

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?

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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.

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SOUTHSIDE SAVANNAH RAIDERS—  
H.R. NO. 566

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**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