SERVICES.—A grant under paragraph (1)(A) may be made in an amount not to exceed $50,000.

''(B) CAPACITY DEVELOPMENT.—

''(i) AMOUNT.—A grant under paragraph (1)(B) may be made in an amount not to exceed $150,000.

''(ii) DURATION.—The total duration of a grant under paragraph (1)(B), including any renewal, may not exceed 3 years.''.

(c) INCREASE IN LIMITATION.—Section 2654(c)(5) of the Public Health Service Act (42 U.S.C. 300ff–54(c)(5)), as redesignated by subsection (b), is amended by striking ''1 percent'' and inserting ''5 percent''.

SEC. 313. AUTHORIZATION OF APPROPRIATIONS.

Section 2655 of the Public Health Service Act (42 U.S.C. 300ff–55) is amended by striking ''in each of'' and all that follows and inserting ''for each of the fiscal years 2001 through 2005.''.

Subtitle C—General Provisions

SEC. 321. PROVISION OF CERTAIN COUNSELING SERVICES.

Section 2662(c)(3) of the Public Health Service Act (42 U.S.C. 300ff–62(c)(3)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''counseling on—'' and inserting ''counseling—'';

(2) in each of subparagraphs (A), (B), and (D), by inserting ''on'' after the subparagraph designation; and

(3) in subparagraph (C)—

(A) by striking ''(C) the benefits'' and inserting ''(C)(i) that explains the benefits''; and

(B) by inserting after clause (i) (as designated by subparagraph (A) of this paragraph) the following clause:

''(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV;

SEC. 322. ADDITIONAL REQUIRED AGREEMENTS.

Section 2664(g) of the Public Health Service Act (42 U.S.C. 300ff–64(g)) is amended—

(1) in paragraph (3)—

(A) by striking ''7.5 percent'' and inserting ''10 percent''; and

(B) by striking ''and'' after the semicolon at the end;

(2) in paragraph (4), by striking the period and inserting ''; and''; and

(3) by adding at the end the following paragraph:

''(5) the applicant will provide for the establishment of a quality management program to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and that improvements in the access to and quality of medical services are addressed.''.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

Subtitle A—Certain Programs for Research, Demonstrations, or Training

SEC. 401. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

Section 2671 of the Public Health Service Act (42 U.S.C. 300ff–71) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking subparagraphs (C) and (D) and inserting the following:

''(C) The applicant will demonstrate linkages to research and how access to such research is being offered to patients.''; and

(B) by striking paragraphs (3) and (4);

(2) in subsection (g), by adding at the end the following: ''In addition, the Secretary, in coordination with the Director of such Institutes, shall examine the distribution and availability of appropriate HIV-related research projects with respect to grantees under subsection (a) for purposes of enhancing and expanding HIV-related research, especially within communities that are underrepresented with respect to such projects.'';

(3) in subsection (f)—

(A) by striking the subsection heading and designation and inserting the following:

''(f) ADMINISTRATION.—

''(1) APPLICATION.—''; and

(B) by adding at the end the following paragraph:

''(2) QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a quality management program.''; and

(4) in subsection (j), by striking ''1996 through 2000'' and inserting ''2001 through 2005''.

SEC. 402. AIDS EDUCATION AND TRAINING CENTERS.

(a) SCHOOLS; CENTERS.—

(1) IN GENERAL.—Section 2692(a)(1) of the Public Health Service Act (42 U.S.C. 300ff–111(a)(1)) is amended—

(A) in subparagraph (A)—

(i) by striking ''training'' and inserting ''to train'';

(ii) by striking ''and including'' and inserting '', including''; and

(iii) by inserting before the semicolon the following: '', and including (as applicable to the type of health professional involved), prenatal and other gynecological care for women with HIV disease'';

(B) in subparagraph (B), by striking ''and'' after the semicolon at the end;

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

(D) by adding at the end the following:

''(D) to develop protocols for the medical care of women with HIV disease, including prenatal and other gynecological care for such women.''.

(2) DISSEMINATION OF TREATMENT GUIDELINES; MEDICAL CONSULTATION ACTIVITIES.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue and begin implementation of a strategy for the dissemination of HIV treatment information to health care providers and patients.

(b) DENTAL SCHOOLS.—Section 2692(b) of the Public Health Service Act (42 U.S.C. 300ff–111(b)) is amended—

(1) by amending paragraph (1) to read as follows:

''(1) IN GENERAL.—

''(A) GRANTS.—The Secretary may make grants to dental schools and programs described in subparagraph (B) to assist such schools and programs with respect to oral health care to patients with HIV disease.

''(B) ELIGIBLE APPLICANTS.—For purposes of this subsection, the dental schools and programs referred to in this subparagraph are dental schools and programs that were described in section 777(b)(4)(B) as such section was in effect on the day before the date of enactment of the Health Professions Education Partnerships Act of 1998 (Public Law 105–392) and in addition dental hygiene programs that are accredited by the Commission on Dental Accreditation.'';

(2) in paragraph (2), by striking ''777(b)(4)(B)'' and inserting ''the section referred to in paragraph (1)(B)''; and

(3) by inserting after paragraph (4) the following paragraph:

''(5) COMMUNITY-BASED CARE.—The Secretary may make grants to dental schools and programs described in paragraph (1)(B) that partner with community-based dentists to provide oral health care to patients with HIV disease in unserved areas. Such partnerships shall permit the training of dental students and residents and the participation of community dentists as adjunct faculty.''.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) SCHOOLS; CENTERS.—Section 2692(c)(1) of the Public Health Service Act (42 U.S.C. 300ff–111(c)(1)) is amended by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

(2) DENTAL SCHOOLS.—Section 2692(c)(2) of the Public Health Service Act (42 U.S.C. 300ff–111(c)(2)) is amended to read as follows:

''(2) DENTAL SCHOOLS.—

''(A) IN GENERAL.—For the purpose of grants under paragraphs (1) through (4) of subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(B) COMMUNITY-BASED CARE.—For the purpose of grants under subsection (b)(5), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

Subtitle B—General Provisions in Title XXVI

SEC. 411. EVALUATIONS AND REPORTS.

Section 2674(c) of the Public Health Service Act (42 U.S.C. 300ff–74(c)) is amended by striking ''1991 through 1995'' and inserting ''2001 through 2005''.

SEC. 412. DATA COLLECTION THROUGH CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–71 et seq.) is amended—

(1) by redesignating section 2675 as section 2675A; and

(2) by inserting after section 2674 the following section:

''SEC. 2675. DATA COLLECTION.

''For the purpose of collecting and providing data for program planning and evaluation activities under this title, there are authorized to

be appropriated to the Secretary (acting through the Director of the Centers for Disease Control and Prevention) such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorization of appropriations is in addition to other authorizations of appropriations that are available for such purpose.''.

SEC. 413. COORDINATION.

Section 2675A of the Public Health Service Act, as redesignated by section 412 of this Act, is amended—

(1) by amending subsection (a) to read as follows:

''(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Health Care Financing Administration coordinate the planning, funding, and implementation of Federal HIV programs to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for support.'';

(2) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively;

(3) by inserting after subsection (b) the following subsection:

''(b) REPORT.—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease.''; and

(4) in each of subsections (c) and (d) (as redesignated by paragraph (2) of this section), by inserting ''and prevention services'' after ''continuity of care'' each place such term appears.

SEC. 414. PLAN REGARDING RELEASE OF PRISONERS WITH HIV DISEASE.

Section 2675A of the Public Health Service Act, as amended by section 413(2) of this Act, is amended by adding at the end the following subsection:

''(e) RECOMMENDATIONS REGARDING RELEASE OF PRISONERS.—After consultation with the Attorney General and the Director of the Bureau of Prisons, with States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary, consistent with the coordination required in subsection (a), shall develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease as of the date on which the individuals were released from the custody of the penal system. The Secretary shall submit the plan to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.''.

SEC. 415. AUDITS.

Part D of title XXVI of the Public Health Service Act, as amended by section 412 of this Act, is amended by inserting after section 2675A the following section:

''SEC. 2675B. AUDITS.

''For fiscal year 2002 and subsequent fiscal years, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.''.

SEC. 416. ADMINISTRATIVE SIMPLIFICATION.

Part D of title XXVI of the Public Health Service Act, as amended by section 415 of this Act, is amended by inserting after section 2675B the following section:

''SEC. 2675C. ADMINISTRATIVE SIMPLIFICATION REGARDING PARTS A AND B.

''(a) COORDINATED DISBURSEMENT.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for coordinating the disbursement of appropriations for grants under part A with the disbursement of appropriations for grants under part B in order to assist grantees and other recipients of amounts from such grants in complying with the requirements of such parts. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

''(b) BIENNIAL APPLICATIONS.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall make a determination of whether the administration of parts A and B by the Secretary, and the efficiency of grantees under such parts in complying with the requirements of such parts, would be improved by requiring that applications for grants under such parts be submitted biennially rather than annually. The Secretary shall submit such determination to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

''(c) APPLICATION SIMPLIFICATION.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for simplifying the process for applications under parts A and B. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.''.

SEC. 417. AUTHORIZATION OF APPROPRIATIONS FOR PARTS A AND B.

Section 2677 of the Public Health Service Act (42 U.S.C. 300ff–77) is amended to read as follows:

''SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

''(a) PART A.—For the purpose of carrying out part A, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(b) PART B.—For the purpose of carrying out part B, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE V—GENERAL PROVISIONS

SEC. 501. STUDIES BY INSTITUTE OF MEDICINE.

(a) STATE SURVEILLANCE SYSTEMS ON PREVALENCE OF HIV.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study to provide the following:

(1) A determination of whether the surveillance system of each of the States regarding the human immunodeficiency virus provides for the reporting of cases of infection with the virus in a manner that is sufficient to provide adequate and reliable information on the number of such cases and the demographic characteristics of such cases, both for the State in general and for specific geographic areas in the State.

(2) A determination of whether such information is sufficiently accurate for purposes of formula grants under parts A and B of title XXVI of the Public Health Service Act.

(3) With respect to any State whose surveillance system does not provide adequate and reliable information on cases of infection with the virus, recommendations regarding the manner in which the State can improve the system.

(b) RELATIONSHIP BETWEEN EPIDEMIOLOGICAL MEASURES AND HEALTH CARE FOR CERTAIN INDIVIDUALS WITH HIV DISEASE.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study concerning the appropriate epidemiological measures and their relationship to the financing and delivery of primary care and health-related support services for low-income, uninsured, and under-insured individuals with HIV disease.

(2) ISSUES TO BE CONSIDERED.—The Secretary shall ensure that the study under paragraph (1) considers the following:

(A) The availability and utility of health outcomes measures and data for HIV primary care and support services and the extent to which those measures and data could be used to measure the quality of such funded services.

(B) The effectiveness and efficiency of service delivery (including the quality of services, health outcomes, and resource use) within the context of a changing health care and therapeutic environment, as well as the changing epidemiology of the epidemic, including determining the actual costs, potential savings, and overall financial impact of modifying the program under title XIX of the Social Security Act to establish eligibility for medical assistance under such title on the basis of infection with the human immunodeficiency virus rather than providing such assistance only if the infection has progressed to acquired immune deficiency syndrome.

(C) Existing and needed epidemiological data and other analytic tools for resource planning and allocation decisions, specifically for estimating severity of need of a community and the relationship to the allocations process.

(D) Other factors determined to be relevant to assessing an individual's or community's ability to gain and sustain access to quality HIV services.

(c) OTHER ENTITIES.—If the Institute of Medicine declines to conduct a study under this section, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

(d) REPORT.—The Secretary shall ensure that—

(1) not later than three years after the date of the enactment of this Act, the study required in subsection (a) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress; and

(2) not later than two years after the date of the enactment of this Act, the study required in subsection (b) is completed and a report describing the findings made in the study is submitted to such committees.

SEC. 502. DEVELOPMENT OF RAPID HIV TEST.

(a) EXPANSION, INTENSIFICATION, AND COORDINATION OF RESEARCH AND OTHER ACTIVITIES.—

(1) IN GENERAL.—The Director of NIH shall expand, intensify, and coordinate research and other activities of the National Institutes of Health with respect to the development of reliable and affordable tests for HIV disease that can rapidly be administered and whose results can rapidly be obtained (in this section referred to a ''rapid HIV test'').

(2) REPORT TO CONGRESS.—The Director of NIH shall periodically submit to the appropriate

committees of Congress a report describing the research and other activities conducted or supported under paragraph (1).

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(b) PREMARKET REVIEW OF RAPID HIV TESTS.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention and the Commissioner of Food and Drugs, shall submit to the appropriate committees of the Congress a report describing the progress made towards, and barriers to, the premarket review and commercial distribution of rapid HIV tests. The report shall—

(A) assess the public health need for and public health benefits of rapid HIV tests, including the minimization of false positive results through the availability of multiple rapid HIV tests;

(B) make recommendations regarding the need for the expedited review of rapid HIV test applications submitted to the Center for Biologics Evaluation and Research and, if such recommendations are favorable, specify criteria and procedures for such expedited review; and

(C) specify whether the barriers to the premarket review of rapid HIV tests include the unnecessary application of requirements—

(i) necessary to ensure the efficacy of devices for donor screening to rapid HIV tests intended for use in other screening situations; or

(ii) for identifying antibodies to HIV subtypes of rare incidence in the United States to rapid HIV tests intended for use in screening situations other than donor screening.

(c) GUIDELINES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.—Promptly after commercial distribution of a rapid HIV test begins, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish or update guidelines that include recommendations for States, hospitals, and other appropriate entities regarding the ready availability of such tests for administration to pregnant women who are in labor or in the late stage of pregnancy and whose HIV status is not known to the attending obstetrician.

TITLE VI—EFFECTIVE DATE

SEC. 601. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect October 1, 2000, or upon the date of the enactment of this Act, whichever occurs later.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from New York (Mr. RANGEL) each will control 20 minutes.

The Chair recognizes the gentleman from Oklahoma (Mr. COBURN).

GENERAL LEAVE

Mr. COBURN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material on H.R. 4807, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to make a statement. We are getting ready to talk a bill that will spend $7.1 billion over the next 5 years. We have 32 minutes to do it in; that is about $215 million a minute as we talk. I think it is unconscionable that we are doing this at this time at night, where the American public cannot see the extent of this epidemic and the problems we have facing it, the way the epidemic has moved into our minority communities, unfortunately, and in a greater rate than in any other communities, and that we are not going to put the resources that are necessarily needed to address that.

Mr. Speaker, I would just make that point; that this is the wrong time of the evening for us to be doing this. I stand here embarrassed that we are not going to be able to have an opportunity to educate the American public about the needs that are addressed in this bill.

Mr. Speaker, first of all, we need to recognize Jeanne White and the loss that she had and her vigor and desire to bring forward a bill to care for people with HIV. We have spent a lot of money in this country already, some of it very successfully, some of it not very successfully; but we have with this bill made some very significant major changes in this legislation.

In 1988, a Presidential commission made recommendations to the Congress and to the Government on what we should do. One of the things that they described in that report is the importance that should be placed on prevention. We have heard our grandmoms tell us for years that an ounce of prevention is worth a pound of cure.

□ 2330

We know that. And I am very thankful for the gentleman from California (Mr. WAXMAN) and his staff as we have been able to work together and with others on the other side of the aisle to bring to the body this bill. Again, I think it is very unfortunate that we, in fact, are doing this at this time.

There are several other components to the bill that we will discuss as we proceed through it.

Mr. Speaker, I include the report referred to earlier.

REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

Submitted to The President of the United States, June 24, 1988

Commissioners: Admiral James D. Watkins, Chairman, United States Navy (Retired); Colleen Conway-Welch, Ph.D.; John J. Creedon; Theresa L. Crenshaw, M.D.; Richard M. Devos; Kristine M. Gebbie, R.N., M.N.; Burton James Lee III, M.D.; Frank Lilly, Ph.D.; His Eminence John Cardinal O'Connor; Beny J. Primm, M.D.; Representative Penny Pullen; Cory Servaas, M.D.; William B. Walsh, M.D.

EXECUTIVE SUMMARY

The Human Immunodeficiency Virus (HIV) epidemic will be a challenging factor in American life for years to come and should be a concern to all Americans. Recent estimates suggest that almost 500,000 Americans will have died or progressed to later stages of the disease by 1992.

Even this incredible number, however, does not reflect the current gravity of the problem. One to 1.5 million Americans are believed to be infected with the human immunodeficiency virus but are not yet ill enough to realize it.

The recommendations of the Commission seek to strike a proper balance between our obligation as a society toward those members of society who have HIV and those members of society who do not have the virus. To slow or stop the spread of the virus, to provide proper medical care for those who have contracted the virus, and to protect the rights of both infected and non-infected persons requires a careful balancing of interests in a highly complex society.

Knowledge is a critical weapon against HIV—knowledge about the virus and how it is transmitted, knowledge of how to maintain one's health, knowledge of one's own infection status. It is critical too that knowledge lead to responsibility toward oneself and others. It is the responsibility of all Americans to become educated about HIV. It is the responsibility of those infected not to infect others. It is the responsibility of all citizens to treat those infected with HIV with respect and compassion. All individuals should be responsible for their actions and the consequences of those actions.

The urgency and breadth of the nation's HIV research effort is without precedent in the history of the Federal Government's response to an infectious disease crisis. However, we are a long way from all the answers. The directing of more resources toward managing this epidemic is critical; equally important is the judicious use of those resources.

The term ''AIDS'' is obsolete. ''HIV infection'' more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic. Federal and state data collection efforts must now be focused on early HIV reports, while still collecting data on symptomatic disease.

Early diagnosis of HIV infection is essential, not only for proper medical treatment and counseling of the infected person but also for proper follow-up by the public health authorities. HIV infection, like other chronic conditions—heart disease, high blood pressure, diabetes, cancer—can be treated more effectively when detected early. Therefore, HIV tests should be offered regularly by health care providers in order to increase the currently small percentage of those infected who are aware of the fact and under appropriate care. Since many manifestations of HIV are treatable, those infected should have ready access to treatment for the opportunistic infections which often prove fatal for those with HIV.

Better understanding of the true incidence and prevalence of HIV infection is critical and can be developed only through careful accumulation of data from greatly increased testing. Quality assured testing should be easily accessible, confidential, voluntary, and associated with appropriate counseling and care services. At the present time, a relatively small percentage of those infected with HIV are aware of their infected status.

Some preventive measures must be undertaken immediately.

Public health authorities across the United States must begin immediately to institute confidential partner notification, the system by which intimate contacts of persons carrying sexually transmitted diseases, including HIV, are warned of their exposure.

The HIV epidemic has highlighted several ethical considerations and responsibilities, including:

the responsibility of those who are HIV-infected not to infect others;

the responsibility of the health care community to offer comprehensive and compassionate care to all HIV-infected persons; and

the responsibility of all citizens to treat HIV infected persons with respect and compassion.

The Commission believes that if the recommendations in this report are fully implemented, we will have achieved the delicate balance between the complex needs and responsibilities encountered throughout our society when responding to the HIV epidemic.

MODELING HIV INFECTION

Disease surveillance began early in the epidemic, before the human immunodeficiency virus (HIV) had been identified or isolated, and before it was known that there could be a lengthy period of infection prior to illness. Because at that time it was possible to identify only those individuals in whom disease are far enough advanced to be symptomatic, monitoring the epidemic meant monitoring disease, rather than monitoring infection. The early concentration on the clinical manifestation of AIDS has had the unintended effect of misleading the public as to the extent of the infection in the population, from initial infection to sero-conversion, to an antibody positive asymptomatic stage to initial indicative symptoms to full-blown AIDS. Continued emphasis on AIDS has also impeded long-term planning efforts necessary to effectively allocate resources for prevention and health care. Decisions on who will receive care, and whose costs will be covered, focused only on those most seriously ill. Continuing to use only the term ''AIDS'' to make treatment, reimbursement, or prevention program decisions is anachronistic and a policy we can no longer afford.

While it is of value to continue monitoring diagnosed AIDS cases, public policy and prevention efforts should be based on an understanding of the extent and distribution of HIV in the population and on the rate at which new infections occur. This is especially critical in dealing with HIV, for which the average length of time between infection and diagnosis is at least eight years, according to the Institute of Medicine.

It is critical that CDC begin now to collect HIV infection data from the states, not just case reports.

The success of any disease or infection surveillance effort is dependent upon coordination at the national, state, and local levels and the sharing of resources and expenses.

The public health profession has a long tradition of respectful, confidential handling of sensitive data and of affected persons; those currently holding public health posts and should be striving to build public confidence by stressing the profession's traditional adherence to this standard.

Until CDC changes the focus of data collection from diagnosed AIDS cases to HIV infections, effectiveness of planning and intervention will be limited.

As of March 1988, CDC acknowledged that a precise statement of the prevalence and rate of spread of HIV infection in the general population is still not available. Most analysts concur with CDC that, based on presently available data, the best estimate of seroprevalence is one million, with a range of up to 1.5 million. Repeatedly, witnesses before the Commission agreed that every reasonable effort should be made to increase the precision of this number, and of the rate of infection within specific population groups.

OBSTACLES TO PROGRESS

The Commission has identified the following obstacles to a nationwide effort to improve the public's response to and participation in programs designed to quantify the HIV epidemic at the federal, state and local levels:

Continued focus on the label ''AIDS,'' contributing to lack of understanding of the importance of HIV infection as the more significant element for taking control of the epidemic.

Lack of strong CDD leadership in the public health community for obtaining and coordinating HIV infection data.

Inadequate counseling resources to assist those tested makes many support and interest groups reluctant to recommend widespread HIV testing.

RECOMMENDATIONS

To respond to these obstacles, the Commission recommends the following:

The Centers for Disease Control must provide clear direction for expanded and improved surveillance, including endorsement and support by national leaders, other federal agencies, and state and local leaders.

States should require reporting of HIV infections. This information should be given to the Centers for Disease Control in appropriate form for statistical analysis, without identifiers.

WOMEN WITH HIV INFECTION

With little exception, HIV research and programs have focused exclusively on homosexual men and intravenous drug users. As a result, there is limited information about the course of HIV infection in women. Diagnosis of AIDS in women may be late or less accurate because the natural history of infection in women is so poorly understood to date. There is some evidence to suggest that it differs from men. The problem of women with HIV infection is particularly important because it is directly linked to the rapid growth of the pediatric AIDS population.

The greatest number of AIDS cases among women occur in the black and Hispanic populations. Of all cases of AIDS in women, 51 percent are black, and 20 percent are Hispanic. The routes of viral transmission are the same for women as for men, but in women, HIV infection occurring directly from intravenous drug use, and through heterosexual contact with an infected man rank first and second, respectively.

One of the most serious problems facing the HIV-infected mother is the guilt she may feel after giving birth to an infected child, her despair as she watches that child die, or her anguish, knowing that after her own imminent death, she will leave children behind.

MINORITIES

The impact of HIV infection on black and Hispanic communities has been felt very strongly; individuals from these groups comprise about 40 percent of all persons with symptomatic HIV infection.

Leadership is critically needed from major national minority organizations and from churches in minority communities.

PARTNER NOTIFICATION

Both public health practice and case law makes clear that persons put at risk of exposure to an infectious disease should be alerted to their exposure. The Commission believes that there should be a process in place in every state by which the official state health agency is responsible for assuring that those persons put unsuspectingly at risk for HIV infection are notified of that exposure. Such a process will enable that agency to work with the infected individual and the patient's primary health care provider to assure that contacts are notified of their exposure and urged to take advantage of the opportunity for testing and counseling.

When interviewed appropriately, any person infected should be able to identify one or more persons from whom the infection may have come or to whom it may have been given. There are options for contacting those persons and ensuring that they, too, are aware of their risks. Those options include patient-managed referral and professional-assisted referral (with notification by an individual's health care provider or with notification by the health department).

As an example, consider the women who has been married for 30 years to a man who, unknown to her, is a bisexual, or the person who believes he or she is involved in a completely monogamous marriage when, in fact, his or her spouse has been having sex with others. These people are completely ignorant of their exposure to the virus and would probably remain so until either their spouse, their child, or they, themselves, developed the clinical symptoms of AIDS. The Commission firmly believes in these individuals' right to be notified of their possible exposure so that they can seek prompt medical attention and avoid potentially exposing others.

RECOMMENDATIONS

The public health department has an obligation to ensure that any partners are aware of their exposure to the virus.

Mr. Speaker, I reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. BROWN of Ohio. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore (Mr. TANCREDO). The gentleman will state it.

Mr. BROWN of Ohio. Mr. Speaker, the gentleman from Oklahoma (Mr. COBURN) implied that we had less than 20 minutes per side. How much time do we have?

The SPEAKER pro tempore. The gentleman from Oklahoma was recognized for 20 minutes.

Without objection, the gentleman from Ohio (Mr. BROWN) is recognized for 20 minutes.

There was no objection.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Oklahoma (Mr. COBURN) complained about the lateness of the hour, and all of us concur with that. An issue as important as this was scheduled literally last among 35 suspensions. We are behind tonight naming post offices, regarding celebrating anniversaries; we are after our sense of Congress resolution regarding the importance of families eating together, something we all support, but a Congressional resolution for that; recognizing the importance of children in the U.S. We obviously recognize that. But to put all of that before this, it is again the sort of do-nothing Republican leadership in Congress that makes these decisions to schedule bills as important as this that we bipartisanly agree on finally after negotiations to put this bill last.

It is clearly not the way this Congress should operate. We should be doing this during the day when Members of Congress are awake and in this Chamber and watching from their offices. Instead we are doing a very, very important bill, the Ryan White CARE Act, in literally the middle of the night. Mr. Speaker, I think none of us approve of that kind of lack of leadership by Republicans in this Chamber.

I want to commend the gentleman from Oklahoma (Mr. COBURN) for his work; the gentleman from California (Mr. WAXMAN) for his work; Roland Foster, in the office of the gentleman from Oklahoma (Mr. COBURN); Paul Kim, in the office of the gentleman from California (Mr. Waxman); and Ellie Dehoney, in my office, for their exceptional work on this legislation.

The battle against HIV/AIDS is more than a medical challenge, although that challenge alone is overwhelming. It is a battle against ignorance, against intolerance, against apathy. It is a battle against isolation, against alienation, against despair. It is a battle against time, it is international, and it is down the street. AIDS is set to kill more people worldwide than World War I, World War II, the Korean War, and the Vietnam War combined.

The Ryan White CARE Act responds to HIV/AIDS, not just as a public health crisis, but as a threat to the stability and cohesiveness of communities and the rights of individuals. It fights the medical epidemic with prevention and with treatment. It fights ignorance, it fights intolerance, it fights apathy with awareness, commitment and compassion, and it fights alienation, isolation and despair by engaging communities in a focus that emphasizes living with HIV/AIDS, not dying with it.

The act was created in the memory of Ryan White, a young teenager who became a national hero in this fight. He was a hemophiliac and contracted HIV through a bad blood transfusion, but Ryan White fought against ignorance, fear and prejudice on behalf of all individuals with HIV/AIDS.

Ryan White died on April 8, 1990, at the age of 18. Ten years later the law named after him carries on his legacy. The Ryan White CARE Act has made a tremendous difference in the lives of people living with HIV/AIDS.

In my district, which includes much of Ohio's only title I eligible metropolitan area, Ryan White programs provide primary care and support services and the kinds of medication that contain HIV/AIDS into a chronic, rather than an acute illness. There is more to do and Ryan White will continue to play a pivotal role.

In Ohio, while AIDS deaths have declined, the incidence of HIV/AIDS has increased dramatically. After declining steadily, the incidence among young gay males is on the rise. HIV/AIDS is expanding into new populations, while continuing to spread in those populations originally at risk.

Prevention is vital, treatment is vital, The Ryan White programs are vital.

Mr. Speaker, I ask for passage of this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. COBURN. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Maryland (Mrs. MORELLA).

Mrs. MORELLA. Mr. Speaker, I thank the gentleman for yielding me time. I thank the gentleman particularly for his leadership on this issue. We have always been very fortunate in this House to have his expertise.

I want to commend the gentleman from California (Mr. WAXMAN), the gentleman from Ohio (Mr. BROWN), and others, including the staff who have worked very hard on this.

I do agree, this is one of the most important measures that we will be voting on. It has made a difference, it will continue to make a tremendous difference, and the need is now greater than ever. I urge my colleagues obviously to support this bill, H.R. 4807, unanimously.

What the bill does is it reauthorizes and enhances care and treatment programs vital to the health and survival of Americans with HIV and AIDS. HIV/AIDS is not a disease that discriminates. It touches all. In fact, my State of Maryland is now known as one of the top ten states and territories reporting the highest number of AIDS cases. This is in part due to the pandemic growth of HIV and AIDS in rural areas and how AIDS is disproportionately affecting women, youth and communities of color.

This is a good bill. It has strong bipartisan support. Our States need this bill to be passed. Women need it, our youth need it; yes, all Americans need it. I urge strong support of this measure.

Mr. BROWN of Ohio. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. WAXMAN), the author of the first Ryan White Act a decade or so ago.

Mr. WAXMAN. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I want to commend the leadership of the House, the Republican leaders of the House for scheduling this bill. While it is 11:36 in Washington, it is only 8:36 in California.

Mr. Speaker, I rise also to urge my colleagues to support H.R. 4807. As the original author of the Ryan White CARE Act and the coauthor of H.R. 4807, I am pleased that this consensus bill is before the House today. With more than 250 bipartisan cosponsors and being reported by voice vote from committee, H.R. 4807 should be acted on expeditiously by the House.

Since we last authorized the CARE Act in 1996, there has been dramatic progress in treating AIDS, but there is still much more to be done. There are new treatments, but there still is no cure. There are fewer deaths, but no new HIV infections and dangerous complacency are on the rise, and the treatment gap grows wider every day for the poor and communities of color.

This is why the CARE Act is so important. Its reauthorization is crucial to the lives and health of hundreds of thousands of Americans, and it is essential that we refine and expand the CARE Act to respond to the epidemic's growing impact on women and adolescents.

H.R. 4807 preserves the structure of the original law and enhances its funding, but it also focuses on services for reaching individuals with HIV and AIDS who are not in care, eliminating disparities in services and access and helping historically underserved communities.

The legislation also begins to shift Ryan White funding to the HIV infected population, not just individuals with AIDS. This is an important transition which will occur when reliable data on HIV prevalence is available, and it is an important transition because we need to find the people who are HIV infected, because with appropriate treatment perhaps many of them can be helped not to develop full-blown AIDS.

The bill will also give priority to communities in severe need of supplemental funds. As HRSA Administrator Claude Fox testified, ''These efforts, building on the current CARE Act, will significantly improve access to important health services for low-income, underinsured, and uninsured persons with HIV.''

The bill also expands the perinatal HIV grant program to $30 million, with an increasing set aside for States with mandatory newborn testing laws. While I do not share the belief that this set aside is necessary, I am pleased that Dr. Fox confirmed that the program will greatly increase the funds available to help end the transmission of HIV to newborns.

The bill also enhances public participation in CARE Act programs and prevention efforts at the Federal, State and local levels, and adopts many important provisions in from the Senate bill.

I want to applaud the gentleman from Oklahoma (Dr. COBURN) for his cooperation on authoring this consensus bill, and acknowledge the contributions of the many community organizations to the legislation.

I want to thank the staff for their hard work, Roland Foster, Paul Kim, Karen Nelson, Marc Wheat, John Ford, Brent Delmonte, and Pete Goodloe.

Mr. Speaker, our friends and colleagues are right, this is an important bill, and I urge full support for it.

Mr. Speaker, I rise in support of H.R. 4807 and urge my colleagues to support the bill.

As the original author of the Ryan White CARE Act and the co-author of H.R. 4807, I am pleased that this consensus legislation is before the House today.

The bill has more than 250 bipartisan cosponsors and was reported by voice vote by the Commerce Committee. The Senate has already acted on its own bill, and H.R. 4807 should be acted on expeditiously by the House.

BACKGROUND ON THE CARE ACT

Mr. Speaker, until 1990, it was volunteers, cities and States who carried the burden of care in the AIDS epidemic—not the Federal government. Enacting the Ryan White CARE Act into law was our government's overdue response to the AIDS crisis, providing urgently needed care to tens of thousands of Americans living with AIDS.

Since we last reauthorized the CARE Act in 1996, there has been dramatic progress in

treating AIDS. Lives have been extended and hope has been renewed. Deaths from AIDS have declined in our country.

But while progress has been made, progress must also be measured by the length of the road ahead. There are treatments, but there is still no cure. There are fewer deaths, but new HIV infections and a dangerous complacency are on the rise.

The epidemic is reaching into every community and every State in America. The treatment gap is growing wider than ever for the poor and for communities of color. And worldwide, the epidemic has killed 18 million people, orphaned millions of children and devastated entire countries.

This is why the CARE Act is so important. The CARE Act is the foundation of our country's response to the AIDS epidemic. Its reauthorization is crucial to the lives and health of hundreds of thousands of Americans. And as AIDS increasingly threatens women, adolescents and our communities of color, it is essential that we refine and expand the CARE Act to respond to these changes in the epidemic.

WHAT H.R. 4807 DOES

Today, the CARE Act provides early intervention services to prevent infection and to forestall illness in those who are infected. It furnishes medicines and outpatient and home health services to those who are ill. And the Act gives direct assistance to States and to the cities hardest hit by the epidemic.

H.R. 4807 preserves the structure of the CARE Act and enhances its funding. But it focuses services for the first time on—reaching individuals with HIV and AIDS who are not in care; eliminating disparities in services and access; and helping historically underserved communities.

The legislation also begins to shift Ryan White funding and services towards the HIV-infected population, not just individuals with AIDS. This is an important transition, and will mean a more equitable and accurate allocation of funds in relation to the demographics of the epidemic. But it will only occur when the Secretary determines that adequate and reliable data on HIV prevalence is available from all States and cities.

The bill also addresses disparities in care through the Title I supplemental funds and a newly created Title II supplemental. Communities and cities in ''severe need'' of additional resources will be given increased priority for these funds, so that all underserved areas—rural or urban—may better serve their patients.

These and other provisions enhance the responsiveness of the CARE Act to the needs of ethnic and racial minorities, consistent with the intent of the Congressional Black Caucus Minority AIDS Initiative. And as HRSA Administrator Claude Fox testified two weeks ago, ''These efforts, building on the current CARE Act, will significantly improve access to important health services for low-income, underinsured, and uninsured persons with HIV.''

When the Title I formula was modified five years ago, a ''hold harmless'' was added to limit any Eligible Metropolitan Area's (EMA) losses over five years to 5 percent of its Title I formula allocation. Our intention was to provide some time to allow EMAs to prepare for changes in their services and reductions in their funding. While there is broad agreement that the best way to avoid the need for a hold harmless is to increase funding overall to Title I, the funding increases to date unfortunately have not been so great as to render the ''hold harmless'' unnecessary. Now that five years have already passed since the formula was changed, the ''hold harmless'' has been adjusted to ensure greater funding equity in the Title I formula. I am particularly pleased that the Administration has made clear that it is unlikely that any new EMA will make use of such a hold harmless for the next three to four years.

H.R. 4807 also expands an existing grant program to end perinatal HIV transmission to $30 million, with an increasing set-aside for States with mandatory newborn testing laws. While I do not share the belief that this set-aside is necessary, I am pleased that all of the funds will be available for voluntary counseling, testing, treatment and outreach to pregnant mothers, as well as for implementing newborn testing programs. Dr. Fox confirmed two weeks ago that this program will greatly increase the funds available to help end the transmission of HIV to newborns.

This bill enhances public participation in both Title I and Title II, with greater representation of persons living with HIV and AIDS. Title I Planning Council meetings and records are opened to public ''sunshine.'' And we call on States to engage in a more participatory public planning process.

The legislation makes other important reforms. It calls for greater coordination of HIV care and prevention efforts at the Federal, State and local levels—something I have always strongly supported. Patients are entitled to a seamless continuum of HIV prevention and care services from outreach, counseling and testing through to diagnostics, treatment and care.

Finally, H.R. 4807 also adopts many important provisions from the Senate's bill, particularly the authorization of early intervention services in Titles I and II, and the creation of new quality management programs for CARE Act services.

CONCLUSION

I want to applaud Dr. Coburn for his personal commitment to fighting AIDS and his cooperation on the bill. I also want to acknowledge the contributions of the many community organizations that participated in developing this legislation. And I want to thank the staff for their diligence and hard work—Roland Foster, Paul Kim, Karen Nelson, Marc Wheat, John Ford, Brent Delmonte and Pete Goodloe.

Mr. Speaker, I want to conclude by citing my friend and colleague the Minority Leader. Two weeks ago, Mr. GEPHARDT spoke on this floor about AIDS in Africa. He said—

> There has never in the history of the world been a threat to life like this . . . This is the moral issue of our time. I pray that this House and all of our great Representatives will stand and deliver on this, the most important moral issue we will ever face.

Mr. Speaker, our friend and colleague was right. His words hold true the world over.

So I ask my colleagues to commit themselves anew to ending the epidemic. I ask them to support this legislation. And I ask them to dedicate this legislation to the memory of our friends, our family and our countrymen who have died of AIDS.

☐ 2340

MAKING IN ORDER ON LEGISLATIVE DAY OF TODAY CONSIDERATION OF H.R. 4920 UNDER SUSPENSION OF THE RULES

Mr. LAZIO. Mr. Speaker, I ask unanimous consent that the Speaker be authorized to entertain a motion that the House suspend the rules and pass H.R. 4920, as amended, at any time on the present legislative day.

The SPEAKER pro tempore (Mr. TANCREDO). Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. COBURN. Mr. Speaker, I continue to reserve my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. TOWNS), who has been a leader in fighting for health care for the disadvantaged.

Mr. TOWNS. Mr. Speaker, let me begin by first thanking the gentleman from Oklahoma (Mr. COBURN) and, of course, the gentleman from California (Mr. WAXMAN) for bringing this bill forward. It is a very important bill, with the way things are going today in this Nation.

I support the Ryan White CARE Act of 2000. We should pass this legislation, which is so vital to this Nation and its future.

Approximately 19 percent of the AIDS cases are in New York State. That means one in five living with AIDS reside in New York State. There are 8,200 living AIDS cases in Brooklyn, the borough that I represent, alone. Seventy-five percent of the cases are minorities and 25 percent are women.

This is just the beginning. I have yet to talk about the 100,000 people estimated to be living with HIV disease who may or may not know their status.

These numbers are truly staggering, and they show the importance and need of reauthorization of the Ryan White CARE Act.

I will not stand here and say that this bill is perfect because it is not, but it does represent a balance and I congratulate my colleagues again for their creativity and strong leadership. However, I must admit there are some things that I would like to see modified, and let me name them; namely, the hold harmless provision in title I of the bill, which my colleague, the gentlewoman from California (Ms. ESHOO) framed so well during the markup in the full Committee on Commerce. I think the point that she made should have been accepted. All the EMAs should be held harmless and brought up to a higher funding level.

There are many good provisions in this bill. It increases consumer participation on the planning council and ensures that the consumers are representative of the epidemic in that particular area. This change will enable the councils to be proactive when it comes to the disease, and the bill moves in the direction of counting HIV not AIDS cases.

In addition, I would like to highlight the Congressional Black Caucus' AIDS initiative language within the Committee Report. The initiative is intended to be a critical component of the strategy of the Department of Health and Human Services to comprehensively address HIV/AIDS. It focuses on the communities hardest hit by the epidemic, and that is the most effective way to tackle the problem. Therefore, I urge my colleagues to support this act.

Mr. COBURN. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I also have a chart I want to show. Firstly, I thank the gentleman from New York (Mr. TOWNS) for his support of the bill and his fair criticism of what he sees as maybe a problem in funding disparities. However, I would tell him that the concerns of the State of New York were really of title II in this bill and not title I, and we changed that funding formula to meet the concerns of the State of New York.

I also would point out, as he can see on a cost adjusted basis, that the State of New York on a basis of a per AIDS case gets approximately $1,900 less per individual in New York City than somebody in San Francisco, and the whole disparity that we are trying to address is not to harm San Francisco but is to make an equalization for those in New York City that they might have an increase in funds.

The gentleman from New York (Mr. TOWNS) also made the statement that probably our problem is that there is just not enough money here, and I would probably tend to agree with him, that that is the base problem.

The other thing that I want to correct in his statement is there are 350,000, at least 350,000 in this country today that are infected with HIV that do not know it. It is not 100,000. It is 350,000. There are another 350,000 who have HIV and do know it, and there are another 350,000 who have full-blown AIDS. The problem is, and the reason this bill has moved some direction towards prevention, is we have made no dent in the case of new HIV infections in 7 years in this country.

The fact is that 40,000 this year, 40,000 next year and 40,000 last year and the 2 years before continue to get infected with this virus and that is why this bill is so important, because it redirects us to where the epidemic is, not to where it was.

We still recognize where it was but we want to put the dollars where the epidemic is.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO), who has been an outspoken and tireless advocate on behalf of AIDS patients.

Ms. ESHOO. Mr. Speaker, I thank the ranking member, the gentleman from Ohio (Mr. BROWN) for yielding me this time.

Mr. Speaker, I rise this evening in support of the Ryan White CARE Act because without question it is the most important legislation Congress has ever enacted to provide life-saving and life-enhancing medical care and social services for people living with HIV and AIDS.

It was intended as a safety net for people battling HIV and AIDS and these are really the two cornerstones of the CARE Act, reliability and stability. Yet contained in this bill that is on the floor this evening is a provision that I and others believe runs contradictory to that safety net principle. Under existing law, an eligible metropolitan area, we call them EMAs, that is our Federal shorthand, those areas receiving title I funds can lose no more than 5 percent of its funding over a 5-year period. This hold harmless provision was specifically designed to prevent the rapid destabilization of existing systems of care when changes in the title I formula were adopted by Congress in 1996. H.R. 4807 changes this dramatically, allowing an EMA to lose 25 percent of its funding over the same time period.

The result will be a rapid decline in availability and quality of care, particularly in EMAs like San Francisco, where the epidemic has hit the hardest. AIDS advocates and EMAs across the country, not just the Bay Area, not just California but the entire country, including the State of New York, have expressed concern that a 25 percent hold harmless could destabilize the systems of care and undermine the very goals of the act. They fear what we already know in our area, that the 25 percent hold harmless could ironically cause great harm.

I support the Senate approach of 10 percent over 5 years and I urge my colleagues, that will eventually become conferees, to support the Senate language. We want to move ahead with this bill but we need to stay true of the hallmark of the act.

□ 2350

Mr. COBURN. Mr. Speaker, I yield myself 2½ minutes.

Mr. Speaker, the AIDS Action Council, the largest AIDS organization in the United States, supports this funding formula. Let us be clear about that.

Number two is Ryan White title I funds, San Francisco last year received over $35 million. At the end of the year, they had a $7 million balance in their checking account. If we take the growth in title I funds that we have seen in this Congress and the two congresses previously, we are averaging 24 to 29 percent per year increase.

Take a million dollars. Under this hold harmless, at the end of 5 years that means they would have $750,000. But at a growth rate of 24 to 29 percent, what they would actually have is well over a million dollars at the end of that 5 years. So we are into the specifics of talking about a cut when there is no cut.

The fact is there is extreme imbalance in the amount of funding that is going to the EMA in San Francisco versus other areas and it is recognized. This legislation is not intended to hurt San Francisco. I will have a private wager with the gentleman and gentlewomen from California that in 5 years there will be more money under this formula for each of those EMAs than there is today, including San Francisco.

Because, in fact, if we increase something 25 percent per year, at the end of 5 years we will not have 200 percent, we will have about 270 percent. So even with the 25 percent cut, if that would happen, and that is just the potential. I understand my colleagues should be concerned to protect what is already coming in.

The second point that I would make is that the testimony from the GAO clearly said that there is a disparity in the funding. And they clearly said that the foundational factor under which we made that funding was based on what the funding was in 1990, which was evidence of those who had HIV, had AIDS, and had died.

So the base that is used for the San Francisco EMA continues to recognize in its base not people living with HIV, but people who have died from AIDS, people living with AIDS. What our formula will say is if HIV increases in San Francisco, they will get more money. As people live longer, they will get more money. And what we do is to make sure somebody who lives in South Carolina in the rural areas has the same opportunity for care and treatment as somebody in San Francisco.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I too rise in support of H.R. 4807, the Ryan White CARE Act Amendments of 2000. I commend my colleagues, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) for their hard work and their leadership in crafting this legislation which is so important to people with HIV and AIDS and their families.

While this bill is not perfect and needs to be fine-tuned, the product we have before us provides a good framework. One of my major concerns with this legislation remains the funding provided for States which have laws requiring mandatory testing of newborns. I oppose mandatory testing of any subpopulation and I strongly believe that this body must give full consideration to the Institute of Medicine study as it relates to this.

I am encouraged, on the other hand, that H.R. 4807 changes funding formulas to encompass all who are infected with HIV and not just provide resources for individuals who have progressed to AIDS. This amendment responds to the changing nature of the

epidemic and the newer treatment protocols. It allows and enables treatment programs to begin and expand critical prevention efforts and encourages reporting of HIV infections by States which do not now report by infection.

Another major area which is of critical concern to the Congressional Black Caucus Health Brain Trust is the community planning councils, their compensation, effectiveness, and operation.

Mr. Speaker, we are encouraged by this bill's requiring that the local planning bodies and grantees reflect the demographics of the disease, that they conduct surveys to identify the epidemiology of the disease in their areas, and that they target funding to where the disease is most prevalent.

Mr. Speaker, I would be remiss if I did not point out that based on current forecasts through fiscal year 2001, funding for the all-important ADAP program falls more than $1 million short of what will be needed for the many low-income, uninsured, and under-insured Americans with HIV infection or AIDS, putting this country far from where we ought to be in fighting this epidemic.

We in the Caucus, our partners in the Congress, and our communities will remain vigilant in the Nation's fight against the HIV/AIDS crisis. The Ryan White CARE Act is a lifeline to countless Americans infected with this virus and it is our best ammunition in the war against this devastating disease.

Clearly, we in the U.S. Congress cannot wait until this disease mirrors the pandemic in Africa. An enhanced, strengthened, responsive and adequately funded Ryan White CARE Act is absolutely essential. I look forward to working closely with my colleagues in the House and the Senate and in the administration to craft and enact a measure that is responsive to the needs of all Americans, and I ask for my colleagues' support of this important legislation.

Mr. Speaker, I rise in support of H.R. 4807, the Ryan White CARE Act Amendments of 2000, and I commend my colleagues Congressmen TOM COBURN and HENRY WAXMAN for their hard work and leadership in crafting this legislation which is so important to persons with HIV and AIDS and their families.

While, this bill is not perfect and needs to be strengthened and fine-tuned, the product we have before us, provides a framework which can be built upon to develop a more comprehensive and responsive reauthorization measure.

One of my major concerns with this legislation, is the funding provided to states which have laws requiring the mandatory testing of newborns. I oppose mandatory testing of any sub-population, and I strongly believe, that this body must give full consideration to the IOM study as it relates to this issue. Let us seriously review those results and appropriately incorporate the findings in the ''mandatory testing'' provision of this reauthorization measure.

I am encouraged that H.R. 4807 also changes city and state funding formulas to encompass all who are infected with HIV, and not just provide resources for individuals who have progressed to AIDS. This amendment responds to the changing nature of the epidemic and the newer treatment protocols which begin medication earlier. It allows for treatment programs to begin and expand critical prevention efforts. This bill also more effectively represents the burden of the disease and the need for care. In addition, this measure makes a concerted effort to support the fact, that the funding ''needs'' to follow the trends of the disease (which are disproportionately and increasingly affecting people of color).

It also encourages reporting of HIV infections by states (many do not now report). Such adherence to reporting, will improve our ability to be more progressive and get in front of this epidemic by increasing prevention and outreach efforts.

Another major area which is of critical concern to the Congressional Black Caucus and the communities we represent (which are primarily people of color), is the community planning councils, their composition, effectiveness and operations. This process has not worked well for many disenfranchised communities under existing authorization. Community input is essential to effective service provision at the local level. Therefore, we are encouraged by this bill requiring, that the local planning bodies and grantees reflect the demographics of the disease and secondly, that they conduct surveys to identify the epidemiology of the disease in their areas.

Lastly, it directs that they target the funding where the disease is most prevalent. We, in the Caucus and our community partners, will be very vigilant on this issue.

In this regard, I also encourage that African Americans and other people of color be appropriately represented in the clinical trials and investigator pools based on the trends of the disease.

I would be remiss if, I did not say that based on the past epidemiology, and several studies and forecasts, FY 2001 funding for the all important ADAP program falls around $100 million dollars short of what will be needed to provide treatment to those infected.

This dramatic shortfall represents the many low income, uninsured and under-insured Americans who will not receive appropriate care, and further puts this country far from where we need to be in fighting this epidemic and saving the lives of those infected and most at-risk.

We in the Caucus and our partners in the Congress and the communities we serve, remain vigilant in the nation's fight against the HIV/AIDS crisis. The Ryan White Care Act is the life line to countless Americans infected with HIV and AIDS. It is our best ammunition in the war against this devastating disease which is plaguing our nation. Clearly, we in the U.S. Congress, must not wait until this disease begins to mirror the pandemic in Africa. An enhanced, strengthened, responsive and adequately funded Ryan White Care Act is absolutely essential to intensified care, treatment, prevention and outreach.

I look forward to working closely with my colleagues in the House and Senate, and in the Administration to ensure the crafting and enactment of a measure that is responsive to the needs of all Americans. I therefore, ask you to respond positively, and vote for this important legislation.

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I submit for the RECORD a letter from the State of New York on the baby AIDS provision that they have in testing, and also the 1990 Senate Ryan White CARE Act Debate Regarding the Need for HIV Partner Notification.

STATE OF NEW YORK,
DEPARTMENT OF HEALTH,
Albany, NY, February 3, 2000.

Hon. TOM A. COBURN, M.D.,
Member of the Congress, U.S. House of Representatives, Cannon House Office Building, Washington, DC.

DEAR DR. COBURN: I have been asked to reply to your letter of December 20, 1999, to Commissioner Novello on prevention of perinatal HIV transmission. The perinatal HIV prevention program at the New York State Department of Health is a comprehensive program that seeks to address many of the steps in the chain of events leading to an HIV-infected child, as identified by the Institute of Medicine in their 1998 report, ''Reducing the Odds.''

An important initial prevention step in this chain of events is to ensure that all pregnant women are enrolled in prenatal care in the first trimester and ideally, have received preconception care. Significant program resources, including new funding from the Centers for Disease Control and Prevention (CDC) for outreach to high risk women, are directed to this purpose in New York State. In 1997, 10.6 percent of all women (according to birth certificate data) and about 10 percent of HIV positive women in New York State (based on chart reviews) received no prenatal care.

The second step in preventing perinatal transmission is to ensure that all women in prenatal care receive HIV counseling and testing according to the U.S. Public Health Service guidelines. In New York State, regulations adopted in 1996 (10 NYCRR sections 98.2(c), 405.21(c), 751.5(a)) require all regulated prenatal care providers (hospitals, clinics, HMO providers) to provide HIV counseling with a clinical recommendation to test, to all prenatal care patients. Such counseling and recommended testing is the standard of medical care in New York State, even for physicians not practicing in regulated settings. The Commissioner has sent a letter to this effect to all prenatal care physicians in the State. The letter was co-signed by the State Medical Society and the State chapters of professional organizations in pediatrics, obstetrics and family practice. The Department also monitors prenatal HIV counseling and testing rates at all regulated health care providers through review of a sample of prenatal care medical records. These data are fed back to providers and technical assistance is provided to improve delivery of these services.

For women who test HIV positive or are known to be HIV positive during pregnancy, the State has developed a network of specialty providers for perinatal HIV medical care. These providers ensure that each HIV positive pregnant woman has a full evaluation for combination antiretroviral therapy depending on her own health status, prescribe zidovudine (ZDV) according to the PACTG 076 regimen for prevention of perinatal transmission, and make referrals for housing, adherence counseling and other supportive services that these women may need to adhere to therapy. New York Medicaid and the State's AIDS Drug Assistance Program (ADAP) provide reimbursement for pharmaceuticals for women in need so that all women have access to preventive therapy.

The Department, with the help of a panel of expert clinicians, publishes detailed clinical treatment guidelines for antiretroviral therapy and prevention of perinatal transmission, and also funds a network of clinical education providers across the state to train clinicians carrying for HIV positive patients.

In the area of newborn HIV testing, Public Health Law (PHL) 2500-f, signed into law by Governor Pataki in 1996, created an exception for newborn HIV testing to the informed consent requirements for HIV counseling and testing in the HIV Confidentiality Law, PHL Article 27–F. It also directed the Commissioner to develop a comprehensive program for the testing of newborns for HIV. This program is further defined in State regulations (10 NYCRR Subpart 69–1) and has gone through two phases. During the first phase, beginning on February 1, 1997, the Department's Newborn Screening Laboratory began HIV testing of all newborn filter paper specimens submitted for metabolic screening without removing patient identifiers and returning those test results to the birth hospital for transmittal to the pediatrician of record. Prior to that time, blinded HIV newborn testing had been done for epidemiological purposes since the late 1980's, and mothers had been encouraged to receive a copy of their newborn's HIV test result since May 1996 (over 90 percent of mothers consented to receive their newborn's HIV test result in that program).

Universal newborn HIV testing has resulted in the identification of all HIV-exposed births. HIV test results from the newborn testing lab are often not available until two weeks after birth. These results are not timely enough to permit administration of ZDV therapy to prevent HIV transmission, but can be used to counsel women to stop breastfeeding which may prevent some cases of transmission. Newborn testing has allowed hospital and health department staff to ensure that over 98 percent of HIV positive mothers are aware of their HIV status and have their newborns referred for early diagnosis and care of HIV infection. In less than 2 percent of cases have women not been located to receive newborn HIV test results and have their HIV-exposed newborns tested for HIV infection. The Department is in the process of reviewing all pediatric medical records up to 6 months of age for HIV-exposed infants born starting in 1997 to determine the quality of HIV care they are receiving and to document the perinatal HIV transmission rate.

The second phase of the newborn HIV testing program began on August 1, 1999. It added regulatory amendments to Subpart 69–1 to require expedited HIV testing in the hospital delivery setting in cases where an HIV test result from prenatal care is not available. This addition to the newborn testing program was undertaken because of evidence that perinatal HIV transmission may be reduced by initiating ZDV therapy during labor or soon after delivery, even if ZDV was not taken during prenatal care (NEJM 1998;339:1409–1414). Hospitals now screen all women admitted for delivery for HIV test results from prenatal care. If a prenatal HIV test result is not available, the hospital must provide the woman with HIV counseling and expedited testing if she consents. If the mother does not consent to HIV testing of herself, the hospital must perform expedited testing on her newborn immediately after birth under the authority of the comprehensive newborn HIV testing law. Expedited tests must be available as soon as possible, but in no case longer than 48 hours. Provisional data from the initial months of the program show that 32 HIV positive women/newborns were identified for the first time by expedited testing at delivery, permitting early initiation of ZDV in most cases; 12 additional positive cases could have been identified if all hospitals had fully implemented the program, and 17 false positive HIV results occurred. False positive preliminary HIV tests occur because Western blot confirmation of preliminary positive results cannot always be obtained in the 48 hour time period. The Department has encouraged the Food and Drug Administration (FDA) to approve additional rapid HIV tests in the near future to alleviate this problem. A significant benefit of the expedited testing program is that delivery hospitals are now working more closely with their prenatal care providers to ensure that HIV counseling and testing is done at the appropriate time during prenatal care and that the test results make it to the delivery hospital.

Rates of participation in prenatal care in New York State are monitored by review of birth certificate data. These rates have been increasing gradually over recent years. Currently about 80–85 percent of women delivering report first or second trimester prenatal care and about 10.6 percent of women report no or unknown prenatal care. There has been no detectable change in prenatal participation trends through 1997 that might be related to the newborn testing program. Anecdotally, we have not heard of problems in this regard. The analysis is currently being updated through 1998. Prenatal care for HIV positive women is also being examined through review of prenatal charts. Limited numbers of women whose HIV status was identified by newborn testing are being interviewed to see what the impact of newborn testing has been.

Ultimately, the goals of the prenatal HIV prevention program in New York are to reduce prenatal HIV transmission to the lowest possible level through; ensuring access to prenatal care for all pregnant women; ensuring counseling and testing of all women in prenatal care; ensuring that all HIV positive pregnant women are offered and adhere to ZDV therapy and are evaluated themselves for combination therapy and other care needs; ensuring that HIV test information is transferred in a timely way to the anticipated birth hospital; and, conducting expedited testing in the delivery setting for all women/newborns for whom prenatal HIV test results are not available.

Newborn testing will continue to be conducted at the Department's Newborn Screening Laboratory to ensure that all HIV positive newborns are identified and referred to care. The newborn testing data also provide valuable, timely information to monitor the epidemiology of perinatal HIV and prevention efforts.

Thank you for your interest in our program. Please let me know if I can provide any further information.

Sincerely,

GUTHRIE S. BIRKHEAD, M.D., M.P.H.,
Director, AIDS Institute.

1990 SENATE RYAN WHITE CARE ACT DEBATE REGARDING THE NEED FOR HIV PARTNER NOTIFICATION

In May 1990, Senators BARBARA MIKULSKI (D–MD) and TED KENNEDY (D–MA) offered an amendment to the original Ryan White CARE Act which passed unanimously that would have required all states to esstablish HIV reporting and partner notification programs as a condition of receiving federal funds under the CARE Act.

Senator MIKULSKI stated that the addition of this requirement was needed ''to improve this legislation.''[1]

Speaking in support of the amendment, Senator KENNEDY stated that, ''it is difficult to argue against doing the utmost in terms of partner notifications.''[2] Senator KENNEDY compared failing to conduct partner notification to having knowledge that someone's life is endangered and not warning them. ''In a case in which there is a clear and present danger, there is a duty to warn,'' KENNEDY asserted.[3]

Senator ORRIN HATCH (R–UT) advocated for the amendment explaining that ''I do not see how in the world we are going to solve this problem and how we are going to notify people who are in jeopardy of getting AIDS unless we have required contact tracing. . . . Contact tracing is absolutelyessential for the ending of this epidemic.''[4]

Senator William Armstrong (R-CO) praised the inclusion of the Kennedy/Mikulski amendment stating ''I think the Kennedy amendment represents a strong step toward instituting responsible public health measures to slow the spread of this devastating epidemic. The Kennedy amendment, agreed to by voice vote, will ensure that the collection of accurate epidemiological information concerning the incidence of the HIV epidemic, and more importantly will allow those innocent individuals who are unknowingly placed a risk of infection to be notified of their risk.''[5]

Responding to Senator Armstrong's statement, Senator KENNEDY conceded ''we agree with Senator Armstrong that partner notification is an essential tool in the fight against AIDS. . . . In unanimously approving the amendment yesterday, I believe the Senate has done what is responsible and necessary.''[6]

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. PELOSI) who, with the gentleman from California (Mr. WAXMAN) has probably done more to fight HIV/AIDS in this institution.

Ms. PELOSI. Mr. Speaker, I thank the gentleman from Ohio (Mr. BROWN) for yielding me this time, and thank him for mentioning me in the same breath as the gentleman from California (Mr. WAXMAN) on the issue of HIV and AIDS.

The gentleman from California (Mr. WAXMAN), in his remarks, pointed to the provisions of this Ryan White reauthorization bill. The distinguished gentleman from Ohio (Mr. BROWN), the ranking member, talked about the need for it. I wish to associate myself with their remarks.

Mr. Speaker, I also want to associate myself with the remarks of the gentleman from New York (Mr. TOWNS) and the gentlewoman from California (Ms. ESHOO) in their pointing out, regretfully, the hold harmless clause that will not be contained in this bill.

I want to point out a few things, because my City of San Francisco, which I represent, has been mentioned here

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[1] Congressional Record—Senate, May 15, 1990, page 10356.

[2] Congressional Record—Senate, May 15, 1990, page 10364.

[3] Congressional Record—Senate, May 15, 1990, page 10360.

[4] Congressional Record—Senate, May 15, 1990, page 10358.

[5] Congressional Record—Senate, May 16, 1990, page 10718.

[6] Congressional Record—Senate, May 16, 1990, page 10720.

this evening. Yes, we have suffered a great deal over the years from HIV/AIDS. When I came to Washington 13 years ago from California, 13,000 people had died in my district at that point from HIV/AIDS. We have suffered over the years greatly. We do not want any other places to bear that pain.

Working with the gentleman from California (Mr. WAXMAN) in a community-based way, the Ryan White authorization bill was developed with community-based input.

Now, and at the time of the reauthorization a number of years ago, it was not taken into consideration that there would be protease inhibitors which would prolong life. What this bill does is penalizes San Francisco for two reasons. First of all, it does not give value to the work which we do with people who are HIV infected to prevent them from getting full-blown AIDS. Only at that time when they have full-blown AIDS would they be counted in this formula.

Secondly, it again does not take into consideration protease inhibitors, because if they would, then they would recognize that people do live longer and they are not predictably dead as they would have been if we looked back 10 years and project out with the life expectancy.

So what I am saying to my colleagues is support the bill. We must move it along. Please agree with the Senate language. The health director of New York State has said that this bill, the Senate bill, is better for New York than that bill which will do harm to New York and to California.

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would challenge what the gentlewoman from California (Ms. PELOSI) had to say. If my colleagues can see in this chart the nominal funding per AIDS case, and the arguments that she just made do not hold water.

The fact is the 13,000 people she describes, California still is getting money for them. Their funding formula in San Francisco still considers those 13,000. There is nothing in this bill as people are identified with HIV, not AIDS, San Francisco will get more money, not less money.

So the argument that there will be less money attributable to recognition of HIV and what is done in the EMA in San Francisco, it holds no water.

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If one looks at this chart, what one sees is that San Francisco, in real dollars, based on 1999 EMA gets $5,958 per AIDS case. The next closest is $3,132 in Miami, Florida. My colleagues can see all the rest of the red there. The vast majority gets 60 percent or less than San Francisco.

The goal of this bill is not to hurt San Francisco. The goal of the bill is to help those very people who do not have access at anywhere close to the level to the program, the medicines, or any other aspect of the Ryan White CARE funds. This is about fairness. This is not about fairness for a white male in Oklahoma. This is about fairness to an African American or Hispanic female in a rural area or in Baltimore who today does not get the same amount of resources directed to them that is available to somebody in San Francisco. It is not about penalizing. It is about fairness.

Mr. Speaker, I gladly yield to the gentlewoman from California (Ms. PELOSI) for her question.

Ms. PELOSI. Mr. Speaker, I thank the gentleman from Oklahoma for yielding to me.

What I would say is what the gentleman is saying is not accurate. The fact is that we will see a decline. What is a mystery to me is that, while the gentleman is participating in this reauthorization of this very important legislation, maybe the top bill we will do this year, and I commend him all for the emphasis on prevention, because that is very, very important, but why we would not be wanting to help people throughout the country, without penalizing those who are fighting this, at the HIV level instead of waiting until people have a full-blown case of AIDS.

Mr. COBURN. Mr. Speaker, reclaiming my time, we will have to disagree. The facts, they are very obvious. The facts are people with HIV today in this country are not and do not have the same reference to treatment and care based on the funding formula that we have. There is no recognition that we want to and there is no admission that we want anybody to get less treatment, nor will there be.

The fact is that, as the gentlewoman from California very well knows, in the San Francisco EMA, they spent $55,000 of Ryan White CARE money to fund the advocacy of an election in California, an initiative balance that had nothing to do with Ryan White.

So we also know many other things about EMA that I do not think we need to go into here. The facts are that, in San Jose, in the same area that the gentlewoman is, we are seeing $3,000 spent, whereas in the San Francisco EMA, it is $5,900.

So I would respectfully disagree with the gentlewoman from California (Ms. PELOSI).

The last point that I would make, if one has never told somebody they have HIV, if one has never been there to tell them that and then know they are not going to have access, regardless of whatever efforts one has, one cannot imagine the feeling knowing that one just put that person in a position of watching themselves die as we stand by.

So I am not about to want anybody in the San Francisco EMA to have that experience because I have had to tell people that, and I doubt very few others in this body have.

So I object to the fact that the gentlewoman would say that we are interested in withholding care for anybody with this disease. That is not what this debate is about. I understand that is where my colleagues want to take it. That is not what this debate is about.

Mr. Speaker, I yield to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I appreciate the gentleman from Oklahoma yielding to me.

Mr. Speaker, first of all to my colleague, we have had experience with the disease and in my own family. I have held someone in my arms and watched them die from it. So that is enough experience, I think, for anyone.

But what this debate is about is not to say that the gentleman from Oklahoma is an unfair person. We are saying that this funding mechanism hurts an area that deserves the same kind of funding for the people that have HIV and AIDS.

Mr. COBURN. Mr. Speaker, reclaiming my time on that statement to say that that area, that EMA gets twice as much money per person with that than anybody else in the country.

If the gentlewoman can stand and defend that while people in Oklahoma are waiting in line and not getting drugs, while people cannot get any of the care in rural areas in this country because more money is consumed in one EMA relative to all the rest, and we can stand by and watch people have to wait for somebody to die before they can get on a drug list, I will not recognize that. I will not accept that. I believe that it is an unfounded statement.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1¼ minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I thank the distinguished ranking member for yielding me this time.

During the hearing that was before our Subcommittee on Health and Environment, which I am a member of, we had very clear testimony from individuals, one of them, the distinguished Health AIDS Director of the State of New York that said that this funding formula would hurt the State of New York and supported the Senate language and said that it would hurt California as well.

Number two, the chart that was just up here and being used I questioned at the committee markup. It was removed because we are changing, shifting gears between title I and other titles, and that does not give a clear picture.

Number three, the GAO admitted on the record, admitted on the record that people that live beyond 10 years did not fit within their fiscal year projections. The analysis that they had done, and they had not done an analysis of this impact.

I think what has been acknowledged is the following: Is that the funding formula on hold harmless will do harm and that what we really need to have are additional resources in the bill so that we do not pit one American citizen that is HIV or with AIDS against one another. That is what is the ultimate fairness.

Mr. COBURN. Mr. Speaker, may I inquire as to the balance of time.

The SPEAKER pro tempore. The gentleman from Oklahoma (Mr. COBURN) has 5 minutes remaining. The gentleman from Ohio (Mr. BROWN) has 45 seconds remaining.

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me make a couple of points. The area which the gentlewoman spoke about was from the concerns of New York were with title II. We adjusted all of that funding, and she is aware that we adjusted that. The State of New York supports this bill.

So let there be no question. We responded to what they recognize was a problem and fixed the title II funding distribution in the bill.

The second thing, the reason we pulled the chart down was so we could put up the other one, which both show the same thing.

The GAO testimony is clear. There is a disproportionate amount of money going for people in the EMA in San Francisco. I do not want to see that drop one penny. I do not believe it will. If I thought it would, I would not be sponsoring this bill.

I believe the statement of the gentleman from New York (Mr. TOWNS) was probably the most profound of all, that we need more money. Dr. Green's testimony about more ADAP funds we authorized whatever may be consumed in this bill, and it is our job to make sure it is appropriated to make sure those people are there.

So I think it is important for us to be clear. The fact is that GAO testimony says there is a marked disproportion. We are not going to fix that all. We are going to fix that a little bit, 2 percent this year, which, in direction, 2 percent this year with what has been appropriated will have no effect on the San Francisco EMA. I would hope that they would recognize that.

Mr. Speaker, I reserve the balance of my time to close.

Mr. BROWN of Ohio. Mr. Speaker, I yield the final 45 seconds to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE. Mr. Speaker, I thank the distinguished ranking member for his kindness in yielding me this time. I thank the gentleman from California (Mr. WAXMAN) for his leadership and the gentleman from Oklahoma (Mr. COBURN) for his leadership on H.R. 4807, the Ryan White CARE Act of 2000.

Mr. Speaker, I have had the displeasure of speaking and recollecting with a friend who is laying comatose in a hospital room dying of AIDS. I had the unfortunate opportunity, I guess, and it is not an opportunity to get a call to say that a friend was dying, and rushing to their bedside and getting there just a little too late, and that friend died of AIDS.

I have had coworkers who have lost their life as well. So this bill is extremely important.

Mr. COBURN. Mr. Speaker, I yield 30 seconds to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, this bill is extremely important because what it does is say that we want to save lives. I believe that we can do a lot with this bill, and I look forward to us doing such.

But in my community they are asking for the Ryan White CARE Act to be reauthorized and to be funded. I want to see more dollars for research and treatment. I want to see more dollars to take care of those communities of which I represent, African American population, Hispanic population.

I think we should recognize this is a worldwide crisis. Forty million children will be orphaned in Africa. We must fight it worldwide and fight it in the United States.

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

(Mr. COBURN asked and was given permission to revise and extend his remarks.)

Mr. COBURN. Mr. Speaker, we have just spent 15 minutes talking about a tug of war over money, and what we should be talking about is prevention and the great things this bill does to keep the next person from getting HIV infected.

When I came to Congress in 1995, one of my goals was to try to raise the level of awareness of how we can prevent this disease. This is not hard. But we have let extraneous issues get before us.

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There is no one on that side that I doubt their compassion for wanting to do the same thing I want to do, and that is to not ever see another person get this disease. The gentlewoman from California (Ms. PELOSI) and the gentlewoman from California (Ms. ESHOO) feel as strongly about that as I do, and I know the gentleman from California (Mr. WAXMAN) does.

The gentleman from California has been a prince to work with. It has been one of the real pleasures of my time in Congress to have worked on this bill with him, and I will remember it and I thank him for his cooperation.

But we cannot forget about what this epidemic is about. There should not be 40,000 new infections this year for this disease. Now, think about it. For every one person who gets this disease, it is a minimum of $10,000 in health care. If we prevent 1,000 from getting it, we save $10 million in health care that year, the next year, and every year. If we drop the infection rate in half in this country, we will save $5 billion in 3 years, just by dropping the infection rate. We will have more money to take care of everybody that has it, plus we will be able to spend $5 billion on cancer research for breast cancer, just by prevention.

We get lost in the wrong issues. The issue is prevention. This bill goes a long way in identifying that. I will work with anybody to make sure nobody gets shortchanged when it comes to this, but we have to work together to make sure that there is no waste; that there is not exorbitant payments to groups that are not doing things to help people with HIV; that we do everything that we can to make sure the next person does not get infected.

I took a lot of heat in 1995 putting a baby AIDS bill into the Ryan White. It never got funded, and what was funded was not used for babies. The State of New York had the courage to put in a baby AIDS bill, where if we did not know the status of the mother they were tested. Today, all babies who are born are tested for HIV; 98.8 percent of them are in care. We have made a tremendous difference just in the discussion of it in the State of New York. I applaud the State of New York for what they have done.

Mr. Speaker, I thank again the gentleman from California (Mr. WAXMAN) and his staff, Paul; my staff, Roland Foster, and I look forward to the conference as we go along, because the House, I am sure, will pass this bill.

Mr. CROWLEY. Mr. Speaker, I rise in strong support of the Ryan White CARE Act Amendments of 2000.

This legislation reflects a number of key priorities for my constituents in Queens and the Bronx, New York City by reauthorizing the most important and most widely encompassing set of programs for people with HIV and AIDS.

On May 23, the AIDS Alliance for Children, Youth and Families held its annual ''Lobby Day'' in Washington to fight for increased resources for those people living with HIV and AIDS.

At this meeting, I had the opportunity to speak with Ms. Martha Diaz of the Montifiore Medical Center in the Bronx, New York, in my Congressional District.

Ms. Diaz deals with children and youths suffering from HIV and AIDS. Instead of actually lobbying me on the issue of reauthorizing Ryan White, she had her guests do the talking—over 100 mothers and children, many suffering from the affliction of AIDS.

Their words were more touching than anything I can state on the floor today. But I am here to support this reauthorization for them and the thousands of Americans who battle this virus everyday of their lives.

In New York, the AIDS crisis is particularly acute. New York City AIDS cases represent over 85 percent of the AIDS cases in New York State and 17 percent of the national total with 180,000 deaths from AIDS and AIDS related illnesses in 1998.

Sadly, this horrible disease has disproportionately affected minorities. The majority of individuals living with AIDS in New York City are people of color.

African Americans are more than eight times as likely as whites to have HIV and AIDS, and Hispanics more than four times as likely.

The most stunning fact I have come across is from the U.S. Department of health and Human Services in October of 1998, when they reported that AIDS is the leading killer of black men age 25–44 and the second leading cause of death for black women aged 25–44.

Together, Black and Hispanic women represent one fourth of all women in the United States but account for more than three quarters of the AIDS cases among women in the country.

These are horrible statistics, but the Ryan White CARE Act is battling to change this story to bring down these horrendously high numbers.

Specifically, this legislation also deals with one of my key projects, that of Babies born with AIDS.

I have long worked in my community notably with Assemblywoman Nettie Mayersohn of Flushing, Queens, New York. Assemblywoman Mayersohn and I have been active, both in Albany and now in Washington, in working to address the issue of newborns with AIDS.

This legislation will amend the current Baby AIDS grant program by adding treatment services for pregnant women with HIV to the list of authorized uses, which include counseling, voluntary testing and outreach for pregnant women with HIV and offset of State implementation of mandatory newborn testing programs.

I ask my colleagues to support this legislation and send a signal to those living with HIV and AIDS that this Congress is not ignoring their needs.

Mr. DREIER. Mr. Speaker, I am pleased to support H.R. 4807 which reauthorizes the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. I want to thank my colleagues on the Commerce Committee and particularly, Representatives COBURN and WAXMAN for their work in bringing forth a bipartisan bill.

The CARE Act is critical to the lives and well-being of hundreds of thousands of individuals living with HIV and AIDS and those who are at risk of contracting HIV. Now in its tenth year, the CARE Act has been instrumental in creating and maintaining a system of care for those individuals without the ability to pay, including state-of-the-art medical services, cutting-edge diagnostic techniques, newly developed pharmaceutical therapies, and social support services.

The CARE Act is significant to many individuals, and H.R. 4807 directs federal funding to growing populations affected by the disease. Specifically, this bill addresses long-standing historical inequities in the distribution of funds across Ryan White Title I areas, the portion of the Act directed to the epicenters of the epidemic, which includes Los Angeles County. These inequities are driven primarily through the implementation of the ''holding harmless'' provision included in the previous reauthorization.

The changing dynamic of the disease means that the CARE Act can no longer disregard the needs of all the other jurisdictions to protect just one jurisdiction. I believe that this bill ensures greater equity in the distribution of Ryan White funds across those jurisdictions most heavily impacted by the AIDS epidemic.

Once again, I want to commend my colleagues on the Commerce Committee for bringing forward this bipartisan legislation, and I urge my colleagues to join me in voting for this measure.

Mr. DAVIS of Virginia. Mr. Speaker, I rise today in strong support of H.R. 4807, the Ryan White CARE Act Amendments of 2000. Since its enactment in 1990, the Ryan White CARE program has provided comprehensive medical and social services to hundreds of thousands of individuals infected with the human immunodeficiency virus (HIV) and AIDS. And I am proud to be a cosponsor of this vitally needed legislation to reauthorize funding to continue the fight against this deadly virus.

Ever 12 minutes another person in the United States is newly infected with HIV, the virus that causes AIDS. This equates to between 800,000 and 900,000 individuals now living with HIV/AIDS. About a third of these individuals have been diagnosed and are in care; another third have been diagnosed, but may not be receiving ongoing care for their HIV disease; and the last third have not been diagnosed and, therefore are not in care.

H.R. 4807 will take the Ryan White CARE program further than it ever has before to reach out and assist these infected individuals. This bill will refine the focus of the Ryan White CARE program, by not only continuing to fund programs to assist those individuals with AIDS, but by also creating programs to assist HIV-positive individuals. AIDS is the end stage of HIV disease and can occur up to 10 or 15 years after infection. By providing HIV-positive individuals with pro-active and aggressive treatment before it progresses into AIDS, we could enhance their quality of life and prevent further transmission of this deadly virus.

H.R. 4807 also takes further measures focused on prevention. States with effective partner notification and HIV surveillance programs will be eligible for additional federal funds. Partner notification programs have been proven particularly effective in finding individuals from traditionally under-served communities and getting them into care. Federal resources will also be provided to assist states with efforts to reduce perinatal HIV transmission and to identify newborns at risk for infection, and individuals infected with HIV would be provided counseling to better empower them to disclose their status to potential partners.

Mr. Speaker, with almost 1,000,000 people living with HIV and AIDS in America today, I am sure that many of us know someone who is suffering or has suffered from this virus. Unfortunately, my sister-in-law's life was tragically cut short by AIDS just four years ago. She had been infected by her ex-husband, and my brother and Kristin had no idea of her infection until she was near death. My entire family is committed to working towards preventing further innocent lives from being stolen away again. While I have consistently voted to support federal programs to treat and prevent AIDS, my wife, Peggy, has done her part as well. In 1997, she biked 300 long miles in the AIDS bike-a-thon to raise money for AIDS charities. My family's commitment to assisting individuals with HIV and AIDS is deep and personal. Mr. Speaker, I ask my fellow colleagues to do their part as well in the fight against AIDS by voting in support of the Ryan White CARE Act Amendments of 2000.

Mr. LARSON. Mr. Speaker, I rise today in support of H.R. 4807, the Ryan White CARE Act Amendments of 2000. The programs that this will fund ensure that those living with HIV and AIDS in major metropolitan areas, as well as elsewhere, continue to get the federal support services they need.

HIV and AIDS are problems that America cannot afford to turn her back on. According to the Centers for Disease Control and Prevention, the number of Americans living with AIDS has more than doubled over the last five years, and it is currently the 5th leading cause of death among people aged 25–44. Such unchecked and exponential growth represents a most extreme threat.

Over the last few years we have seen a dramatic increase in spending for AIDS and HIV research, and accordingly, we have made some great progress regarding the treatment and understanding of this horrible disease. However, we must not forget about the 650,000–900,000 people who currently live with this disease and may have neither the means nor the opportunity to get the treatment they need and deserve. It is for these people, and for those who will be infected before such a time when a vaccine and other prevention methods are widely accessible and affordable, that we must pass the Ryan White CARE Act Amendments of 2000.

Under this act, funding to metropolitan areas will not only be based on the number of AIDS cases, but will also take into account the number of HIV infections. If we are to win this war we must do what we can to tackle AIDS in its early stages, and this means the treatment of people who suffer from HIV infection and not just the full-blown virus.

Under the act, grants for dealing with perinatal transmission of HIV are increased from $10 to $30 million. This increased funding will add treatment services for pregnant women infected with HIV, and will increase the funding for service on the current list which includes counseling, voluntary testing, and outreach.

Although we are extremely grateful for the recent advances in the treatment of HIV and AIDS, they still represent a very real threat to the well-being and security of our nation. By passing the Ryan White CARE Act Amendments of 2000 we will come one step closer to winning the war on HIV and AIDS, and we will come one step closer to helping those already infected with HIV and AIDS live more productive and healthier lives.

Mr. Speaker, distinguished colleagues, we must pass H.R. 4807. It is imperative to the well being of our country, and it is imperative to me as a public servant, and it is imperative to anybody who has seen the devastating effects of HIV and AIDS. I urge all of my colleagues to support H.R. 4807 so that we can continue to provide these important programs to those living with this disease.

Mr. BILIRAKIS. Mr. Speaker, I rise today in support of H.R. 4807, the Ryan White CARE Act Amendments of 2000. The Health and Environment Subcommittee held a hearing on the bill earlier this month. On July 13th, the full Commerce Committee approved the bill by voice vote, after adopting several bipartisan amendments to further refine and strengthen this important legislation.

The swift movement of this measure is a testament to its bipartisan nature, and I want to commend Congressmen TOM COBURN and HENRY WAXMAN for their hard work. I was pleased to join many of my Committee colleagues as an original cosponsor of the bill.

The Ryan White Comprehensive AIDS Resouces Emergency or ''CARE'' Act was enacted in 1990, and Congress approved bipartisan legislation to reauthorize the law in 1996. The Ryan White CARE Act provides critical funding for health and social services to the estimated one million Americans living with HIV and AIDS. The bill before us, H.R. 4807, will ensure that these patients continue to receive the care and medications they need to enhance and prolong their lives.

H.R. 4807 makes an important change by relying on the number of HIV-infected individuals—as opposed to only the number of persons living with AIDS—as the basis for allocating funding under Titles I and II of the Ryan White CARE Act. By targeting resources to the ''front line'' of the epidemic, we will be able to reduce transmission rates and ensure the necessary infrastructure is in place to provide care to HIV-positive individuals as soon as possible. This change will allow the federal government to be pro-active, instead of reactive, in the fight against HIV and AIDS.

It should be noted, however that this shift will only occur when reliable data on HIV prevalence is available. The bill also includes a ''hold harmless'' provision to ensure that no metropolitan area will suffer a drastic reduction in CARE Act funds.

H.R. 4807 also increases the focus on prevention. States with effective partner notification and HIV surveillance programs will be eligible for additional federal funds. Several witnesses at our Subcommittee hearing emphasized the importance of partner notification programs as an effective way to identify individuals from traditionally under-served communities and help them obtain care. This emphasis on prevention services is part of a comprehensive effort under the bill to eliminate barriers to access to care.

In closing, Mr. Speaker, I want to again recognize the hard work of all the Members who worked together on a bipartisan basis to advance this reauthorization bill. H.R. 4807 is a critical piece of legislation that can literally save lives, and I urge all Members to join me today in supporting this important legislation.

The SPEAKER pro tempore (Mr. TANCREDO). The question is on the motion offered by the gentleman from Oklahoma (Mr. COBURN) that the House suspend the rules and pass the bill, H.R. 4807, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 3250

Mr. COBURN. Mr. Speaker, I ask unanimous consent to withdraw my name from H.R. 3250.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT OF 2000

Mr. LAZIO. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4920) to improve service systems for individuals with developmental disabilities, and for other purposes, as amended.

The Clerk read as follows:

H.R. 4920

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 ''Developmental Disabilities Assistance and Bill of Rights Act of 2000''.

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

Sec. 1. Short title; table of contents.

TITLE I—PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Subtitle A—General Provisions

Sec. 101. Findings, purposes, and policy.
Sec. 102. Definitions.
Sec. 103. Records and audits.
Sec. 104. Responsibilities of the Secretary.
Sec. 105. Reports of the Secretary.
Sec. 106. State control of operations.
Sec. 107. Employment of individuals with disabilities.
Sec. 108. Construction.
Sec. 109. Rights of individuals with developmental disabilities.

Subtitle B—Federal Assistance to State Councils on Developmental Disabilities

Sec. 121. Purpose.
Sec. 122. State allotments.
Sec. 123. Payments to the States for planning, administration, and services.
Sec. 124. State plan.
Sec. 125. State Councils on Developmental Disabilities and designated State agencies.
Sec. 126. Federal and non-Federal share.
Sec. 127. Withholding of payments for planning, administration, and services.
Sec. 128. Appeals by States.
Sec. 129. Authorization of appropriations.

Subtitle C—Protection and Advocacy of Individual Rights

Sec. 141. Purpose.
Sec. 142. Allotments and payments.
Sec. 143. System required.
Sec. 144. Administration.
Sec. 145. Authorization of appropriations.

Subtitle D—National Network of University Centers for Excellence in Developmental Disabilities Education, Research, and Service

Sec. 151. Grant authority.
Sec. 152. Grant awards.
Sec. 153. Purpose and scope of activities.
Sec. 154. Applications.
Sec. 155. Definition.
Sec. 156. Authorization of appropriations.

Subtitle E—Projects of National Significance

Sec. 161. Purpose.
Sec. 162. Grant authority.
Sec. 163. Authorization of appropriations.

TITLE II—PROGRAM FOR DIRECT SUPPORT WORKERS WHO ASSIST INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Sec. 201. Findings.
Sec. 202. Definitions.
Sec. 203. Reaching up scholarship program.
Sec. 204. Staff development curriculum authorization.
Sec. 205. Authorization of appropriations.

TITLE III—REPEAL

Sec. 301. Repeal.

TITLE I—PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Subtitle A—General Provisions

SEC. 101. FINDINGS, PURPOSES, AND POLICY.

(a) FINDINGS.—Congress finds that—

(1) disability is a natural part of the human experience that does not diminish the right of individuals with developmental disabilities to live independently, to exert control and choice over their own lives, and to fully participate in and contribute to their communities through full integration and inclusion in the economic, political, social, cultural, and educational mainstream of United States society;

(2) in 1999, there were between 3,200,000 and 4,500,000 individuals with developmental disabilities in the United States, and recent studies indicate that individuals with developmental disabilities comprise between 1.2 and 1.65 percent of the United States population;

(3) individuals whose disabilities occur during their developmental period frequently have severe disabilities that are likely to continue indefinitely;

(4) individuals with developmental disabilities often encounter discrimination in the provision of critical services, such as services in the areas of emphasis (as defined in section 102);

(5) individuals with developmental disabilities are at greater risk than the general population of abuse, neglect, financial and sexual exploitation, and the violation of their legal and human rights;

(6) a substantial portion of individuals with developmental disabilities and their families do not have access to appropriate support and services, including access to assistive technology, from generic and specialized service systems, and remain unserved or underserved;

(7) individuals with developmental disabilities often require lifelong community services, individualized supports, and other forms of assistance, that are most effective when provided in a coordinated manner;

(8) there is a need to ensure that services, supports, and other assistance are provided in a culturally competent manner, that ensures that individuals from racial and ethnic minority backgrounds are fully included in all activities provided under this title;

(9) family members, friends, and members of the community can play an important role in enhancing the lives of individuals with developmental disabilities, especially when the family members, friends, and community members are provided with the necessary community services, individualized supports, and other forms of assistance;

(10) current research indicates that 88 percent of individuals with developmental disabilities live with their families or in their own households;

(11) many service delivery systems and communities are not prepared to meet the impending needs of the 479,862 adults with developmental disabilities who are living at home with parents who are 60 years old or older and who serve as the primary caregivers of the adults;

(12) in almost every State, individuals with developmental disabilities are waiting for appropriate services in their communities, in the areas of emphasis;

(13) the public needs to be made more aware of the capabilities and competencies of individuals with developmental disabilities, particularly in cases in which the individuals are provided with necessary services, supports, and other assistance;

(14) as increasing numbers of individuals with developmental disabilities are living, learning, working, and participating in all aspects of community life, there is an increasing need for a well trained workforce that is able to provide the services, supports, and other forms of direct assistance required to enable the individuals to carry out those activities;

(15) there needs to be greater effort to recruit individuals from minority backgrounds into professions serving individuals with developmental disabilities and their families;