

High School in Abington, PA, for being selected by the Corporation for National Service as a National Service-Learning Leaders Schools. Abington is one of only two schools in Pennsylvania to receive this honor, and has been selected as part of the first-ever class of Service-Learning Leader Schools.

This designation is only awarded to schools that have broad-based service-learning activities throughout the school, and who have thoughtfully and effectively integrated service into school life and curriculum, promoted civic responsibility, improved school and student performance, and strengthened the surrounding communities with their participation.

National Service-Learning Leader Schools do not simply hold an honorary title. Along with the honor, Abington accepts responsibility for helping other schools integrate service into their curriculum. During Abington's 2-year term as a Service-Learning Leader, it will serve as a model of best practices to other schools and actively help them incorporate service-learning into their school life and curriculum. Specifically, Abington will lead, mentor, and coach other schools by sharing materials, making presentations, and participating in peer exchanges.

As part of its Service-Learning Leader activities, Abington will send representatives to Washington, DC this June in order to attend a Leader Schools Leadership Institute, during which delegates will receive specific training on establishing service programs in their schools, and in helping other schools to do the same.

Once again, congratulations to Abington Senior High School. The entire Thirteenth District is proud of them, and commends them for their excellent work in instilling civic responsibility in students and for serving the community.

INTRODUCTION OF H.R. 1977, THE HAROLD HUGHES, BILL EMERSON SUBSTANCE ABUSE TREATMENT PARITY ACT

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. RAMSTAD. Mr. Speaker, every day, politicians talk about the goal of a "drug-free America."

Mr. Speaker, let's get real! We will never even come close to a drug-free America until we knock down the barriers to chemical dependency treatment for the 26 million American people presently addicted to drugs and/or alcohol.

That's right, Mr. Speaker. 26 million alcoholics and addicts in the United States today.

150,000 Americans died last year from drug and alcohol addiction.

Alcohol and drug addiction, in economic terms, cost the American people \$246 billion last year. American taxpayers paid over \$150 billion for drug-related criminal and medical costs alone in 1997—more than they spent on education, transportation, agriculture, energy, space and foreign aid combined.

According to the Health Insurance Association of America, each delivery of a new child that is complicated by chemical addiction results in an expenditure of \$48,000 to \$150,000

in maternity care, physicians' fees and hospital charges. We also know that 65 percent of emergency room visits are drug/alcohol related.

The National Center on Addiction and Substance Abuse found that 80 percent of the 1.7 million prisoners in America are behind bars because of drugs and/or alcohol addiction.

Another recent study showed that 85 percent of child abuse cases involve a parent who abuses alcohol or other drugs. 70 percent of all people arrested test positive for drugs. Two-thirds of all murders are drug-related.

Mr. Speaker, how much evidence does Congress need that we have a national epidemic of addiction? An epidemic crying out for a solution that works. Not more cheap political rhetoric. Not more simplistic, quick fixes that obviously are not working.

Mr. Speaker, we must get to the root cause of addiction and treat it like other diseases. The American Medical Association told Congress and the nation in 1956 that alcoholism and drug addiction are a disease that requires treatment to recover.

Yet today in America only 2 percent of the 16 million alcoholics and addicts covered by health plans are able to receive adequate treatment.

That's right. Only 2 percent of alcoholics and addicts covered by health insurance plans are receiving effective treatment for their chemical dependency, notwithstanding the purported "coverage" of treatment by their health plans.

That's because of discriminatory caps, artificially high deductibles and copayments, limited treatment stays as well as other restrictions on chemical dependency treatment that are different from other diseases.

If we are really serious about reducing illegal drug use in America, we must address the disease of addiction by putting chemical dependency treatment on par with treatment for other diseases. Providing equal access to chemical dependency treatment is not only the prescribed medical approach; it's also the cost-effective approach.

We have all the empirical data, including actuarial studies, to prove that parity for chemical dependency treatment will save billions of dollars nationally while not raising premiums more than one-half of one percent, in the worst case scenario!

It's well-documented that every dollar spent for treatment saves \$7 in health care costs, criminal justice costs and lost productivity from job absenteeism, injuries and sub-par work performance.

A number of studies have shown that health care costs, alone, are 100 percent higher for untreated alcoholics and addicts compared to recovering people who have received treatment.

Mr. Speaker, as a recovering alcoholic myself, I know firsthand the value of treatment. As a recovering person of almost 18 years, I am absolutely alarmed by the dwindling access to treatment for people who need it. Over half of the treatment beds are gone that were available 10 years ago. Even more alarming, 60 percent of the adolescent treatment beds are gone.

Mr. Speaker, we must act now to reverse this alarming trend. We must act now to provide greater access to chemical dependency treatment.

That's why today I am introducing the Harold Hughes, Bill Emerson Substance Abuse

Treatment Parity Act—the same bill that had the broad, bipartisan support last year of 95 cosponsors.

This legislation would provide access to treatment by prohibiting discrimination against the disease of addiction. The bill prohibits discriminatory caps, higher deductibles and copayments, limited treatment stays and other restrictions on chemical dependency treatment that are different from other diseases.

This is not another mandate because it does not require any health plan which does not already cover chemical dependency treatment to provide such coverage. It merely says those which offer chemical dependency coverage cannot treat it differently from coverage for medical or surgical services for other diseases.

In addition, the legislation waives the parity for substance abuse treatment if premiums increase by more than 1 percent and exempts small businesses with fewer than 50 employees.

Mr. Speaker, it's time to knock down the barriers to chemical dependency treatment. It's time to end the discrimination against people with addiction.

It's time to provide access to treatment to deal with America's No. 1 public health and public safety problem.

We can deal with this epidemic now or deal with it later.

But it will only get worse if we continue to allow discrimination against the disease of addiction.

As last year's television documentary by Bill Moyers pointed out, medical experts and treatment professionals agree that providing access to chemical dependency treatment is the only way to combat addiction in America. We can build all the fences on our borders and all the prison cells that money can buy. We can hire thousands of new border guards and drug enforcement officers. But simply dealing with the supply side of this problem will never solve it.

That's because our nation's supply side emphasis does not adequately attack the underlying problem. The problem is more than illegal drugs coming into our country; the problem is the addiction that causes people to crave and demand those drugs. We need more than simply tough law enforcement and interdiction; we need extensive education and access to treatment.

Drug czar Barry McCaffrey understands. He said recently, "Chemical dependency treatment is more effective than cancer treatment, and it's cheaper." General McCaffrey also said, "We need to redouble our efforts to insure that quality treatment is available."

Mr. Speaker, General McCaffrey is right and all the studies back him up. Treatment does work and it is cost-effective.

Last September, the first national study of chemical dependency treatment results confirmed that illegal drug and alcohol use are substantially reduced following treatment. This study, by the Substance Abuse and Mental Health Services Administration, shows that treatment rebuilds lives, puts families back together and restores substance abusers to productivity.

According to Dr. Ronald Smith, Captain, Navy Medical Corps and former Vice Chairman of Psychiatry at the National Naval Medical Center, the U.S. Navy substance abuse treatment program has an overall recovery rate of 75 percent.

The Journal of the American Medical Association (JAMA) on April 15, 1998 reported that a major review of more than 600 research articles and original data conclusively showed that "addiction conforms to the common expectations for chronic illness and addiction treatment has outcomes comparable to other chronic conditions." It states that relapse rates for treatment for drug/alcohol addiction (40%) compare favorably with those for 3 other chronic disorders: adult-onset diabetes (50%), hypertension (30%) and adult asthma (30%).

A March 1998 GAO report also surveyed the various studies on the effectiveness of treatment and concluded that treatment is effective and beneficial in the majority of cases.

A number of state studies also show that treatment is cost-effective and good preventive medicine.

A Minnesota study extensively evaluated the effectiveness of its treatment programs and found that Minnesota saves \$22 million in annual health care costs because of treatment.

A California study reported a 17 percent improvement in other health conditions following treatment—and dramatic decreases in hospitalizations.

A New Jersey study by Rutgers University found that untreated alcoholics incur general health care costs 100 percent higher than those who receive treatment.

So, the cost savings and effectiveness of chemical dependency treatment are well-documented. But putting the huge cost-savings aside for a minute, what will treatment parity cost?

First, there is no cost to the federal budget. Parity does not apply to FEHBP, Medicare or Medicaid.

First, there is no cost to the federal budget. Parity does not apply to FEHBP, Medicare or Medicaid.

According to a national research study that based projected costs on data from states which have already enacted chemical dependency treatment parity, the average premium increase due to full parity would be 0.2 percent. (Mathematical Policy Research study, March 1998)

A Milliman and Robertson study projected the worst-case increase to be 0.5 percent, or 66 cents a month per insured.

That means, under the worst-case scenario, 16 million alcoholics and addicts could receive treatment for the price of a cup of coffee per month to the 113 million Americans covered by health plans. At the same time, the American people would realize \$5.4 billion in cost-savings from treatment parity, according to the California Drug and Alcohol Treatment Assessment.

U.S. companies that provide treatment have already achieved substantial savings. Chevron reports saving \$10 for each \$1 spent on treatment. GPU saved \$6 for every \$1 spent. United Airlines reports a \$17 return for every dollar spent on treatment.

And, Mr. Speaker, no dollar value can quantify the impact that greater access to treatment will have on the spouses, children and families who have been affected by the ravages of addiction. Broken families, shattered lives, messed-up kids, ruined careers.

Mr. Speaker, this is not just another policy issue. This is a life-or-death issue for 16 million Americans who are chemically dependent, covered by health insurance but unable to access treatment.

We know one thing for sure. Addiction, if not treated, is fatal. That's right—addiction is a fatal disease.

Last year, 95 House members from both sides of the political aisle co-sponsored this substance abuse treatment parity legislation.

This year, let's knock down the barriers to treatment for 16 million Americans.

This year, let's do the right thing and the cost effective thing and provide access to treatment.

This year, let's pass treatment parity legislation to deal with the epidemic of addiction in America.

Mr. Speaker, the American people cannot afford to wait any longer.

I urge all members to cosponsor the Harold Hughes, Bill Emerson Substance Abuse Treatment Parity Act.

SOUTHSIDE SAVANNAH RAIDERS—
H.R. NO. 566

HON. JACK KINGSTON

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. KINGSTON. Mr. Speaker, today, I rise to recognize the outstanding achievements of the Southside Savannah Raiders, and I present to you this resolution.

Whereas, the Southside Savannah Raiders, the terrific youth baseball team for boys 14 years old and under, won the 1998 State Baseball Championship promoted by the Georgia Association of Recreation and Parks Departments; and

Whereas, the victorious Raiders are sponsored by the Vietnam Veterans of America Chapter 671, but all of Savannah shared in their victory in Brunswick on July 18, 1998; and

Whereas, the Southside Savannah Raiders had an overall record of 32 wins and five losses during the 1998 season while clinching the League, City, District 2, and Georgia Games titles; and

Whereas, these fine young athletes demonstrated exceptional ability, motivation, and team spirit throughout their rigorous season, and the experience they have shared has provided them many wonderful memories, friendships, and values; and

Whereas, the members of the 1998 Raiders are Joey Boaen, Christopher Burnsed, Brady Cannon, Robert Cole, Brian Crider, Matthew Dotson, Kevin Edge, Michael Hall, Mark Hamilton, Garrett Harvey, Zach Hillard, Bobby Keel, Corey Kessler, Chris Palmer, Matt Thomas, and Ellis Waters; and the coaches are Linn Burnsed, Danny Boaen, and Gene Dotson, *now therefore, be it resolved by the House of Representatives*; that the members of this body congratulate the Southside Savannah Raiders on their state championship and wish each member of the team all the success in the future.

Be it further resolved that the Clerk of the House of Representatives is authorized and directed to transmit an appropriate copy of this resolution to the Southside Savannah Raiders.

CHILDREN'S LEAD SCREENING ACCOUNTABILITY FOR EARLY-INTERVENTION ACT OF 1999

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 27, 1999

Mr. MENENDEZ. Mr. Speaker, I am pleased today to introduce the Children's Lead Screening Accountability for Early-Intervention Act of 1999. This important legislation will strengthen federal mandates designed to protect our children from lead poisoning—a preventable tragedy that continues to threaten the health of our children.

Childhood lead poisoning has long been considered the number one environmental health threat facing children in the United States, and despite dramatic reductions in blood lead levels over the past 20 years, lead poisoning continues to be a significant health risk for young children. CDC has estimated that about 890,000, or 4.4 percent of children between the ages of one and five have harmful levels of lead in their blood. Even at low levels, lead can have harmful effects on a child's intelligence and his, or her, ability to learn.

Children can be exposed to lead from a number of sources. We are all cognizant of lead-based paint found in older homes and buildings. However, children may also be exposed to non-paint sources of lead, as well as lead dust. Poor and minority children, who typically live in older housing, are at highest risk of lead poisoning. Therefore, this health threat is of particular concern to states, like New Jersey, where more than 35 percent of homes were built prior to 1950.

In 1996, New Jersey implemented a law requiring health care providers to test all children under the age of 6 for lead exposure. But during the first year of this requirement, there were actually fewer children screened than the year before, when there was no requirement at all. Between July 1997 and July 1998, 13,596 children were tested for lead poisoning. The year before that more than 17,000 tests were done.

At the federal level, the Health Care Financing Administration (HCFA) has mandated that Medicaid children under 2 years of age be screened for elevated blood lead levels. However, recent General Accounting Office (GAO) reports indicate that this is not being done. For example, the GAO has found that only about 21% of Medicaid children between the ages of one and two have been screened. In the state of New Jersey, only about 39% of children enrolled in Medicaid have been screened.

Based on these reviews at both the state and federal levels, it is obvious that improvements must be made to ensure that children are screened early and receive follow up treatment if lead is detected. That is why I am introducing this legislation which I believe will address some of the shortcomings that have been identified in existing requirements.

The legislation will require Medicaid providers to screen children and cover treatment for children found to have elevated levels of lead in their blood. It will also require improved data reporting of children who re tested, so that we can accurately monitor the results of the program. Because more than 75%—or nearly 700,000—of the children found to have