have no problem with it. We support the gentleman's amendment.

Mr. STUPAK. Mr. Chairman, with those comments from the distinguished gentleman, I would like to thank him, the gentleman from South Carolina [Mr. SPENCE], the gentleman from North Carolina [Mr. COBLE], the gentleman from Virginia [Mr. BATEMAN], the gentleman from Minnesota [Mr. OBERSTAR], and others for their help on this.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Michigan [Mr. STUPAK].

The amendment was agreed to.

The CHAIRMAN. Are there further amendments to the bill?

Under the rule, the Committee rises.

Accordingly the Committee rose; and the Speaker pro tempore (Mr. KINGSTON) having assumed the chair, Mr. REGULA, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2149) to reduce regulation, promote efficiencies, and encourage competition in the international ocean transportation system of the United States, to eliminate the Federal Maritime Commission, and for other purposes, pursuant to House Resolution 419, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendments? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The CHAIRMAN. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. OBERSTAR. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 239, nays 182, not voting 12, as follows:

[Roll No. 144]

YEAS—239

Allard	Boehlert	Chabot
Archer	Boehner	Chambliss
Armey	Bono	Christensen
Bachus	Boucher	Chrysler
Baker (CA)	Brewster	Clement
Baker (LA)	Browder	Clinger
Ballenger	Brownback	Coble
Barr	Bryant (TN)	Coburn
Barrett (NE)	Bunn	Collins (GA)
Bartlett	Bunning	Combest
Barton	Burr	Condit
Bass	Burton	Cooley
Bateman	Buyer	Cox
Bereuter	Callahan	Cramer
Bevill	Calvert	Crane
Bilbray	Camp	Crapo
Bilirakis	Campbell	Cremeans
Bliley	Canady	Cubin
Blute	Castle	Cunningham
Davis	Istook	Quillen
de la Garza	Johnson (CT)	Radanovich
Deal	Johnson, Sam	Ramstad
DeLay	Jones	Regula
Diaz-Balart	Kasich	Riggs
Dickey	Kelly	Roberts
Dooley	Kim	Rohrabacher
Doolittle	King	Ros-Lehtinen
Dornan	Klug	Roth
Dreier	Knollenberg	Roukema
Duncan	Kolbe	Royce
Dunn	LaHood	Salmon
Ehlers	Largent	Sanford
Ehrlich	Latham	Saxton
Emerson	LaTourette	Scarborough
Ensign	Laughlin	Schaefer
Everett	Lazio	Seastrand
Ewing	Leach	Sensenbrenner
Fawell	Lewis (CA)	Shadegg
Fields (TX)	Lewis (KY)	Shaw
Flanagan	Lightfoot	Shays
Foley	Lincoln	Shuster
Fowler	Linder	Skeen
Fox	Livingston	Smith (MI)
Franks (CT)	LoBiondo	Smith (NJ)
Franks (NJ)	Longley	Smith (TX)
Frelinghuysen	Lucas	Solomon
Funderburk	Manzullo	Souder
Gallegly	Martinez	Spence
Ganske	Martini	Stearns
Gekas	McCollum	Stenholm
Geren	McCrery	Stockman
Gilchrest	McDade	Stump
Gillmor	McHugh	Talent
Goodlatte	McInnis	Tanner
Goodling	McIntosh	Tate
Greene (UT)	McKeon	Tauzin
Greenwood	Meyers	Taylor (MS)
Gunderson	Mica	Taylor (NC)
Gutknecht	Miller (FL)	Thomas
Hall (TX)	Minge	Thornberry
Hancock	Montgomery	Tiahrt
Hansen	Moorhead	Torkildsen
Hastert	Morella	Upton
Hastings (WA)	Murtha	Vucanovich
Hayes	Myrick	Walker
Hayworth	Nethercutt	Walsh
Hefley	Neumann	Wamp
Heineman	Ney	Watts (OK)
Herger	Norwood	Weldon (FL)
Hilleary	Nussle	Weldon (PA)
Hobson	Orton	Weller
Hoekstra	Oxley	White
Hoke	Packard	Whitfield
Horn	Parker	Wicker
Hostettler	Paxon	Wolf
Houghton	Petri	Young (AK)
Hunter	Pombo	Young (FL)
Hutchinson	Porter	Zeliff
Hyde	Portman	Zimmer
Inglis	Pryce	

NAYS—182

Abercrombie	Doyle	Hoyer
Ackerman	Durbin	Jackson (IL)
Andrews	Edwards	Jackson-Lee
Baesler	Engel	(TX)
Baldacci	English	Jacobs
Barcia	Eshoo	Jefferson
Barrett (WI)	Evans	Johnson (SD)
Becerra	Farr	Johnson, E. B.
Beilenson	Fattah	Johnston
Bentsen	Fazio	Kanjorski
Bishop	Fields (LA)	Kennedy (MA)
Bonior	Filner	Kennedy (RI)
Borski	Flake	Kennelly
Brown (CA)	Foglietta	Kildee
Brown (FL)	Forbes	Kingston
Brown (OH)	Ford	Kleczka
Cardin	Frank (MA)	Klink
Chapman	Frisa	LaFalce
Clayton	Frost	Lantos
Clyburn	Furse	Levin
Coleman	Gejdenson	Lewis (GA)
Collins (IL)	Gephardt	Lipinski
Collins (MI)	Gibbons	Lofgren
Conyers	Gilman	Lowey
Costello	Gonzalez	Luther
Coyne	Gordon	Maloney
Cummings	Green (TX)	Manton
Danner	Gutierrez	Markey
DeFazio	Hall (OH)	Mascara
DeLauro	Hamilton	Matsui
Dellums	Harman	McCarthy
Deutsch	Hastings (FL)	McDermott
Dicks	Hefner	McHale
Dingell	Hilliard	McKinney
Dixon	Hinchey	McNulty
Doggett	Holden	Meehan
Meek	Poshard	Stokes
Menendez	Quinn	Studds
Metcalf	Rahall	Stupak
Millender-McDonald	Rangel	Tejeda
Miller (CA)	Reed	Thompson
Mink	Richardson	Thornton
Moakley	Rivers	Thurman
Mollohan	Roemer	Torres
Moran	Rose	Towns
Nadler	Roybal-Allard	Traficant
Neal	Rush	Velazquez
Oberstar	Sabo	Vento
Obey	Sanders	Visclosky
Olver	Sawyer	Volkmer
Ortiz	Schiff	Ward
Owens	Schroeder	Waters
Pallone	Schumer	Watt (NC)
Pastor	Scott	Waxman
Payne (NJ)	Serrano	Williams
Payne (VA)	Sisisky	Wilson
Pelosi	Skaggs	Wise
Peterson (FL)	Skelton	Woolsey
Peterson (MN)	Slaughter	Wynn
Pickett	Smith (WA)	Yates
Pomeroy	Spratt	
	Stark	

NOT VOTING—12

Berman	Clay	Molinari
Bonilla	Goss	Myers
Bryant (TX)	Graham	Rogers
Chenoweth	Kaptur	Torricelli

☐ 1825

Mr. DICKS changed his vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. SHUSTER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous matter on H.R. 2149 the bill just passed.

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

There was no objection.

CONFERENCE REPORT ON S. 641, RYAN WHITE CARE ACT AMENDMENTS OF 1996

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that it now be in order to proceed immediately to consider the conference report on the Senate bill (S. 641), to reauthorize the Ryan White CARE Act of 1990, and for other purposes, and that all points of order against the conference report and against its consideration be waived, and that the conference report be considered as read.

The Clerk read the title of the Senate bill.

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

Mr. WAXMAN. Reserving the right to object, Mr. Speaker, I want to clarify that this will allow us to move forward on the House floor to consider the Ryan White reauthorization bill, allowing discussion of that legislation and a vote.

Mr. BILIRAKIS. Mr. Speaker, if the gentleman will yield, I would say to the gentleman, yes, by all means.

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

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

There was no objection.

The SPEAKER pro tempore. Pursuant to the unanimous consent agreement, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of Tuesday, April 30, 1996, at page H4287).

The SPEAKER pro tempore. The gentleman from Florida [Mr. BILIRAKIS] and the gentleman from California [Mr. WAXMAN] will each be recognized for 30 minutes.

The Chair recognizes the gentleman from Florida [Mr. BILIRAKIS].

□ 1830

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

(Mr. BILIRAKIS asked and was given permission to include extraneous material.)

Mr. BILIRAKIS. Mr. Speaker, I rise in strong support of the conference agreement on the Ryan White CARE Act Amendments of 1996. This conference report represents a balanced compromise between the House and Senate positions and updates and improves these important programs.

I want to join my colleagues in saying how pleased I am that the conference on the Ryan White program has finally been completed. It has taken much longer than any of us would have liked. We are now at the point where the remainder of the fiscal year 1996 funds are about to be distributed to the States. Without the reauthorization and an adjustment to the formula, approximately 20 States were expected to lose a significant portion of their grants relative to fiscal year 1995. It is our expectation that those remaining funds will be allocated based on the formulas contained in the conference agreement.

I want to briefly summarize some of the key provisions of the conference agreement. The bill charges the criteria by which cities become eligible for title I funds and modifies both the title I and title II formulas. The allocations to cities under title I for emergency relief grants will be based on the estimated number of living cases of AIDS in the area over the most recent 10-year period.

The formula for the title II CARE grants to the States are based on two distribution factors: The State factor and the non-EMA factor. The minimum allotments to States with 90 or more cases is increased from $100,000 to $250,000.

The conference agreement provides criteria for how members of title I planning councils should be selected; these criteria include conflict of interest standards. Additionally, it requires that the composition of the planning council reflect the demographics of the epidemic in the area. The conference agreement requires the Secretary to give priority in awarding supplemental grants to cities that demonstrate a more severe need based on the prevalence of: Sexually transmitted diseases, substance abuse, tuberculosis, mental illness, and homelessness.

The bill also requires cities to allocate a percentage of its funds for providing services to women, infants, and children, including treatment measures to prevent the perinatal transmissions of HIV. It also defines and places limits on administrative costs.

Other provisions of the bill provide that: States must spend a portion of their grants on therapeutics to treat HIV disease including measures for the prevention and treatment of opportunistic infections; all four titles contribute 3 percent to the projects of National Significance; clarification that the intent of title IV is to increase the number of women and children in clinical research projects; transfer of the dental reimbursement program from title 7 of the Public Health Service Act; and reauthorization of all programs at such sums through fiscal year 2000.

This is a conference report which represents compromise and hard work by both the House and Senate. We are proud of our efforts and are hopeful that by passing this conference report today, we can provide much-needed services, education, and treatment to those afflicted with this terrible disease.

I also want to take this opportunity to thank my staff, especially Melody Harned, for their hard work on this legislation as well as Kay Holcombe of the committee's minority staff.

I include a section-by-section summary of the bill in the RECORD at this point.

SUMMARY OF CONFERENCE AGREEMENT ON S. 641, THE RYAN WHITE CARE ACT AMENDMENTS OF 1996

Section 1. Short Title.

Section 2. References.

Section 3. General Amendments.

Part A—Emergency Relief for Areas With Substantial Need for Services (Cities):

1. Eliminates the ability for an area to become eligible based on per capita incidence of 0.0025. Changes the timeframe of the cumulative AIDS case count from total cumulative (from the beginning of the epidemic) to the total for the 5-year period prior to the year for which the grant is being made.

2. Limits eligibility for new grants to cities with populations of 500,000 or more. (All cities currently receiving funds and cities which will receive funds in FY 1996 are grandfathered).

3. Adds to the list of representatives to be included on the planning councils: (a) federally qualified health centers, (b) substance abuse treatment providers, (c) individuals from historically underserved populations, (d) the State Medicaid agency and the State agency administering Title II, and (e) grantees under Part D.

4. Clarifies that in establishing priorities, planning councils are to use the following factors: (a) documented needs of the HIV-infected population, (b) cost and outcome effectiveness data of proposed interventions, (c) priorities of HIV-infected communities for whom services are intended, and (d) availability of other resources.

5. Requires the planning council to participate in the statewide coordinated statement of need.

6. Requires the composition of the planning council to reflect the demographics of the epidemic in the area. Also requires that nominations to the council be conducted through an open process based on publicized criteria which includes a conflict of interest standard. Prohibits the planning council from being chaired solely by an employee of the grantee.

7. Prohibits the planning council from designating or otherwise being directly involved in the selection of specific service providers.

8. Requires planning councils to develop grievance procedures. Requires the Secretary to develop model grievance procedures.

DISTRIBUTION OF GRANTS

1. Formula Grant—Specifies that no city may receive a reduction from the amount received in FY95 greater than 0 percent in FY96, 1 percent in FY97, 2 percent in FY98, 3.5% in FY99 and 5% in FY 2000.

2. Supplemental Grant—Requires cities applications for supplemental grants to demonstrate the inclusiveness of the planning council membership and that proposed services are consistent with local and statewide statements of need, and that funds for the preceding year were spent in accordance with the priorities developed by the planning council.

3. Supplemental Grant—Requires the Secretary to give priority in awarding supplemental grants to cities that demonstrate a more severe need based on the prevalence of: sexually transmitted diseases, substance abuse, tuberculosis, mental illness, and homelessness.

4. Prohibits the Secretary from awarding a grant unless funds for the preceding fiscal year were expended in accordance with the priorities established by the planning council.

USE OF AMOUNTS

1. Clarifies that substance abuse and mental health treatments and prophylactic treatment for opportunistic infections are permissible uses of funds.

2. Clarifies that substance abuse treatment programs and mental health programs are eligible to receive funds from cities to provide services.

3. Requires the city to allocate a percentage of its funds for providing services to women, infants, and children, including treatment measures to prevent the perinatal transmissions of HIV. The minimum for each city will be the percentage of the HIV population constituted by women, infants and children infected with HIV.

4. Specifies that administrative costs of all subgrantees may not exceed an average of 10 percent. Defines administrative activities.

APPLICATION

1. Authorizes the Secretary to phase-in the use of a single application and a single grant for formula grants and supplemental grants.

TECHNICAL ASSISTANCE; PLANNING GRANTS

1. Authorizes the Secretary to make grants of $75,000 to cities who will become eligible for Part A grants (cities) the following fiscal year. The purpose of the grant is to assist the area in preparing for the responsibilities associated with being a Part A grantee.

2. A maximum of 1 percent of Part A funds may be used for planning grants. If a city receives a planning grant, the amount it receives the subsequent fiscal year (under the Part A formula) will be reduced by the amount of the planning grant.

3. Permits current grantees to provide technical assistance to new grantees.

Part B—Care Grant Program (States)

1. Specifies that an authorized use of funds is to provide outpatient and ambulatory health and support services (services authorized under Part A).

2. Amends the 15 percent set-aside for women and children to require states to allocate a percentage of its funds for providing services to women, infants, and children, including treatment measures to prevent the perinatal transmissions of HIV. The minimum for each state will be the percentage of the HIV population constituted by women, infants and children infected with HIV.

HIV CARE CONSORTIA

1. Specifies that private for profit entities are eligible to receive funds to provide services, if they are the only available provider of quality HIV care in the area.

2. Clarifies that substance abuse and mental health treatment and prophylactic treatment for opportunistic infections are permissible uses of funds.

3. Requires the consortium to consult with Part D grantees in establishing a needs assessment.

4. Deletes the requirement that states with 1% or more of the AIDS cases must spend 50% of their grant on consortia.

PROVISIONS OF TREATMENTS

1. Requires States to spend a portion of its grant on therapeutics to treat HIV disease including measures for the prevention and treatment of opportunistic infections.

2. Requires states to document the progress made in making therapeutics available to individuals eligible for assistance.

3. Requires the Secretary to review State drug reimbursement programs and assess barriers to expanded availability.

STATE APPLICATION

1. Requires the State in its application to provide a description of how the allocation of resources is consistent with the Statewide statement of need. Requires the State to periodically convene a meeting of specified individuals to develop the statement of need.

PLANNING, EVALUATION, AND ADMINISTRATION

1. Prohibits States from using more than 10 percent of its grant for planning and evaluation. Prohibits states from using more than 10 percent of its grant for administration. However, the total for planning, evaluation and administration cannot exceed 15 percent. Requires states to ensure that the average of administrative costs of entities that receive funds from the states does not exceed 10 percent. Defines administrative activities.

TECHNICAL ASSISTANCE

1. Clarifies that the technical assistance which the Secretary may provide includes technical assistance in developing and implementing statewide statements of need.

COORDINATION

1. Requires the Secretary to ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration coordinate Federal HIV programs. Requires the Secretary to report to Congress by October 1, 1996 on such coordination efforts.

Part C—Early Intervention Services

1. Requires grantees to spend not less than 50 percent of the grant, providing on-site or at sites where other primary care services are rendered, the following four service categories: (a) testing, (b) referrals for health services, (c) clinical and diagnostic services, and (d) provision of therapeutic measures.

2. Specifies that private for profit entities are eligible to receive funds to provide services, if they are the only available provider of quality HIV care in the area.

PLANNING AND DEVELOPMENT GRANTS

1. Authorizes the Secretary to make grants to assist entities in qualifying for a Title III(b) grant. The amount of each grant is not to exceed $50,000. Preference is given to entities that provide HIV primary care services in rural or underserved areas. A maximum of 1 percent of the Title III(b) appropriation is authorized to be used for such grants.

REQUIRED AGREEMENTS

1. Adds planning and evaluation to activities considered administration and increases the permissible percentage from 5% to 7.5%.

2. Requires applicants to submit evidence that the proposed program is consistent with the statewide statement of need.

AUTHORIZATION OF APPROPRIATIONS

1. Reauthorizes the program at such sums as necessary for fiscal years 1996 through 2000.

Part D—Grants for Coordinated Services and Access to Research for Women, Infants, Children, and Youth

1. Clarifies that the purpose of the grants is to (a) provide opportunities for women and children to participate as subjects in clinical research projects and (b) provide health care to women and children on an outpatient basis.

2. Clarifies that the Secretary may not make a grant unless the applicant agrees: (a) to make reasonable efforts to identify women and children who would be appropriate participants in research and offers the opportunity to participate, (b) to use criteria provided by the research project in such identification, (c) to offer other specified services such as referrals for substance abuse and mental health treatment and incidental services such as transportation or child care, (d) to comply with accepted standards of protection for human subjects.

3. In order for a grantee to continue receiving funds (in a third or subsequent year), the Secretary must determine that a significant number of women and children are participating in projects of research. Permits the Secretary to take into account circumstances in which a grantee is temporarily unable to comply with this requirement for reasons beyond its control (i.e., completion of the clinical trial). Authorizes the Secretary to grant waivers of the significant number requirement if the grantee is making reasonable progress toward achieving this goal. This waiver authority expires Oct. 1, 1998.

4. Clarifies that receipt of services is not dependent upon a patient's consent to participate in research.

5. Clarifies that grant funds are not be to used to conduct research, but to provide services which enable women and children to participate in such research.

6. Requires the Secretary to establish a list of research protocols to which the Secretary gives priority regarding the prevention and treatment of HIV disease in women and children.

7. Requires the coordination of the NIH with the activities carried out under this title. Requires the Secretary to develop a list of research protocols which are appropriate for the purposes of this section. Requires the entity actually conducting the research to be appropriately qualified. Specifies that an entity is to be considered qualified if any of its research protocols have been recommended for funding by NIH.

8. Reauthorizes the program at such sums as necessary for fiscal years 1996 through 2000.

EVALUATIONS AND REPORTS

1. Requires the Secretary to conduct an evaluation provided for in current law by October 1, 1996.

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

1. Modifies the funding source for SPNS. Current law funds SPNS through a 10 percent tap on Title II. The bill would impose a 3 percent tap on all four titles.

2. Clarifies that special projects should include the development and assessment of innovative service delivery models designed to: address the needs of special populations and ensure the ongoing availability of services for Native Americans.

3. Requires the Secretary to make information concerning successful models available.

TRANSFER OF THE AIDS EDUCATION AND TRAINING CENTERS (AETCS) AND THE DENTAL REIMBURSEMENT PROGRAM

1. Transfers to Title 26 from Title 7 of the Public Health Service Act section 776, the AIDS Education and Training Centers (AETCs) and the Dental Reimbursement Program.

2. Clarifies that training health care personnel in the diagnosis, treatment, and prevention of HIV infection, includes the prevention of perinatal transmission and measures for the prevention and treatment of opportunistic infections.

3. Reauthorizes both programs at such sums as necessary for fiscal years 1996 through 2000.

Sec. 4 Amount of Emergency Relief Grants (Cities)

1. Modifies the Title I formula. Allocations to cities will be based on the estimated number of living cases of AIDS in the area. The number of living cases is determined through a weighted average of cases over the most recent 10 year period.

Sec. 5 Amount of Care Grants

1. Modifies the Title II formula. Distributes Part B funds to states based on a formula that calculates two distribution factors: the state factor, based on weighted AIDS case counts for each state and the non-EMA factor based on weighted AIDS case counts for areas within the state outside of Part A eligible areas. The state factor is given a weight of 80% and the non-EMA factor is given a weight of 20%. This formula results in the transfer of funds among states. As a result funding losses are capped at the following percentages relative to FY95 funding levels: 0% in FY96, 1% in FY97, 2% in FY98, 3.5% in FY99, and 5% in FY2000.

Minimum allotments to states with 90 or more cases is increased from $100,000 to $250,000.

Funds appropriated specifically for the Drug Assistance Program (an eligible use of funds under Part B) shall be allocated based on states entire weighted case counts. ($52 million provided for FY96).

Sec. 6 Consolidation of Authorization of Appropriations

1. Reauthorizes Part A and Part B at such sums as necessary for fiscal years 1996 through 2000.

2. Authorizes the Secretary to develop a methodology for adjusting the amounts allocated to Part A and Part B. Requires the Secretary to report on such methodology by July, 1996.

Sec. 7 Perinatal Transmission of HIV Disease

1. Requires all states to implement the CDC guidelines on voluntary HIV testing and counseling for pregnant women.

2. Authorizes $10 million in grant funds to: (a) make available to pregnant women counseling on HIV disease; (b) make available outreach efforts to pregnant women at high risk of HIV who are not currently receiving prenatal care; (c) make available to such women voluntary HIV testing; (d) implement mandatory newborn testing at an earlier date than required. Only states that implement the CDC guidelines are eligible for

these funds. Priority is given to states with high HIV seroprevalence rates among childbearing women.

3. Requires the CDC, with 4 months of enactment, to develop and implement a reporting system for states to use in determining the rate of new AIDS cases resulting from perinatal transmission and the possible causes of transmission.

4. Requires the Secretary to contract with the Institute of Medicine to conduct an evaluation of the extent to which state efforts have been effective in reducing perinatal transmission HIV and an analysis of the existing barriers to further reduction in such transmission.

5. Within two years following the implementation of the CDC reporting system, the Secretary will make a determination whether mandatory HIV testing of all infants in the US whose mothers have not undergone prenatal HIV testing has become a routine practice. This determination will be made in consultation with states and experts. If the Secretary determines that such testing has become routine practice, after an additional 18 months, a state will not receive Part B funding unless it can demonstrate one of the following:

(a) A 50% reduction (or a comparable measure for states with less than 10 cases) in the rate of new AIDS cases resulting from perinatal transmission, comparing the most recent data to 1993 data:

(b) At least 95% of women who have received at least two perinatal visits have been tested for HIV; or

(c) A program for mandatory testing of all newborns whose mothers have not undergone perinatal HIV testing.

6. Requires states which implement mandatory testing of newborn infants to prohibit health insurance companies from discontinuing coverage for a person solely on the basis that the person is infected with HIV or that the individual has been tested for HIV. Prohibition does not apply to persons who knowingly misrepresent their HIV status.

Sec. 8 Spousal Notification

1. Prohibits the Secretary from making a grant to a State unless the state takes such action to require that a good faith effort be made to notify a spouse of a known HIV infected person that such spouse may have been exposed to HIV and should seek testing.

Sec. 9 Optional Participation of Federal Employees in AIDS Training Programs

1. Provides that a Federal employee may not be required to attend or participate in an AIDS or HIV training program if such employee refuses, except for training necessary to protect the health and safety of the employee (training in universal precautions to prevent transmission of HIV). Provides that an employer may not retaliate in any manner against such employee.

Sec. 10 Prohibition on Promotion of Certain Activities

1. Prohibits funds being used to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Sec. 11 Limitation on Appropriation

1. Provides that the total amounts of Federal funds expended in any fiscal year for AIDS and HIV activities may not exceed the total amounts expended in such fiscal year for activities related to cancer.

Sec. 12 Additional Provisions

1. Adds funeral service practitioners to the definition of emergency response employee.

2. Makes technical and conforming changes.

Sec. 13 Effective Date

1. The effective date is October 1, 1996 except for the following provisions, for which the effective date is the date of enactment: (a) eligibility of new cities under Part A; (b) formula for Part A; (c) formula for Part B; (d) provisions concerning perinatal transmission of HIV; (e) consolidation of authorization for Part A and Part B; and (f) the setasides for Special Projects of National Significance.

Mr. Speaker, I urge my colleagues to join me in supporting this important conference report.

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

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

Mr. Speaker, I am extremely pleased we have completed our work on the House-Senate conference and we have reached an agreement to allow us to reauthorize the Ryan White Act. This is an important program in dealing with the AIDS epidemic throughout this country.

I think from the very beginning of this reauthorization everyone wanted to continue the program, but we had some issues that we had to resolve. One issue that took some discussion was the question of how to direct our attention to deal with trying to prevent the transmission of AIDS to newborns.

Appropriately, the conference said that we should put an emphasis on encouraging pregnant women to be tested so that if they were HIV positive and undertook therapy, they could in fact stop the transmission of HIV to the newborn. But in the case where there has not been a test with the mother, we wanted to establish a procedure for having newborns tested. I think we came up with a good compromise position that will move things in the right direction and deal constructively with this problem.

The second area that we had to resolve were the funding formulas for distribution of money under this act to cities and to States under title I and title II. It makes sense to continue the two separate authorizations for these two titles. Second, we agreed in changes in the formulas which were designed in light of new information and the changing nature of the AIDS epidemic. We did not want to allow large shifts in funding that cities and States severely affected by the epidemic would face, so we did have tight limits on any losses from these areas.

In addition, we tailored the funding formulas appropriately to take into account the continuing enormous need for funding in States and cities like my own State of California and Los Angeles district, as well as the State and city of New York, States of Florida and Texas, and others where the AIDS epidemic began and where it will always remain a significant problem.

On a personal note, I am pleased that the formulas we adopted do result in significant increases of funds for Los Angeles and for the State of California, where the need for services for people with HIV and AIDS and for access to drug therapies for the very large number of affected people remains to severe problem.

Mr. Speaker, in conclusion, and I am going to make a further statement for the RECORD to reflect the views that I have on this legislation, let me say I am extremely proud to have been the original author of the Ryan White CARE Act and to have been a part of its reauthorization. This is a law that has worked, and it will continue to be an integral and essential part of this country's response to the AIDS epidemic.

I want to express my appreciation to the chairman of the Committee on Commerce, Mr. BLILEY, and the chairman of the Subcommittee on Health and the Environment, Mr. BILIRAKIS, for the cooperative and truly bipartisan way in which this legislation has proceeded. I want to acknowledge the hard work of the GAO staff who helped us with title I and II formula calculations, and I want to thank the committee staff, Melody Harned of the majority and Kay Holcombe of the minority, for their significant contributions to this process.

Mr. Speaker, I am extremely pleased that we have completed our work in the House-Senate conference and have reached agreement about the reauthorization of the Ryan White CARE Act. Programs under this Act provide health care services for people with HIV disease and AIDS throughout this country, through public health departments in cities and states; through community-based organizations; and through a variety of primary care providers and social service organizations dedicated to helping patients and families affected by this devastating disease. One very important Ryan White program focuses on the need for more research on AIDS and HIV disease in woman and children. Another focuses on programs directed toward prevention of HIV infection and AIDS. In total, this legislation represents a successful and very important comprehensive approach to HIV and AIDS, and its reauthorization is surely among the most significant legislative accomplishments of this Congress.

I think from the very beginning of this reauthorization, Members on both sides of the aisle and on both sides of the Capitol have completely agreed on one point: that we should reauthorize these important programs. We did, however, have several areas of difference which needed to be resolved and have been resolved in the conference. One of these related to the matter of HIV testing of women and newborns. This is a difficult and contentious issue, and I am extremely pleased that we were able to reach agreement.

Under this agreement, we have broadened the grant program included in the House bill so that grants can be used to assist States to implement the CDC guidelines relating to counseling and voluntary HIV testing of pregnant women, as well as to determine the HIV status of newborns. I am especially pleased with this change because I think it places emphasis where we can do the most good—preventing the perinatal transmission of HIV infection. The legislation then asks the Secretary to make a determination, in consultation with appropriate medical organizations, about whether it is the standard of practice in medicine to test newborns for HIV. If the Secretary makes this determination, then, in order to continue to receive Title II funding under Ryan White,

States would need to meet one of two performance standards. The State could demonstrate that, through voluntary counseling and testing programs, it is determining the HIV status of 95 percent of women who are in prenatal care. Alternatively, the State can demonstrate that it has reduced pediatric AIDS, contracted through perinatal transmission, by 50 percent, compared to the 1993 level. This date is important in that it reflects the time at which we learned that treatment of HIV-positive pregnant women with AT can prevent perinatal transmission.

Only if States cannot demonstrate the achievement of one of these specified goals would they be required to put in place either legislative or regulatory requirements relating to the mandatory HIV testing of newborns, as a condition of their continuing to receive title II funding under the Ryan White Act.

Further, any State that did choose this route would be required to have in place important protections such as requirements that health insurance could not be denied or canceled, based on the fact that an individual has been tested or is HIV-positive. These provisions are over and above the protections already provided in the Americans with Disabilities Act and under applicable State law.

The ADA requires that all persons with disabilities—including those with HIV or AIDS—be protected from arbitrary insurance discrimination. In other words, under the ADA, an employer or insurance company cannot treat people with HIV or AIDS differently from people with other serious conditions that pose equal financial risk. That is clear.

Many State laws also provide a State remedy already for such discrimination. That is also clear.

The Coburn-Waxman amendment as included in this bill would go further and provide protection to people who have simply undergone testing for HIV, whether or not they are perceived by the insurance company as having HIV. The goal of this amendment is clear. We are all trying to reduce any disincentives for anyone to be tested. The Coburn/Waxman amendment also provides a different enforcement device to assure that such discrimination is prohibited, that is, that States could lose their Ryan White money.

With all three of these protections in place—ADA, State law, and Ryan White, the conferees feel that we will make significant public health strides in getting people who may be afraid of being tested less afraid.

I am pleased with this result, because I think we have placed the emphasis where it should be—not on testing as an end in itself, but on reducing the number of babies born with HIV. Reaching pregnant women, and educating them about the importance, both to them and to their babies, of knowing their HIV status at a time when it will do the most good and actually prevent perinatal HIV transmission, is what we should be doing. After all, our goal here is to stop the transmission of HIV to babies. I think this compromise emphasizes and also helps us achieve that goal.

A second issue that has proven difficult to resolve is how funding under this act is distributed to cities and States. The conference report deals with these issues in three ways. First, the conferees agreed that, particularly in light of the increases in funding for both titles I and II under the fiscal year 1996 appropriations bill, it made sense to continue authorizing two separate appropriations for these two titles. Second, we agreed that although changes in the formulas were designed were needed, in light of new information and the changing nature of the AIDS epidemic, we did not want to allow such large shifts in funding that cities and States severely affected by the epidemic could not absorb them. Thus, while we have agreed to make significant changes in the way funds are allocated to cities and States, we have placed tight limits on losses.

In addition, we have tailored the funding formulas appropriately to take account of the continuing enormous need for funding in States and cities, like my home State of California, and my Los Angeles district, as well as the State and city of New York, and the States of Florida and Texas, and others where the AIDS epidemic began and where it always will remain a significant problem.

On a personal note, I am pleased that the formulas we adopted do result in significant increases of funds for Los Angeles, and for the State of California, where the need for services for people with HIV and AIDS and for access to drug therapies for the very large number of affected people remains a severe problem.

Mr. Speaker, in conclusion let me say that I am extremely proud to have been an original author of the Ryan White CARE Act and to have been a part of its reauthorization. This is a law that has worked and will continue to be an integral and essential part of this country's response to the AIDS epidemic.

And finally, I want to express my appreciation to the chairman of the Commerce Committee, Mr. BLILEY, and the chairman of the Health Subcommittee, Mr. BILIRAKIS, for the cooperative and truly bipartisan way in which this legislation has proceeded. I want to acknowledge the hard work of the GAO staff, who helped us with the title I and II formula calculations. I particularly want to thank the committee staff—Melody Harned of the majority and Kay Holcombe of the minority—for their significant contributions to the process.

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

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Maryland [Mrs. MORELLA].

Mrs. MORELLA. I thank the gentleman for yielding me the time.

Mr. Speaker, I rise in support of the passage of the Ryan White CARE Act, and I congratulate the conferees on their persistence in reaching agreement on several difficult issues. A final agreement on this reauthorization bill has been a long time in coming, and it is critical that we pass this bill today.

The CARE Act provides medical care to more than 350,000 people living with HIV/AIDS. Under the Act, local communities make the decisions as to how funding should be allocated, in a manner consistent with this Congress' efforts to give States and localities greater control.

In regard to the issue of HIV testing for infants and pregnant women, I commend the conferees for choosing to focus on the voluntary testing of pregnant women, instead of the mandatory testing of infants. This approach is supported by the medical and public health community as the most effective way of preventing perinatal transmission of HIV. The final provisions include funding to assist States to implement the CDC guidelines which call for voluntary HIV counseling, testing, and treatment for pregnant women.

Mr. Speaker, every Member here agrees that we must do everything possible to reduce perinatal transmission of HIV. The CDC guidelines will provide access to early interventions that will actually prevent perinatal transmission, and link them to HIV care and services.

Preserving a patient-provider relationship of trust is essential to keeping women in the health care system. Many voluntary counseling and testing programs exist, at Harlem Hospital and others; the physicians who run these programs will tell you that it is because the testing is voluntary that they are successful. In these programs, almost all women, after talking with their provider, will choose testing and the treatment recommended by their provider. We should devote our resources to replicating these models, rather than to efforts that will do nothing to prevent perinatal transmission.

Mr. Speaker, this bill is not perfect, but is the best agreement that could be reached.

Mr. Speaker, I congratulate the chairman of the subcommittee, the full committee, the ranking member of the full committee, the subcommittee, and the conferees. We should all vote for this bill.

Mr. WAXMAN. Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts [Mr. STUDDS], who played such a very important role in the work on the Ryan White bill and our approach to the full AIDS epidemic.

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

Mr. STUDDS. Mr. Speaker, as an original cosponsor of this legislation, I rise to express my strong support for the conference report. This agreement is a welcome one which was far too long in coming.

Nearly 6 years ago, I joined with colleagues on both sides of the aisle in passing the Ryan White Care Act. Since then, this legislation has been a lifeline for hundreds of thousands of people in States and communities across the land.

We could not know then that AIDS would become the primary killer of American men and women in the prime of their lives. Nearly half a million cases have been reported to the Centers for Disease Control and Prevention, and nearly half that number have died. Included in those sobering statistics are two former Members of this House and many members of our families and our official family.

As the AIDS epidemic has expanded, it has placed an enormous burden on the public health system, including both the communities in which the early cases were concentrated and

those in which significant case loads are a more recent development. The public health burden has also increased with the emergence of promising but costly new drugs for treating the disease. The conference report attempts to reconcile these competing demands in a way that will help ensure continuity of care for every person living with HIV/AIDS.

I would also like to say a word about one provision that has attracted a good deal of attention and concern—the portion of the bill dealing with the HIV testing of newborns. The compromise that has been reached is precisely that—a compromise. On the one hand, it affirms explicitly what I think we are believe: That every pregnant woman should be tested for the AIDS virus, that those who test positive should be offered the best treatments currently available, and that the soundest and surest way of ensuring that both of these things will happen is to provide the woman with counseling and voluntary testing.

On the other hand, a State that fails to meet specified targets through these voluntary measures could conceivably find its title II funding curtailed unless it agrees to institute mandatory testing of newborn infants. While I respect the convictions of those who favor such a result, the simple fact is that mandatory newborn testing cannot prevent HIV transmission from mother to child and is not supported by the responsible medical community.

Under the conference agreement, no State would be required to institute mandatory testing of newborns unless the Secretary finds that the medical community has changed its mind and such testing has become routine practice. In essence, it could not be required unless it is already taking place—a logic which Yogi Berra would surely appreciate. Nevertheless, I think it would have been wiser to give State health authorities the resources they need to implement voluntary testing without holding a gun to their heads and threatening the very funds on which so many vulnerable people depend.

Fortunately, the agreement we have reached virtually assures that no State will ever be put in that position. I believe the provision will allow every State to reduce its rate of perinatal transmission by voluntary means to a level and within a time frame that is both achievable and desirable, in a manner that is respectful of the critical relationship between the woman and her physician.

The effort to reauthorize this legislation has been a long and tortuous process. It has been, from first to last, a bipartisan effort. This is as it should be, for the AIDS virus does not discriminate by race or creed or sexual orientation—or even by party affiliation. This is a crisis that compels us to put aside such differences, and I commend Chairman BILIEY, Mr. BILIRAKIS, Mr. WAXMAN, and our fellow conferees for doing so.

I urge my colleagues to join together in that spirit to pass the conference report without delay.

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from California [Mr. BILBRAY], a member of the subcommittee.

Mr. BILBRAY. Mr. Speaker, I would like to commend Chairman BILIRAKIS and the ranking member of our Health Subcommittee, Mr. WAXMAN, for the cooperative effort that we see here today. I hate to say it is too bad, that you watch, you will not see this on the front page of the papers or you are not going to see this on national television, the cooperative effort on something that is a major, health issue. I hope we see more of this kind of cooperation and I hope that the American people take notice of this success.

I am pleased to see the conference report, Mr. speaker, that adequately funds the communities that are in desperate need of these funds to be able to address the heavy impacts of AIDS and HIV. I am also very pleased to see that this legislative piece actually directs and corrects some of the mistakes that were made from the past.

Both Republicans and Democrats have worked together at developing a formula that is fair and equitable and truly applies to the need. The old formula actually had misconstrued numbers in it, Mr. Speaker, where there were actually communities getting funds based on numbers of people that had already passed away.

□ 1845

I do not think anybody meant that to happen. What I am very proud of is this body, bipartisanly, has been able to work together to straighten out the mistakes of the past and make the Ryan White CARE Act not only stronger and better, but also fairer.

I would like to take a moment to address one item, and that is an item brought up, and that is the issue of testing. I have an AIDS Advisory Committee member in my district that consists of health care experts and also advocates in San Diego for the AIDS community. They express major concerns about the mandatory testing component that was originally included. But by trying to work together and find a good compromise, this bill, through the conference process, has been able to work it out and actually present an alternative.

I think the conference report addressed the concerns that allow the time in the States of this Union to be able to work with the Centers for Disease Control and their regulations to make a voluntary system that will work out, to counsel pregnant women, make sure there is the money, up to $10 million, to help not only to test, but also to counsel in the case of high risk women who fall in this category.

With this compromise, we are able to get the job done. We are going to be able to break new ground, enter into new territory, and try to be more proactive in the first truly aggressive prevention strategy. I think that we should be very proud of that, Mr. Chairman.

I understand that my advisory committee looked at this compromise, and though they had major concerns about the original proposal, feel that this is a very sound and humane way to approach this. I think it is one of those issues that will show that we not only can be humane, but we can also be smart and intelligent. With a crisis like the AIDS crisis we are confronted with, this is going to be something we need to do more of.

Again, I thank Chairman BILIRAKIS and also my colleague from California for a job well done, and let us begin with this as an example of what we need to do more of, and not allow it to end here.

Mr. WAXMAN. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. TOWNS], a very important member of the subcommittee who played an active role in the reauthorization of this legislation.

Mr. TOWNS. Mr. Speaker, I am very pleased that we finally have the opportunity to vote on a conference concerning the reauthorization of the Ryan White CARE Act. I want to particularly commend the Chairman of the committee, the gentleman from Florida [Mr. BILIRAKIS], for his tireless efforts to reauthorize this legislation. I want to also thank the ranking minority member, the gentleman from California [Mr. WAXMAN], for his work not only on this bill but also for the tremendous role he has played in the past in working on the Ryan White Act. And, I am certain the majority and minority staff are to be equally commended for their efforts.

There is no more critical issue than funding for health care services to combat the AIDS virus. Those of us from New York State continue to have the unfortunate distinction of the highest number of AIDS and HIV infection cases in the Nation. In fact, the Ft. Greene community in my congressional district, has the highest incidence of new AIDS cases of any area in New York City.

Mr. Speaker, Ryan White programs have been critical to New York's ability to provide a continuum of care which has greatly improved the quality of life for people with AIDS and HIV infection. For example, as a result of Ryan White dollars, the HIV/AIDS dental program was able to provide over $300,000 to Brooklyn Hospital in my district for oral health services to AIDS patients who had little or no dental insurance.

The changing nature of the AIDS epidemic and its impact on minority communities is recognized in this legislation. The average person would assume that the leading cause of death for African-American men is homicide. They would be wrong, however. AIDS now kills more black men than gunshot wounds. Eighty-four percent of the

AIDS cases involving children, age 12 and under, can be found in the Black community. And, AIDS has now become the second leading cause of death for black women. I.V. drug use and T.B. have exacerbated these mortality statistics in minority communities.

It is my hope, Mr. Speaker, that with today's action we can move quickly to provide the funds that our cities and small towns so desperately need to address the AIDS crisis in communities across this Nation. I believe that this reauthorization of the Ryan White CARE Act meets the needs of rural and suburban areas without devastating our metropolitan areas, which still have the burden of treating the largest number of AIDS and HIV infected patients.

This bill has been a long time coming, and I am happy we were able to get through the conference process and where we are today. I would like to encourage my colleagues to vote for the passage of this legislation.

There is a need for this legislation to pass and to pass very quickly. I am not totally pleased with the formula, but I am happy that some sensitivity was shown to those large areas, those metropolitan areas, that have a severe crisis.

So I would like to again salute the leadership on both sides, the minority and the majority, for taking these factors into consideration. It is not perfect and a lot still needs to be done, but I am happy we are moving in the right direction.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin [Mr. KLUG], a member of the subcommittee and full committee.

Mr. KLUG. Mr. Speaker, to my colleagues on the Health Subcommittee on Commerce, this is a nice way to end the day after fairly contentious hearings on trying to figure out a way to reform the Food and Drug Administration, so that we can get pharmaceutical products and medical devices to the market faster, but at the same time not compromising public safety.

This is a fitting end for the day, because we end occasionally, as this subcommittee can, and I hope will more often in the future, in a strong spirit of bipartisan cooperation to move forward a very important piece of legislation.

This is an interesting kind of coming together of the minds, not only from both sides of the aisle, but, frankly, an interesting collaboration from people who represent very different parts of the country.

I represent Madison, WI, which, like most other smaller cities in the United States, also has AIDS problems. But in the past we feel that we have been shortchanged because so many of the resources were plowed into New York and San Francisco, which obviously just based on current numbers had a much more serious problem. But in the future communities like Madison and Milwaukee will be just as dramatically impacted. I am glad to see the gentleman from California [Mr. WAXMAN] and the gentleman from Florida [Mr. BILIRAKIS], as well as the gentleman from Michigan [Mr. DINGELL] and the gentleman from Virginia [Mr. BLILEY], were able to move closer to Senate spending levels, which at the end of the day frankly will take funding in Wisconsin that was just a little bit over $1 million and, with the different kind of grant programs, push it to nearly $2 million.

I think we have all learned over the last decades that AIDS affects every part of the country, and, obviously, given the name of the bill itself, affects very different demographic groups, whether it is a young boy who has been victimized by the AIDS virus as a result of being exposed to hemophilia in a blood transfusion, or somebody who contracts AIDS from intravenous drug users, or whatever the case may be. The bottom line is all of those people need compassion and at the end all of those people need money.

Again, I congratulate the gentleman from Florida [Mr. BILIRAKIS] for his leadership, and the gentleman from California [Mr. WAXMAN] for all of his help on this bill as well.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from New York [Mr. ACKERMAN].

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

Mr. ACKERMAN. Mr. Speaker, I rise in full support of the conference report and want to take a moment to thank the chairman and the ranking member of the subcommittee and the full committee as well for the hard work and dynamic leadership that they have exhibited in bringing all parties and points of view together in this very, very important legislation.

I want to especially take a moment to acknowledge the hard work and important work that has been done in what has been called the AIDS baby part of this legislation. This is a very, very important and creative first step that we are taking, first emphasizing as strongly as we can the voluntary aspects, to try to get as many pregnant women counseled and tested for the HIV virus and then absent that, or after that, to whatever extent that does or does not work, and we all hope that will be as effective a method as possible, to then take those neonates whose mothers' HIV status is unknown, and to mandatorily test them so as to be able to save additional lives and to put off the onset of so much tragedy and emotion in so many people's lives.

I want to thank the members of the conference committee and urge everybody to support the report.

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin [Mr. GUNDERSON].

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

Mr. GUNDERSON. Mr. Speaker, first I rise in support of the conference report; to the commitment tonight continues. Second, I rise to extend my deep and sincere appreciation to the gentleman from Florida [Mr. BILIRAKIS], the chairman of the subcommittee, to the gentleman from Virginia [Mr. BLILEY], chairman of the full committee, certainly to the gentleman from California [Mr. WAXMAN], to the gentleman from Oklahoma, [Mr. COBURN], and others who have worked so hard to bring this day to its reality.

The fact is that this is a difficult process and there were some issues that were obviously very difficult, the infant testing issue, the formula for title II. But both of those issues have been resolved in, I think, a very positive and constructive way.

I can tell you from a Wisconsin perspective, because we now have some reforms in the title II program, we can look toward an increase in our funding in 1996 over 1995 of from $1 million to $1.5 million. In addition, because we now have a drug assistance program, we can look at the potential because it has been funded under the appropriation process, of literally $254,000 in that regard.

I would hope that we would send a message tonight, a message that has been developed over the last 2 weeks, that shows that this Congress on a bipartisan basis, and, yes, that includes the Republican majority, has sent the word that we understand and we care and we want to help. We did it first and foremost last week when we repealed the DOD–HIV provisions. We did it second last week when we included money for the AIDS drug assistance program, because we recognize that the new protocols are there but the funding is going to be one of the emerging challenges in the next few years to deal with in this area. We did it, third, because we increased the overall funding for Ryan White. Whoever thought under a Republican-controlled Congress that we would stand here tonight and tell you that Ryan White funding is up 17 percent over what it was last year? And now, tonight, we bring you a reauthorization of the Ryan White program.

It has been a good two weeks and it is important. Many of you recall, certainly those of you who attended that hearing that began this reauthorization process a few months ago when Mr. BILIRAKIS gave me the honor of being the lead witness, I brought a former Republican staff member who had retired November a year ago with AIDS with me to that witness table and said ''Hear from one of our own on Capitol Hill who has AIDS.''

Tonight as we pass this reauthorization, some 8 months later, his partner died of AIDS in November, and he lies in Sibley Hospital himself tonight as the ravage of this disease continues. I think it is important as those among the 300,000-plus in this country who have lost their life to AIDS, and the over 1 million who continue to battle the fight continue, that they know as

their battle goes on they do it with the support of the U.S. Congress.

Mr. Speaker, I am happy to speak in favor of the Ryan White CARE Reauthorization Act conference report. To say that this reauthorization has been a long time in coming may be an understatement. Certainly, we all had hoped that this reauthorization could have been completed sooner, but the issues this conference committee grappled with were delicate and complex. Importantly, their deliberations were careful and fair, and I think that their final product is one of which they can be proud and which we should all support. I congratulate the conference committee on their work. I plan to vote in favor of this conference report, in favor of reauthorization, and I urge my colleagues to do the same.

HIV disease, including AIDS, is devastating and has already wreaked a tremendous toll on this country and its citizens. The Centers for Disease Control and Prevention [CDC] reports that over a half million Americans have been diagnosed with AIDS, and that already over 300,000 have died. It is estimated that approximately 650,000 to 1 million more Americans are infected with HIV, and that roughly 40,000 new infections occur in the United States each year. The costs, financially, emotionally, socially, and legally, that HIV has extracted from this country have been great, but what these projections indicate is that they will only increase in the years ahead. The Ryan White CARE Act programs represent the most visible and significant response the Federal Government has made to the HIV epidemic. It has provided services and support for thousands of people affected by this disease, and through this reauthorization, we can insure that such programs will continue to be available for the next 5 years.

I would like to offer a few comments on some of the specific successes that I see in the reauthorization conference report. I view these as successes because workable and bipartisan compromises were reached, compromises that will allow us to move forward in effectively meeting the challenges HIV poses to this country.

First, funds for emergency assistance programs, those programs that serve metropolitan areas hit hardest, and for comprehensive care programs, will be linked and appropriated based on a plan devised by the Health and Human Service Secretary. This linkage will help prevent needless fighting for funds within the AIDS community and between different organizations and advocates that all have the common goal of improving the lives of people affected by HIV. In addition, the big picture of the HIV epidemic will most likely determine the disbursement of funds rather than narrowly circumscribed geographic regions or special interests.

In addition, the formula that was adopted for the distribution of title II, or part B, funds moves toward greater fairness. Previously, all funds were distributed based on all AIDS cases in a State. AIDS cases are not distributed equally across States, however, so there was great disparity in the funding levels for different States. But, the suffering caused by AIDS knows no State boundaries and is not limited to the States with the highest case counts. The new formula recognizes this important fact and disburses funds based on total AIDS case counts in a State as well as AIDS case counts that occur outside of hard-hit metropolitan areas.

My home State of Wisconsin, for example, has reported 3,239 cases for AIDS through March 1996. This total may not sound like much to my colleagues from New York, California, Florida, or Texas. But, the fact remains that for each of these cases, there is an individual whose life has been irrevocably changed, who faces new challenges everyday, and whose family and friends have been affected. Many of us know firsthand the pain of HIV and AIDS, including the pain of losing a loved one too early, and this pain is not diminished simply because we live in a low incidence area or State.

In addition, the CDC recently reported that the rate of proportionate increases in AIDS cases was high in the Midwest, and higher than the rates in the Northeast and West. In fact, during the period between 1993 and October 1995, higher proportions of cases among adolescent and young adults occurred in small metropolitan and rural areas in the Midwest and the South. Total case counts do not reveal the depth of suffering inflicted by AIDS, nor do they reveal where changes in transmission patterns are occurring. The new formulas for distributing funds move us forward in being responsive to these changes and to alleviating the suffering of all Americans affected by HIV.

Also in the name of fairness, this reauthorization stipulates that money to support AIDS drug programs, appropriated at $52 million in fiscal year 1996, will be based on total case counts. The committee has adopted the simple and compelling logic that these drugs and drug programs are intended to benefit anyone and everyone in a State with HIV disease. As long as funds for drugs and treatments remain a separate provision in appropriations, they will continue to be distributed based on the numbers of people who are affected in a State.

Lastly, there is a provision in the reauthorization that insures that cities that receive funds under title I will not lose money. For the first 2 years, these cities are held harmless and the funds that could be lost are capped at 5 percent in fiscal year 2000. Thus, there is relative insulation from dramatic changes in funding levels, even if there are substantial changes in AIDS case counts.

These formulas for distributing funds, complicated as they may be, insure that there are no losers. The States with relatively large case counts are protected from losing money, yet the new formulas benefit States with relatively few cases, too. It is a delicate balance to divide funds to combat a truly national epidemic; this conference report has successfully accomplished this difficult task.

Another issue on which a delicate compromise has been crafted has to do with perinatal testing for HIV. HIV testing, and whether it should be anonymous or confidential, mandatory or voluntary, has long been a controversial topic. I believe that testing today is a critical part of good public health. Recent advances in the treatment of HIV disease have been developed and are becoming increasingly available. To test HIV positive is no longer the death sentence that many perceived it to be previously. For individuals to access these new and effective treatments, however, they must know that they are HIV positive. Testing should be encouraged and should take place in a supportive and sensitive context. With respect to pediatric HIV, scientific research also has indicated that early treatment of a mother can reduce the risks that her baby will be born with HIV.

An important piece of this reauthorization is the way in which perinatal testing has been addressed. Rather than imposing a strict and perhaps impossible testing standard on all States, the reauthorization is flexible in its treatment of different States. In addition, critical goals or guideposts are laid out by which States can gauge their progress toward eliminating needless and tragic infant HIV infection. The conference committee has succeeded in providing carrots and not just sticks for implementing effective HIV testing programs as well as evaluation criteria by which success can be judged.

To conclude, I urge a vote in favor of this conference report. Let all of us demonstrate our compassion, concern, and commitment to fighting the HIV epidemic in this country and to ensuring the high quality of life of Americans affected by HIV disease.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Texas [Ms. JACKSON-LEE].

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, may I take a moment of personal privilege to offer my gratitude to the conference committee, to the leadership, the Republican leadership, and chairman and ranking member, and as well to the ranking member and subcommittee chairs that have worked so actively. In particular, let me add my applause and appreciation to the gentleman from California [Mr. WAXMAN] who has visited the 18th Congressional District in Texas and noted in fact that my district has one of the highest rates of HIV cases in this Nation.

So I humbly come to applaud the work, primarily because we should recognize that HIV is not a respecter of sex or race. High numbers of Hispanics and African-Americans in my community are now suffering from HIV.

This effort, the Ryan White CARE Act, also brings groups together, those who are in a different lifestyle, along with other members of the community. It is important to know that this HIV, which results in AIDS, affects people of all ages, genders, races, social and economic status and sexual orientations.

In the years following the disease's discovery, nearly half a million Americans have been diagnosed with AIDS and more than a quarter of a million men and women and children have died of AIDS. In Texas, the cumulative number of reported AIDS cases from the beginning of the epidemic in 1981 through 1994 is 30,712. The cumulative number of reported AIDS deaths for this time period is 18,435.

When I visited the Thomas Street Clinic that works not only with adults between the ages of 25 to 44, but senior citizens and children, I see the grip of AIDS. More importantly, I think it is important that this conference committee has come together to allow for voluntary testing of pregnant women

and as well counseling. That helps the unborn child, the innocent child. That will help as we look toward the total elimination of the HIV virus and its devastation.

Again let me add through the Ryan White program, over 300,000 Americans living with HIV receive community-based care and support that allows them to live in their homes and neighborhoods. I join and hope my colleagues will give this an enormous vote of confidence by voting for the Ryan White CARE Act of 1996.

Mr. Speaker, let me again applaud my colleagues so that we can work together to ensure that people will live and not die from HIV.

Mr. Speaker, I rise today in support of the conference report for the Ryan White CARE Act Amendments of 1996. Next to the Medicaid Program, the Ryan White CARE Act represents the single largest Federal investment in the care and treatment of people living with HIV/AIDS in the United States.

This act authorizes a set of Federal grant programs to provide assistance to localities disproportionately affected by the HIV epidemic. Grants are made to States, to certain metropolitan areas, and to other public or private nonprofit entities both for the direct delivery of treatment services and for the development, organization, coordination, and operation of more effective service delivery systems for individuals and families with the HIV disease. The CARE Act supports a wide range of community based services, including primary and home health care, case management, substance abuse treatment and mental health services, nutritional and housing services. Through Ryan White programs, over 300,000 Americans living with HIV/AIDS receive community-based care and support that allows them to live in their homes and neighborhoods and avoid costly in-hospital care, care that is currently the most expensive kind of health care in America. Particularly in the urban AIDS epicenters, Ryan White funds form a safety net holding communities that have been devastated by the epidemic together.

The CARE Act promotes cost effective systems of care for people living with HIV/AIDS. The use of case management services and community based alternatives ensures that the federal government is using its resources most effectively. Similarly, antibody testing and early intervention services provided through title III(B) allow individuals to monitor their health status on a regular basis and receive early, preventative care, rather than waiting until an acute episode requires more costly hospitalization.

The CARE Act provides maximum flexibility to cities and States, allowing them to develop local systems of care based on the specific service needs of people living with HIV/AIDS in their area. Title I of the CARE Act requires that each local HIV services planning council—comprised of local public health, community-based service providers and people living with HIV/AIDS assess local needs and make recommendations as to which services are needed. Similarly, through title II, each State is given maximum flexibility to craft a service mix that is responsive to the specific service needs in that State.

One of the most important programs funded by the Care Act in Texas is the AIDS Drug Assistance Program [ADAP]. Texas' ADAP is administered by the HIV/STD Medication Program at the Texas Department of Health and it provides free or low-cost HIV prescription drugs to individuals who would otherwise have no access to basic HIV treatments. The program currently has 4,775 clients enrolled and so far in fiscal year 1996 3,437 have been provided with medications they might not have otherwise received. Approximately 35 to 40 percent of the clients are Medicaid eligible at some time. Funds from the ADAP are only used to pay for drugs the clients cannot receive with Medicaid benefits. All clients have incomes below 200 percent of the poverty line.

Mr. Speaker, the AIDS epidemic is one that cries out for immediate and forceful action. The human immunodeficiency virus [HIV], which causes AIDS, does not discriminate. It affects people of all ages, genders, races, socioeconomic statuses, and sexual orientations. In the years following the disease's discovery, nearly half a million Americans have been diagnosed with AIDS, and more than a quarter of a million men, women, and children have died of AIDS. In Texas, the cumulative number of reported AIDS cases from the beginning of the epidemic in 1981 through 1994 is 30,712. The cumulative number of reported AIDS deaths for this time period is 18,435.

Mr. Speaker, AIDS is the leading killer of Americans between the ages 25 and 44. AIDS is killing the youngest and most vital part of our workforce and our whole Nation suffers as a result. The Centers for Disease Control and Prevention estimated that in 1992 the indirect cost of the AIDS epidemic to the U.S. economy was $23.3 billion, primarily due to wages lost by workers. Clearly, we must invest in HIV prevention, education and treatment. I support the conference report and I urge my colleagues to do so as well.

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Florida [Mr. FOLEY].

□ 1900

Mr. FOLEY. Mr. Speaker, let me thank the gentlewoman from Texas for her acknowledgment. That was very gracious and very kind, and I hope I hear more of that tonight from the other side because this truly is a bipartisan effort in helping people that have been stricken by a very deadly and tragic disease.

With the passage of the conference report on the Ryan White CARE amendment today we have a valuable opportunity to continue our commitment in the fight against AIDS. This legislation secures vital medical care and treatment for Americans suffering with this tragic disease and gives States more flexibility to provide them with a wider range of support services.

Since 1981, over 250,000 Americans have died from AIDS and more than a million others are expected to be infected. Sadly, the number of women, children, and teenagers infected with HIV continues to grow dramatically.

In my home district in Florida, the city of West Palm Beach has the single second highest rate of HIV infections in females. The legislation recognizes these concerns and sets up special grants to provide health services to women, infants, and children.

As more and more of our Nation's communities are affected by the AIDS epidemic, preserving the partnerships we have developed between the Federal, State and local governments to meet these health care needs is critical.

I want to single out the gentleman from Florida [Mr. BILIRAKIS] for his leadership on this important legislative initiative, but I also want to take a moment to thank some people that are often derided by both the media and the other side of the aisle as the radical extreme of this party. I want to say, thank you, Mr. NEWT GINGRICH. He first brought the Ryan White Act onto this House floor under a suspended calendar to prevent it from being intruded on by harmful amendments.

Let me thank the gentleman from Louisiana, BOB LIVINGSTON, chairman of the Committee on Appropriations, for working so closely with Mr. BILIRAKIS to secure $105 million additional for the funding of the Ryan White Act this year alone.

Let me thank my Republican colleagues for recognizing the severity of AIDS; that it affects Republicans, that it affects Democrats, that it affects Independents, that it affects men, it affects women, it affects blacks, whites, and Hispanics, that it affects heterosexuals as well as homosexuals. It affects America, our families, our children.

This legislation brings us to the point where we are fighting a dreaded disease and we are fighting it in a bipartisan spirit, caring for the soul of the human being rather than their ethnicity, their race, their gender, their preference or their voting status.

I think we embark today on a day of bipartisan spirit, and I hope the media genuinely reflects that it is a Republican majority that brings a bill to this floor to show care and compassion for human beings; it is a Republican majority, in concert with the gentleman from California [Mr. WAXMAN], and the minority who brings a bill together that funds a tragic, tragic thing in American life. It fights AIDS, it fights the battle, and it provides for human suffering when they need help the most.

Again my commendations to the gentleman from Florida [Mr. BILIRAKIS] for his excellent leadership, and I urge the floor to vote solidly for the reenactment of the Ryan White Act.

Mr. WAXMAN. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, I thank the gentleman from California [Mr. WAXMAN] for yielding the time, and I rise in strong support of the conference report for the Ryan White CARE Reauthorization Act.

My State knows all too well the pain and agony that HIV and AIDS bring. Connecticut has the fifth highest number of AIDS cases per capita in the Nation. In my district, the city of Hartford has been particularly hard hit.

AIDS is clearly a health crisis we must address now.

Last fall, Hartford and two adjoining counties were, for the first time, awarded title I Ryan White funding. This money will enable people living with AIDS to receive services so important to those ill—from housing to child care to respite care.

The formula under this conference report ensures that communities, like Hartford, with growing caseloads get the emergency funds they need to respond to this crisis. More importantly, it ensures the thousands of men, women, and children affected by the disease get the support they need to live their lives with dignity.

I urge a ''yes'' vote on this conference report.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. HORN].

Mr. HORN. Mr. Speaker, I join others in commending the gentleman from Florida, Chairman BILIRAKIS, for bringing the Ryan White Act to the floor for reauthorization.

Mr. Speaker, I rise today in strong support of S. 641, the Ryan White Comprehensive AIDS Resources Emergency Reauthorization Act of 1995. Thousands of men and women and children with HIV and AIDS depend on the continuation of these vital services and this vital program.

Ryan White services include outpatient health and medical services, pharmaceuticals, funding for the continuation of private health insurance and home care, which is essential. Without such assistance, tens of thousands of people will be adversely affected. Without such assistance increased suffering will ensue.

I have been an early active supporter of the Ryan White program since coming to Congress in 1993, and in the 103d and the 104th Congresses this bipartisan act and appropriate funds and increases have been allocated by the Members with overwhelming majorities. Sufficient funding for AIDS research, care, and prevention must be the consistent goal of all future Congresses until this horror is eradicated from the Earth.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey [Mr. PAYNE].

Mr. PAYNE of New Jersey. Mr. Speaker, I would like to commend my colleagues for their work in the fight against AIDS in our community. By producing this very important document, we here, in the spirit of bipartisanship, have taken another step to deal with the devastation and the threat that this disease poses to our society.

AIDS is growing fastest among women and children in our society. By early 1993, 253,448 people in the United States had been diagnosed with AIDS.

In my district in Newark, we have one of the highest reported percentages of women with AIDS. In fact, I held the first congressional hearing in my district on the AIDS issue.

Later, we held a hearing on the problem of abandoned infants, where women infected with AIDS testified about the problems they encounter and their personal plight.

As an original cosponsor of the Ryan White bill, I know the real travesty of this disease and we can prevent it. If this document is any indication, I believe there is some hope that we turn this tragedy into a triumph.

I look forward to working very closely with my colleagues to eliminate the threat to our community and our society.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma [Mr. COBURN] who has added an awful lot of grassroots and personal experience to the subcommittee and to the full committee and, obviously, to this particular piece of legislation, and we are very grateful for his work on Ryan White.

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

Mr. COBURN. Mr. Speaker, I thank the chairman of the committee. We come here tonight happy that we have accomplished some things that are new, some things that are important, but, most of all, to provide support for those that need our support in terms of facing HIV infection.

Some things have been added to this bill, which needed to be added a long time ago, and the first of those is a prohibition on discrimination based on either HIV status or the seeking of an HIV test. It is long overdue and I am glad to see it included.

Spousal notification is something that is needed. It is right. It is proper. It is a part of this bill as well.

And then, finally, putting in perspective where we have seen the best AIDS research come forward; that in terms of treating newborn infants and infants conceived to women who are HIV positive. The science is great, the science is very promising, and, hopefully, this science will lead to further discoveries and further breakthroughs that will treat those that are so ravaged by this disease.

Mr. Speaker, I want to thank the gentleman from California [Mr. WAXMAN] and those of the other side of the aisle who worked to help us forge out a compromise. I believe we have forged out a good one and I am hopeful we can get this money going straight away to help those who need it.

Mr. WAXMAN. Mr. Speaker, I yield myself 2 minutes for the purpose of engaging in a colloquy with the gentleman from Florida.

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

Mr. WAXMAN. Mr. Speaker, this bill provides that funds appropriated solely for the drug assistance program be allocated based on statewide case counts. I ask the gentleman from Florida; is that correct?

Mr. BILIRAKIS. Mr. Speaker, will the gentleman yield?

Mr. WAXMAN. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Speaker, I would say to the gentleman that that is correct.

Mr. WAXMAN. The bill also specifies that 3 percent of the appropriations for each title of the Ryan White program be set aside for the special projects of national significance; that 1 percent be set aside for technical assistance; and 1 percent for the Public Health Service evaluation funds.

It was my understanding that the $52 million for the drug assistance program would not be subject to these set-asides nor would this sum be included in calculating the set-aside taken from the formula grant. Was that the gentleman's understanding as well?

Mr. BILIRAKIS. Mr. Speaker, if the gentleman will continue to yield, yes, it was my understanding, Mr. WAXMAN, and I hope this colloquy and conversations with the Health Resources and Services Administration will help to clarify this point prior to funds being distributed to States.

Mr. WAXMAN. Mr. Speaker, I thank the gentleman for entering into this colloquy so we can clarify this.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from Connecticut [Mr. SHAYS].

Mr. SHAYS. Mr. Speaker, I just really want to express my gratitude to the gentleman from Florida [Mr. BILIRAKIS] and the ranking member, the gentleman from California [Mr. WAXMAN], for working so well together, and the full chairman of the committee as well as the gentleman from Oklahoma [Mr. COBURN], in particular, a new member who has helped bring together and help forge some very important elements to this bill.

Mr. Speaker, I am grateful that we are seeing a 17 percent increase in the Ryan White funding over last year. I am particularly grateful that we are seeing for the first time the prohibiting of health insurance discrimination against someone who suspects or in fact is HIV positive.

We have a million people in our country who are HIV positive, we have 300,000 who have died of AIDS. This country needs to come together to heal the wounds and to help them, and I am just extraordinarily grateful for the leaders on both sides of the aisle who have depoliticized this and made a significant step forward in helping the people in our country who need the help the most.

Mr. GILMAN. Mr. Speaker, over 250,000 Americans have died from AIDS, the dreaded equal opportunity killer which first became known to Americans in 1981. It is a health crisis which must be addressed now. This legislation accomplishes many of our most important goals—to modify the eligibility requirements and allocation formulas for grants to State and local governments; to give States increased flexibility to provide a wider range of treatments and support services; to emphasize the provision of services for women, infants, and children by instituting special grant set-

asides; to cap administrative and evaluation expenses for grant programs, and; to require states to implement center for disease control guidelines regarding HIV testing and counseling for pregnant women.

In short, this legislation not only demonstrates bipartisan humanitarian spirit of this Congress, but by working together in areas of mutual concern we can accomplish worthy goals. Accordingly, I am in strong support of the Ryan White CARE Act amendments conference support and urge its immediate passage.

Mr. BLILEY. Mr. Speaker, I am pleased that we are bringing to the floor the reauthorization of the Ryan White CARE Act.

I am particularly pleased that we were able to work on a bipartisan basis to develop this legislation. I believe that we have developed a bill that responds to changes in the HIV and AIDS epidemic, addresses some concerns with the current implementation of the Ryan White program, includes provisions regarding the perinatal transmission of HIV, and attempts to reach a compromise on funding formulas.

As is always the case, the funding formulas proved to be the most difficult issue to resolve. It was further complicated by the fact that States have not adopted the new definition of AIDS in a uniform fashion, which without a reauthorization would have resulted in large shifts of money this year. In addition, there have been some very exciting therapeutic breakthroughs over the past several months. While these breakthroughs represent tremendous hope in the treatment of HIV/AIDS, they result in additional financial strains on States. For these reasons, I believe it was very important, in agreeing on the title II formula, that we kept in mind both the disruptions caused by large shifts in money and the need to provide the non-EMA States with greater funds.

We believe we have achieved a fair compromise between the original House and Senate positions. We significantly increase funding for non-EMA States while limiting the losses to large States with title I cities. The formula we have agreed upon is a modified version of the Senate formula. I do want to point out however, that in the fiscal year 1996 appropriations bill, which just passed, an additional $52 million was provided solely for the drug assistance program. The conference agreement provides that these funds will be allocated based on the statewide case count rather than the Senate formula. I believe this is important because the States provide drugs to all individuals with HIV/AIDS regardless of where they live through the drug assistance program.

The other key issue was that of perinatal transmission of HIV. All the conferees, and I am certain all Members of the House and Senate, share the same goal—reducing the transmission of HIV to infants, and in those cases where transmission is not prevented, identifying and treating those babies as soon as possible. It is our sincere hope that the provisions included in the conference agreement will achieve that goal.

I also want to point out that we have received a letter from CBO stating that the bill does not invoice the Unfunded mandates Reform Act of 1995. And I ask that the letter from CBO follow my statement.

I want to thank all the conferees and their staffs for their perseverance and hard work on this conference agreement. I also want to thank the staff at the General Accounting Office who spent many long hours running iterations of the formulas.

I urge my colleagues to join me in supporting the conference agreement.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 1, 1996.

Hon. THOMAS J. BLILEY, Jr.
Chairman, Committee on Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: At the request of your staff, the Congressional Budget Office has reviewed the conference committee's discussion draft of S. 641, the Ryan White CARE Act Amendments of 1996, for intergovernmental and private sector mandates. The bill contains two intergovernmental mandates and no private sector mandates. The cost of the intergovernmental mandates would not exceed the $50 million threshold established in Public Law 104–4, the Unfunded Mandates Reform Act of 1995.

S. 641 would require states to determine annually the number of AIDS cases reported within their boundaries that result from perinatal transmission. The cost associated with this requirement would be insignificant because most states are already gathering this type of information.

The bill would also require states to adopt the Center for Disease Control's (CDC's) guidelines concerning HIV counseling and voluntary testing for pregnant women. In order to offset the costs associated with adopting these guidelines, the bill would authorize the appropriation of $10 million in each of fiscal years 1996 through 2000. Any state that does not adopt the guidelines would not be eligible for this funding, but the bill does not clearly relieve states of responsibility for adopting the CDC guidelines if they choose not to take any of the grant money. While CBO does not expect the costs of promulgating the CDC guidelines to be significant, public hospitals and clinics could face additional costs in implementing the guidelines. However, many hospitals and clinics are already carrying out these AIDS-related activities on their own or because their states have already adopted the CDC guidelines. In the time available, CBO has not been able to estimate the additional costs with precision, but we believe that the costs to public facilities would be well below the $50 million threshold. Furthermore, the bill authorizes funds that would at least partially offset these costs.

Finally, as a condition of receiving their Ryan White grant money, states may have to require all newborns to be tested for HIV. This requirement would not be a mandate as defined by Public Law 104–4, because it is clearly a condition for receiving federal financial assistance.

If you wish further details on this estimate, we will be pleased to provide them. The analyst for intergovernmental mandates is John Patterson, and the analyst for private sector mandates is Linda Bilheimer.

Sincerely,

JUNE E. O'NEILL, *Director.*

Mr. LAZIO of New York. Mr. Speaker, I rise today to support S. 641, the Ryan White CARE Act amendments conference Report. I am a cosponsor of the House bill. It is long overdue and I am glad that Congress is finally completing its work on this measure.

New York has been hit especially hard by the AIDS epidemic as close to 20 percent of all AIDS cases are in my home State.

Since its enactment, the Ryan White CARE Act has provided a wider range of services for people of all racial, ethnic, and social-economic classes throughout the United States who are struggling with HIV disease. These funds provide a coordinated continuum of care for these individuals. Some of the services supported by the CARE Act include outpatient health and medical serrices, pharmaceuticals, funding for continuation of private health insurance, and some health care.

As a society we have a responsibility to provide for those who are truly needy. Since its original enactment the Ryan White program has helped tens of thousands of AIDS victims in my home State of New York State as well as those throughout the country.

We need to reauthorize the Ryan CARE Act without any further delay and I urge all my colleagues to vote for its passage.

Mrs. MINK of Hawaii. Mr. Speaker, I rise in strong support of the conference report on the Ryan White CARE Reauthorization Act of 1995. The importance of this act cannot be overstated; in the 6 years since its enactment, it has been a lifeline of support to hundreds of thousands of AIDS and HIV victims throughout the country.

The challenges of our fight against AIDS are not unfamiliar to us. Since the onset of this epidemic over 15 years ago, we have struggled to contain this virus via surveillance and prevention efforts, as researchers worldwide scrambled for a cure. Meanwhile, numbers of people affected with the AIDS has spiraled upward. According to the Centers for Disease Control, more than 440,000 cases of AIDS have been reported in this country, and over 1 million are HIV-infected. Over 100 Americans die each day from the disease. Health care costs for treating the virus have risen astronomically, taking an unwieldy economical toll on its victims. Discrimination rising out of fear and lack of awareness about the AIDS and HIV has exacerbated the sense of emotional isolation faced by its victims. This is all in addition to the physical agony the disease wreaks on the body.

The scope of this crisis clearly commands the attention and resources of the American people. The Ryan White CARE Act of 1990 made available much needed Federal money to help ease the physical, emotional, and economic toll of the disease on its victims. Our Nation was caught so unprepared for the advent and explosion of AIDS and HIV in the last two decades, that this legislation provided needed relief for our reeling health services delivery system. In the 6 years since the law authorized grants to States and cities for AIDS treatment and support programs as alternatives to inpatient care, much of the burden that urban and rural hospitals face has been alleviated and the quality of life for those suffering with the virus has greatly improved. National AIDS organizations and Federal, State, and local public health officials have testified to the success of the program, while underscoring that the urgency of the AIDS epidemic has not subsided and that there exists a continued need for the CARE Act.

We are entering a new phase in our battle against the virus. A recent article in the New York Times discussed the arrival of a new class of drugs known as protease inhibitors, which, taken in combination with standard older drugs, provide the most potent therapy against HIV to date. These new treatments are unfortunately very expensive. Where Medicare and private insurance defer some of the cost, many patients are depending on the AIDS drug reimbursement program of the CARE Act as a means of easing their suffering. I strongly believe that it is especially critical as we are on the brink of medically treating this disease, that we do not withdraw our funding support.

Fighting against this killer virus is the universal charge of all Americans. AIDS is no longer a disease of a select few, but instead touches the lives of more and more people in our society. The epidemic has spread into suburban and rural areas in every State of this country and entered the ranks of sports heroes and movie stars. AIDS is currently the No. 1 killer of all Americans between the ages of 25 and 44. It does not discriminate between gender or sexual orientation. It cuts across all races and socio-economic classes. As of July 1994, 5,000 children had received an AIDS diagnosis. It is our collective social responsibility to provide for our most vulnerable citizens the best that we can, and I urge my colleagues to support this conference report.

Mr. WAXMAN. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the conference report.

The previous question was ordered.

The SPEAKER pro tempore (Mr. EWING). The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GUNDERSON. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 402, nays 4, not voting 27, as follows:

[Roll No. 145]

YEAS—402

Abercrombie
Ackerman
Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Baldacci
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Bass
Bateman
Becerra
Bentsen
Bereuter
Bevill
Bilbray
Bilirakis
Bishop
Blute
Boehlert
Boehner
Bonior
Bono
Borski
Brewster
Browder
Brown (CA)
Brown (FL)
Brown (OH)
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clayton
Clement
Clinger
Clyburn
Coble
Coburn
Coleman
Collins (GA)
Collins (IL)
Collins (MI)
Combest
Condit
Conyers
Cooley
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cremeans
Cubin
Cummings
Cunningham
Danner
Davis
Deal
DeFazio
DeLauro
DeLay
Dellums
Deutsch
Diaz-Balart
Dickey
Dixon
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Emerson
English
Ensign
Eshoo
Evans
Everett
Ewing
Farr
Fattah
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Flake
Flanagan
Foglietta
Foley
Forbes
Ford
Fowler
Fox
Frank (MA)
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Geren
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Graham
Green (TX)
Greene (UT)
Greenwood
Gunderson
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (FL)
Hastings (WA)
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hilliard
Hinchey
Hoekstra
Hoke
Holden
Horn
Hostettler
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Jones
Kanjorski
Kasich
Kelly
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Lantos
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
LoBiondo
Lofgren
Longley
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McDermott
McHale
McHugh
McInnis
McIntosh
McKeon
McKinney
McNulty
Meehan
Meek
Menendez
Metcalf
Meyers
Mica
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Packard
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Rush
Sabo
Salmon
Sanders
Sanford
Sawyer
Saxton
Schaefer
Schiff
Schroeder
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Spratt
Stark
Stearns
Stenholm
Stockman
Stokes
Studds
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas
Thompson
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torres
Towns
Traficant
Upton
Velazquez
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Wamp
Ward
Waters
Watt (NC)
Watts (OK)
Waxman
Weldon (PA)
Weller
White
Whitfield
Wicker
Williams
Wise
Wolf
Woolsey
Wynn
Yates
Young (AK)
Young (FL)
Zeliff
Zimmer

NAYS—4

Funderburk
Istook
Scarborough
Stump

NOT VOTING—27

Ballenger
Barton
Beilenson
Berman
Bliley
Bonilla
Boucher
Bryant (TX)
Clay
de la Garza
Dicks
Dingell
Engel
Gibbons
Goss
Hayes
Hobson
Houghton
Kaptur
Livingston
McDade
Miller (FL)
Molinari
Shaw
Torricelli
Weldon (FL)
Wilson

□ 1933

Messrs. MARKEY, DIXON, and COBLE changed their votes from ''nay'' to ''yea.''

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. WELDON of Florida. Mr. Speaker, on rollcall No. 145, I was inadvertently detained. Had I been present, I would have voted ''yea.''

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and submit extraneous material on the conference report to S. 641.

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Is there objection to the request of the gentleman from Florida?

There was no objection.

RYAN WHITE CARE ACT REAUTHORIZATION

(Ms. PELOSI asked and was granted permission to address the House for 1 minute.)

Ms. PELOSI. Mr. Speaker, I rise in support of the Ryan White Care Act reauthorization conference report. This legislation is needed to continue the vital services provided under the Ryan White Program. I commend the conferees for their hard work in reaching agreements on many difficult issues.

The final agreement revises formulas for distribution of funds for the emergency assistance program for cities and for the grants to States for AIDS-related health care. The conferees have balanced their approach to maximize fairness to all involved.