

S. 950

At the request of Mr. REID, the names of the Senator from New York (Mr. SCHUMER) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 950, a bill to amend the Clean Air Act to address problems concerning methyl tertiary butyl ether, and for other purposes.

S. 1017

At the request of Mr. DODD, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from South Dakota (Mr. DASCHLE) were added as cosponsors of S. 1017, a bill to provide the people of Cuba with access to food and medicines from the United States, to ease restrictions on travel to Cuba, to provide scholarships for certain Cuban nationals, and for other purposes.

S. 1037

At the request of Mrs. HUTCHISON, the names of the Senator from Missouri (Mr. BOND) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 1037, a bill to amend title 10, United States Code, to authorize disability retirement to be granted posthumously for members of the Armed Forces who die in the line of duty while on active duty, and for other purposes.

S. 1050

At the request of Mr. SANTORUM, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 1050, a bill to protect infants who are born alive.

S. RES. 68

At the request of Mr. JOHNSON, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. Res. 68, a resolution designating September 6, 2001 as "National Crazy Horse Day."

S. RES. 71

At the request of Mr. HARKIN, the names of the Senator from Hawaii (Mr. INOUE), the Senator from Indiana (Mr. BAYH), the Senator from New York (Mrs. CLINTON), the Senator from Maryland (Ms. MIKULSKI), and the Senator from Nevada (Mr. REID) were added as cosponsors of S. Res. 71, a resolution expressing the sense of the Senate regarding the need to preserve six day mail delivery.

AMENDMENT NO. 805

At the request of Mr. TORRICELLI, the names of the Senator from California (Mrs. BOXER) and the Senator from Nevada (Mr. REID) were added as cosponsors of amendment No. 805 proposed to H.R. 1, a bill to close the achievement gap with accountability, flexibility, and choice, so that no child is left behind.

#### STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HATCH (for himself and Mr. KERRY):

S. 1066. A bill to amend title XVIII of the Social Security Act to establish

procedures for determining payment amounts for new clinical diagnostic laboratory tests for which payment is made under the Medicare Program; to the Committee on Finance.

Mr. HATCH. Mr. President, I rise to introduce the Medicare Patient Access to Preventive and Diagnostic Tests Act. This bipartisan legislation will establish new procedures under Medicare for determining the coding and payment amounts for clinical diagnostic laboratory tests. I am pleased to have my colleague, Senator JOHN KERRY, as the lead Democratic sponsor of this bill. Similar legislation has been introduced in the House of Representatives by Congresswoman JENNIFER DUNN and Congressman JIM MCDERMOTT.

Innovative clinical laboratory tests help save lives and reduce health care costs by detecting diseases, such as cancer, heart attacks, and kidney failure in their early stages, when they are more treatable. However, there are serious flaws in the way that the Center for Medicare and Medicaid Services, CMS, formally known as HCFA, currently sets reimbursement rates for diagnostic tests.

This cumbersome bureaucratic system makes it difficult for physicians and laboratories to offer these diagnostic tests to their patients who need them. Due to institutionalized flaws in the current Medicare reimbursement system, revolutionary and innovative diagnostic tests may not benefit patients for years to come. In addition, it has been shown that lower laboratory payments correlate with lower utilization. The payment rates vary significantly from region to region and State to State.

For example, in my home State of Utah, a patient is sent for blood work to test for kidney disease. Based upon the 2001 Medicare Lab Reimbursement schedule, the Utah lab would receive \$2.12 for performing the test. However, labs in Arizona, Nevada, Montana, New Mexico and Wyoming, would receive \$6.33 to perform the same test. This makes no economic or medical sense to me.

A recent Institute of Medicine, IoM, report stated that Medicare payments for outpatient clinical laboratory services should be based on a single, rational fee schedule. Medicare should account for market-based factors such as local labor costs and prices for goods and services in establishing the fee schedule. In addition, CMS should provide opportunities for stakeholder input and develop better communication with contractors while policies are being developed and after these policies are adopted.

Our bill, based upon the principles of this IoM report, would require CMS to establish a national fee schedule for new and current tests, based upon an open, transparent, and rational public process for incorporating new tests, as well as to provide clear explanations of the reasoning behind its reimbursement decisions. This new process would

be based upon science based methodologies for setting prices for new technologies that are designed to establish fair and appropriate payment levels for these items and services.

CMS's procedures would provide that the payment amount for tests would be established under either the so-called gap-filling or cross-walking methodologies, and they would specify the rules for deciding which methodology will be used and how it will be employed. In particular, the legislation would require that if a new test is clinically similar to a test for which a fee schedule amount has already been established, through cross-walking, CMS will pay the same fee schedule amount for the new test. In determining whether tests are clinically similar, CMS will not take into account economic factors.

Finally, this new process would provide a mechanism for any laboratory or other stakeholder to challenge CMS fee schedule decisions. The cost of these changes is small in light of the significant impact on improving the quality of patient care.

I hope my colleagues will join me in cosponsoring this bill. The laudable goal of this bipartisan legislation is to establish an open and transparent public process for incorporating new laboratory tests into the Medicare program. Many seniors currently do not have full access to the medical care they need due to the antiquated process for assigning billing codes and setting reimbursement rates. We need to bridge the gap between seniors and the life-saving lab tests they need to preserve their health and promote their well-being.

I ask my colleagues to join with me in supporting this legislation and ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1066

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

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Patient Access to Preventive and Diagnostic Tests Act".

#### SEC. 2. CODING AND PAYMENT PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORATORY TESTS UNDER MEDICARE.

(a) DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395f(h)) is amended by adding at the end the following new paragraph:

"(9)(A) The Secretary shall establish procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2002 (in this subsection referred to as 'new tests'). Such procedures shall provide that—

"(i) the payment amount for such a test will be established only on—

"(I) the basis described in paragraph (10)(A); or

“(II) the basis described in paragraph (10)(B); and

“(i) the Secretary shall determine whether the payment amount for such a test is established on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B) only after the process described in subparagraph (B) has been completed with respect to such test.

“(B) Determinations under subparagraph (A)(ii) shall be made only after the Secretary—

“(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which the establishment of a payment amount under paragraph (10) is being considered for a year;

“(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations from the public on the appropriate basis under paragraph (10) for establishing payment amounts for the tests on such list;

“(iii) not less than 30 calendar days after publication of such notice, convenes a meeting to receive such comments and recommendations, with such meeting—

“(I) including representatives of each entity within the Health Care Financing Administration (in this paragraph referred to as ‘HCFA’) that will be involved in determining the basis on which payment amounts will be established for such tests under paragraph (10) and implementing such determinations;

“(II) encouraging the participation of interested parties, including beneficiaries, device manufacturers, clinical laboratories, laboratory professionals, pathologists, and prescribing physicians, through outreach activities; and

“(III) affording opportunities for interactive dialogue between representatives of HCFA and the public;

“(iv) makes minutes of such meeting available to the public (through an Internet site and other appropriate mechanisms) not later than 15 calendar days after such meeting;—

“(v) taking into account the comments and recommendations received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under paragraph (10) for each such code, together with an explanation of the reasons for each such determination, and the data on which the determination is based;

“(vi) on the same day such list is made available, causes to have published in the Federal Register notice of a public meeting to receive comments and recommendations from the public on the proposed determinations;

“(vii) not later than August 1 of each year, but at least 30 calendar days after publication of such notice, convenes a meeting to receive such comments and recommendations, with such meeting being conducted in the same manner as the meeting under clause (iii);

“(viii) makes a transcript of such meeting available to the public (through an Internet site and other appropriate mechanisms) as soon as is practicable after such meeting; and

“(ix) taking into account the comments and recommendations received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of whether the payment amount for such tests will be determined on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B), together with the rationale for each such de-

termination, the data on which the determination is based, and responses to comments and suggestions received from the public.

“(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

“(i) identify the rules and assumptions to be applied by the Secretary in considering and making determinations of whether the payment amount for a new test should be established on the basis described in paragraph (10)(A) or the basis described in paragraph (10)(B);

“(ii) make available to the public the data (other than proprietary data) considered in making such determinations; and

“(iii) provide for a mechanism under which—

“(I) an interested party may request an administrative review of an adverse determination;

“(II) upon the request of an interested party, an administrative review is conducted with respect to an adverse determination; and

“(III) such determination is revised, as necessary, to reflect the results of such review.

“(D) For purposes of this subsection—

“(i) the term ‘HCPCS’ refers to the Health Care Financing Administration Common Procedure Coding System; and

“(ii) a code shall be considered to be ‘substantially revised’ if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

“(10)(A) Notwithstanding paragraphs (1), (2), and (4), if a new test is clinically similar to a test for which a fee schedule amount has been established under paragraph (5), the Secretary shall pay the same fee schedule amount for the new test.

“(B)(i) Notwithstanding paragraphs (1), (2), (4), and (5), if a new test is not clinically similar to a test for which a fee schedule has been established under paragraph (5), payment under this subsection for such test shall be made on the basis of the lesser of—

“(I) the actual charge for the test; or

“(II) an amount equal to 60 percent (or in the case of a test performed by a qualified hospital (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for the test for a locality or area for the year (determined without regard to the year referred to in paragraph (2)(A)(i), or any national limitation amount under paragraph (4)(B), and adjusted annually by the percentage increase or decrease under paragraph (2)(A)(i));

until the beginning of the third full calendar year that begins on or after the date on which an HCPCS code is first assigned with respect to such test, or, if later, the beginning of the first calendar year that begins on or after the date on which the Secretary determines that there are sufficient claims data to establish a fee schedule amount pursuant to clause (ii).

“(ii) Notwithstanding paragraphs (2), (4), and (5), the fee schedule amount for a clinical diagnostic laboratory test described in clause (i) that is performed—

“(I) during the first calendar year after clause (i) ceases to apply to such test, shall be an amount equal to the national limitation amount that the Secretary determines (consistent with clause (iii)) would have applied to such test under paragraph (4)(B)(viii) during the preceding calendar year, adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such first calendar year; and

“(II) during a subsequent year, is the fee schedule amount determined under this clause for the preceding year, adjusted by the percentage increase or decrease that applies under paragraph (5)(A) for such year.

“(iii) For purposes of clause (ii)(I), the national limitation amount for a test shall be set at 100 percent of the median of the payment amounts determined under clause (ii)(I) for all payment localities or areas for the last calendar year for which payment for such test was determined under clause (i).

“(iv) Nothing in clause (ii) shall be construed as prohibiting the Secretary from applying (or authorizing the application of) the comparability provisions of the first sentence of such section 1842(b)(3) with respect to amounts determined under such clause.”.

(b) ESTABLISHMENT OF NATIONAL FEE SCHEDULE AMOUNTS.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act, as amended by subsection (a), is amended—

(A) in paragraph (2), by striking “paragraph (4)” and inserting “paragraphs (4), (5), and (10)”;

(B) in paragraph (4)(B)(viii), by inserting “and before January 1, 2002,” after “December 31, 1997,”;

(C) by redesignating paragraphs (5), (6), and (7), as paragraphs (6), (7), and (8), respectively; and

(D) by inserting after paragraph (4) the following new paragraph:

“(5) Notwithstanding paragraphs (2) and (4), the Secretary shall set the fee schedule amount for a test (other than a test to which paragraph (10)(B) applies) at—

“(A) for tests performed during 2002, an amount equal to the national limitation amount for that test for 2001, and adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such year; and

“(B) for tests performed during a year after 2002, the amount determined under this subparagraph for the preceding year, adjusted by the percentage increase or decrease determined under paragraph (2)(A)(i) for such year.”.

(2) CONFORMING AMENDMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395(a)) are each amended by striking “the limitation amount for that test determined under subsection (h)(4)(B).”.

(c) MECHANISM FOR REVIEW OF ADEQUACY OF PAYMENT AMOUNTS.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as amended by subsection (b), is amended by adding at the end the following:

“(11) The Secretary shall establish a mechanism under which—

“(A) an interested party may request a timely review of the adequacy of the existing payment amount under this subsection for a particular test; and

“(B) upon the receipt of such a request, a timely review is carried out.”.

(d) USE OF INHERENT REASONABLENESS AUTHORITY.—Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended by adding at the end the following:

“(E)(i) The Secretary may not delegate the authority to make determinations with respect to clinical diagnostic laboratory tests under this paragraph to a regional office of the Health Care Financing Administration or to an entity with a contract under subsection (a).

“(ii) In making determinations with respect to clinical diagnostic laboratory tests under this paragraph, the Secretary—

“(I) shall base such determinations on data from affected payment localities and all sites of care; and

“(II) may not use a methodology that assigns undue weight to the prevailing charge

levels for any 1 type of entity with a contract under subsection (a)."

(e) PROHIBITION.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as amended by subsection (c), is amended by adding at the end the following new paragraph:

"(12)(1) Notwithstanding the preceding provisions of this subsection, the Secretary may not establish a payment level for a new test that is lower than the level for an existing, clinically similar test solely on the basis that the new test may be performed by a laboratory with a certificate of waiver under section 353(d)(2) of the Public Health Service Act (42 U.S.C. 263a(d)(2)).

"(2) Nothing in paragraph (1) shall be construed to limit the authority of the Secretary to establish a payment level for a new test that is lower than the level for an existing, clinically similar test if such payment level is determined on a basis other than the basis described in such paragraph or on more than 1 basis."

(f) EFFECTIVE DATES.—

(1) ESTABLISHMENT OF PROCEDURES.—The Secretary of Health and Human Services shall establish the procedures required to implement paragraphs (9), (10), (11), and (12) of section 1833(h) of the Social Security Act (42 U.S.C. 1395(h)), as added by this section, by not later than January 1, 2002.

(2) INHERENT REASONABLENESS.—The amendments made by subsection (d) shall apply to determinations made on or after the date of enactment of this Act.

By Mr. GRASSLEY (for himself, Mr. TORRICELLI, and Mr. CRAIG):

S. 1067. A bill to amend the Internal Revenue Code of 1986 to expand the availability of Archer medical savings accounts; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today, on behalf of myself and my colleague, Senator TORRICELLI, I am introducing legislation, the Medical Savings Availability Act of 2001, which would make the availability of medical savings accounts permanent and would make it possible for any individual to purchase a medical savings account. Our bill would liberalize existing law authorizing medical savings accounts in a number of other respects.

Medical savings accounts are a good idea. They are basically IRAs, an idea everybody understands, which must be used for payment of medical expenses.

The widespread use of medical savings accounts should have several beneficial consequences.

They should reduce health care costs. Administrative costs should be lower. Consumers with MSAs should use health care services in a more discriminating manner. Consumers with MSAs should be more selective in choosing providers. This should cause those providers to lower their prices to attract medical savings account holders as patients.

Medical savings accounts can also help to put the patient back into the health care equation. Patients should make more cost-conscious choices about routine health care. Patients with MSAs would have complete choice of provider.

Medical savings accounts should make health care coverage more de-

pendable. MSAs are completely portable. MSAs are still the property of the individual even if they change jobs. Hence, for those with MSAs, job changes do not threaten them with the loss of health insurance.

Medical savings accounts should increase health care coverage. Perhaps as many as half of the more than 40 million Americans who are uninsured at any point in time are without health insurance only for four months or less. A substantial number of these people are uninsured because they are between jobs. Use of medical savings accounts should reduce the number of the uninsured by equipping people to pay their own health expenses while unemployed.

Medical savings accounts should promote personal savings. Since pre-tax monies are deposited in them, there should be a strong tax incentive to use them.

As I understand it, there are approximately 100,000 MSA accounts covering a total of approximately 250,000. I understand also that approximately one-third of those who have set up medical savings accounts were previously uninsured.

But medical savings accounts have fallen short of their promise because of various restrictions in the authorizing law.

The present law has a sunset of December, 2001, which has discouraged insurers from offering such plans. Current MSA law prohibits around 70 percent of the working population from purchasing them because purchase is limited to the self-employed or to employees of small businesses of less than 50 employees.

The bill we are introducing today would eliminate the restrictions that have limited the availability of MSAs: First, it would remove the December, 2001, sunset provision and make the availability of MSAs permanent; second, it would repeal the limitations on the number of MSAs that can be established; third, it stipulates that the availability of these accounts is not limited to employees of small employers and self-employed individuals; fourth, it increases the amount of the deduction allowed for contributions to medical savings accounts to 100 percent of the deductible; fifth, it permits both employees and employers to contribute to medical savings accounts; sixth, it reduces the permitted deductibles under high deductible plans from \$1,500 in the case of individuals to \$1,000 and from \$3,000 in the case of couples to \$2,000; seventh, the bill would permit medical savings accounts to be offered under cafeteria plans; and finally, the bill would encourage preferred provider organizations to offer MSAs.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1067

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Medical Savings Account Availability Act of 2001".

**SEC. 2. EXPANSION OF AVAILABILITY OF ARCHER MEDICAL SAVINGS ACCOUNTS.**

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(1) of such Code (relating to eligible individual) is amended to read as follows:

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

"(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

"(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

"(I) which is not a high deductible health plan, and

"(II) which provides coverage for any benefit which is covered under the high deductible health plan."

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/2 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan."

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking "75 percent of".

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

"(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year."

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking "\$1,500" in clause (i) and inserting "\$1,000"; and

(B) by striking "\$3,000" in clause (ii) and inserting "\$2,000".

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

“(g) COST-OF-LIVING ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 1997’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(2) SPECIAL RULES.—In the case of the \$1,000 amount in subsection (c)(2)(A)(i) and the \$2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting ‘calendar year 2000’ for ‘calendar year 1997’.

“(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.”

(f) PROVIDING INCENTIVES FOR PREFERRED PROVIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS ACCOUNTS.—Clause (ii) of section 220(c)(2)(B) of such Code is amended by striking “preventive care if” and all that follows and inserting “preventive care.”

(g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking “106(b).”

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

By Mrs. BOXER:

S. 1068. A bill to provide refunds for unjust and unreasonable charges on electric energy; to the Committee on Energy and Natural Resources.

Mrs. BOXER. Mr. President, earlier this week the Federal Energy Regulatory Commission issued an order to provide price mitigation to California's electricity market. This order is a stunning turnaround for an agency that refused to recognize that this energy crisis is a regional problem and that cost-based pricing is in order. However, FERC's order does not adequately address past grievances regarding refunds for overcharges by the generators.

Therefore, today I am introducing the Electricity Gouging Relief Act in an effort to bring much needed relief to consumers, businesses and the State of California from price gouging by electricity generators. This legislation helps to right past wrongs by providing rebates in cases where companies were engaged in gouging.

Generators' profits increased on average by 508 percent between 1999 and 2000. One company, Reliant Energy, experienced a 1,685 percent increase in profits in the same time period. This compares to a 16 percent increase in profits across the electric and gas industry and an increase in demand of only four percent.

My bill would require the Federal Energy Regulatory Commission, FERC, to order refunds for past electricity purchases in cases where FERC determined that the prices charged by the generators were “unjust and unreasonable.” The bill would affect electricity

sales that took place between June 1, 2000—when price spikes first occurred in San Diego and June 19, 2001—the day before FERC's order became effective.

I encourage my colleagues to support this bill. FERC's actions on Monday are a step in the right direction. Now, we need to refund overcharges by the generators to consumers.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1068

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Electricity Gouging Relief Act of 2001”.

**SEC. 2. REFUNDS FOR EXCESSIVE CHARGES.**

Section 206 of the Federal Power Act (16 U.S.C. 824e) is amended by adding at the end the following:

“(e) REFUNDS FOR EXCESSIVE CHARGES.—

“(1) Notwithstanding any other provision of this section, the Commission shall, within 60 days after enactment of this subsection, order a refund for the portion of charges on the transmission or sale or electric energy that are or have been deemed by the Commission to be unjust or unreasonable. Such refunds shall include interest from the date on which the charges were paid.

“(2) The refunds ordered under paragraph (1) shall apply to charges paid between June 1, 2000 and June 19, 2001.”

By Mr. LEVIN (for himself, Mr. KOHL, Mr. FEINGOLD, Mr. SCHUMER, Mr. JOHNSON, and Ms. STABENOW):

S. 1069. A bill to amend the Natural Trails System Act to clarify Federal authority relating to land acquisition from willing sellers from the majority of the trails in the System, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. LEVIN. Mr. President, today I am introducing the Willing Seller Amendments of 2001 which would amend the National Trails System Act, NTSA, to provide Federal authority to acquire land from willing sellers to complete nine national scenic and historic trails authorized under the Act. The legislation gives the Federal agencies administering the trails the ability to acquire land from willing sellers only. The legislation would not commit the Federal Government to purchase any land or to spend any money but would allow managers to purchase land to protect the national trails as opportunities arise and as funds are appropriated.

For most of the national scenic and historic trails, barely one-half of their congressionally authorized length and resources are protected. Without willing seller authority, Federal trail managers' hands are tied when development threatens important links in the wild landscapes of the national scenic trails or in the sites that authenticate the stories of the historic trails. With willing seller authority, sections of

trail can be moved from roads where hikers and other trail users are unsafe, and critical historic sites can be preserved for future generations to experience. Moreover, this authority protects private property rights, as landowners along the nine affected trails are currently denied the right to sell land to the Federal Government if they desire to do so.

Willing seller authority is crucial for the North Country National Scenic Trail, which runs through my home State of Michigan, because completion of the Trail faces significant challenges. These challenges which relate to development pressure and the need to cross long stretches of private and corporate held lands are common themes throughout the seven states linked by the 4,600-mile long North Country Trail.

This legislation is also vital on a national level and accomplishes several important goals. First, it restores basic property rights—Section 10 (c) of the National Trails System Act as currently written diminishes the right of thousands of people who own land along four national scenic trails and five national historic trails to sell their property or easements on their property, by prohibiting federal agencies from buying their land. Many of these landowners have offered to sell their land to the Federal Government to permanently protect important historical resources that their families have protected for generations or to maintain the continuity of a national scenic trail. Providing this authority to Federal agencies to purchase land from willing sellers along these nine trails will restore this basic property right to thousands of landowners.

Second, it restores the ability of Federal agencies to carry out their responsibility to protect nationally significant components of our nation's cultural, natural and recreational heritage. The National Trails System Act authorizes establishment of national scenic and historic trails to protect important components of our historic and natural heritage. One of the fundamental responsibilities given to the Federal agencies administering these trails is to protect their important cultural and natural resources. Without willing-seller authority, the agencies are prevented from directly protecting these resources along nine trails—nearly one-half of the National Trails System.

Third, it restores consistency to the National Trails System Act, NTSA. Congress enacted the National Trails System Act in 1968 “. . . to provide for the ever-increasing outdoor recreation needs of an expanding population and . . . to promote the preservation of, public access to, travel within, and enjoyment and appreciation of the open-air, outdoor areas and historic resources of the Nation . . . by instituting a national system of recreation, scenic and historic trails . . .” The agencies are authorized to collaborate

with other Federal agencies, State and local governments and private organizations in planning, developing and managing the trails; to develop uniform standards for marking, interpreting and constructing the trails; to regulate their use; and to provide grants and technical assistance to cooperating agencies and organizations. The NTSA is supposed to provide these and other authorities to be applied consistently throughout the National Trails System. However, land acquisition authority, an essential means for protecting the special resources and continuity that are the basis for these trails, has been inconsistently applied. The Federal agencies have been given land acquisition authority for thirteen of the twenty-two national scenic and historic trails but have been denied authority to acquire land for the other nine trails. This bill restores consistency to the National Trails System Act by enabling the Federal agencies to acquire necessary land for all twenty-two national scenic and historic trails.

Finally, this legislation enables Federal agencies to respond to opportunities to protect important resources provided by willing sellers. The willing seller land acquisition authority provided for these nine trails and subsequent appropriations from the Land and Water Conservation Fund will enable the Federal agencies administering them to respond to conservation opportunities afforded by willing landowners.

I am pleased today to introduce this important legislation to restore parity to the National Trails System and provide authority to protect critical resources along the nation's treasured national scenic and historic trails.

By Mr. REED:

S. 1070. A bill to amend the XXVII of the Public Health Service Act and part 7 of subtitle B of title 1 of the Employee Retirement Income Security Act of 1974 to establish standards for the health quality improvement of children in managed care plans and other health plans; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, today I am introducing legislation that I believe is very pertinent to the current debate over managed care protections. My longstanding concern has been to ensure that the needs of children in managed care are not left out of the debate. That is why I am reintroducing the Children's Health Insurance Accountability Act.

This legislation sets the standard for what kinds of protections ought to be in place for children who receive care through health maintenance organizations. Specifically, this bill provides common sense protections for children in managed care plans such as: access to necessary pediatric primary care and specialty services; appeal rights that address the special needs of children, including an expedited review if a

child's life or development is in jeopardy; quality measurements of health outcomes unique to children; utilization review rules that are specific to children with evaluation from those with pediatric expertise; and child-specific information requirements that will help parents and employers choose health plans on the basis of care provided to children.

I am pleased that the major provisions of this legislation are incorporated into the McCain-Edwards-Kennedy Patient Protection bill, S. 1052. It is difficult enough to have a sick child, but to face barrier after barrier to necessary care for your child is unconscionable. Our current system is often failing our kids when they most need us. It is this simple: if we do not have health plan standards, there is no guarantee that we are providing adequate care for our children. And when it comes to our children, we should not take risks.

Not one of us can deny that managed care plays a valid role in our health care system. Managed care's emphasis on preventive care has benefits for young and old alike. And HMOs have resulted in lower co-payments for consumers and higher immunization rates for our children. However, many questions have arisen about patient access to medical services and the consequences of cost-cutting measures and other incentives under managed care.

The Children's Health Insurance Accountability Act seeks to address these concerns as they relate to children. Children are not small adults and often have very different health and developmental needs. We should be sure that we are always vigilant when it comes to their health and well-being, not only in the context of patient protection legislation, but in other policy measures we consider this year.

I am pleased that this legislation is supported by a number of children's health and advocacy organizations, including the American Academy of Pediatrics, the Children's Defense Fund and the National Association of Children's Hospitals.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1070

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Children's Health Insurance Accountability Act of 2001".

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) Children have health and development needs that are markedly different than those for the adult population.

(2) Children experience complex and continuing changes during the continuum from birth to adulthood in which appropriate health care is essential for optimal development.

(3) The vast majority of work done on development methods to assess the effectiveness of health care services and the impact of medical care on patient outcomes and patient satisfaction has been focused on adults.

(4) Health outcome measures need to be age, gender, and developmentally appropriate to be useful to families and children.

(5) Costly disorders of adulthood often have their origins in childhood, making early access to effective health services in childhood essential.

(6) More than 200 chronic conditions, disabilities and diseases affect children, including asthma, diabetes, sickle cell anemia, spina bifida, epilepsy, autism, cerebral palsy, congenital heart disease, mental retardation, and cystic fibrosis. These children need the services of specialists who have in depth knowledge about their particular condition.

(7) Children's patterns of illness, disability and injury differ dramatically from adults.

**SEC. 2. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.**

(a) PATIENT PROTECTION STANDARDS.—Title XXVII of the Public Health Service Act is amended—

(1) by redesignating part C as part D; and

(2) by inserting after part B the following:

“PART C—CHILDREN'S HEALTH PROTECTION STANDARDS

**“SEC. 2770. ACCESS TO CARE.**

“(a) ACCESS TO APPROPRIATE PRIMARY CARE PROVIDERS.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider for a child of such enrollee—

“(A) the plan or issuer shall permit the enrollee to designate a physician who specializes in pediatrics as the child's primary care provider; and

“(B) if such an enrollee has not designated such a provider for the child, the plan or issuer shall consider appropriate pediatric expertise in mandatorily assigning such an enrollee to a primary care provider.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of services.

“(b) ACCESS TO PEDIATRIC SPECIALTY SERVICES.—

“(1) REFERRAL TO SPECIALTY CARE FOR CHILDREN REQUIRING TREATMENT BY SPECIALISTS.—

“(A) IN GENERAL.—In the case of a child who is covered under a group health plan, or health insurance coverage offered by a health insurance issuer and who has a mental or physical condition, disability, or disease of sufficient seriousness and complexity to require diagnosis, evaluation or treatment by a specialist, the plan or issuer shall make or provide for a referral to a specialist who has extensive experience or training, and is available and accessible to provide the treatment for such condition or disease, including the choice of a nonprimary care physician specialist participating in the plan or a referral to a nonparticipating provider as provided for under subparagraph (D) if such a provider is not available within the plan.

“(B) SPECIALIST DEFINED.—For purposes of this subsection, the term ‘specialist’ means, with respect to a condition, disability, or disease, a health care practitioner, facility, or center (such as a center of excellence) that has extensive pediatric expertise through appropriate training or experience to provide high quality care in treating the condition, disability or disease.

“(C) REFERRALS TO PARTICIPATING PROVIDERS.—A plan or issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer

does not have an appropriate specialist that is available and accessible to treat the enrollee's condition and that is a participating provider with respect to such treatment.

“(D) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers a child enrollee to a nonparticipating specialist, services provided pursuant to the referral shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

“(E) SPECIALISTS AS PRIMARY CARE PROVIDERS.—A plan or issuer shall have in place a procedure under which a child who is covered under health insurance coverage provided by the plan or issuer who has a condition or disease that requires specialized medical care over a prolonged period of time shall receive a referral to a pediatric specialist affiliated with the plan, or if not available within the plan, to a nonparticipating provider for such condition and such specialist may be responsible for and capable of providing and coordinating the child's primary and specialty care.

“(2) STANDING REFERRALS.—

“(A) IN GENERAL.—A group health plan, or health insurance issuer in connection with the provision of health insurance coverage of a child, shall have a procedure by which a child who has a condition, disability, or disease that requires ongoing care from a specialist may request and obtain a standing referral to such specialist for treatment of such condition. If the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall authorize such a referral to such a specialist. Such standing referral shall be consistent with a treatment plan.

“(B) TREATMENT PLANS.—A group health plan, or health insurance issuer, with the participation of the family and the health care providers of the child, shall develop a treatment plan for a child who requires ongoing care that covers a specified period of time (but in no event less than a 6-month period). Services provided for under the treatment plan shall not require additional approvals or referrals through a gatekeeper.

“(C) TERMS OF REFERRAL.—The provisions of subparagraph (C) and (D) of paragraph (1) shall apply with respect to referrals under subparagraph (A) in the same manner as they apply to referrals under paragraph (1)(A).

“(c) ADEQUACY OF ACCESS.—For purposes of subsections (a) and (b), a group health plan or health insurance issuer in connection with health insurance coverage shall ensure that a sufficient number, distribution, and variety of qualified participating health care providers are available so as to ensure that all covered health care services, including specialty services, are available and accessible to all enrollees in a timely manner.

“(d) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits for children with respect to emergency services (as defined in paragraph (2)(A)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

“(A) without the need for any prior authorization determination;

“(B) whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services; and

“(C) without regard to any other term or condition of such coverage (other than exclusion of benefits, or an affiliation or waiting period, permitted under section 2701).

“(2) DEFINITIONS.—In this subsection:

“(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(B) EMERGENCY SERVICES.—The term ‘emergency services’ means—

“(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)); and

“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

“(3) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance issuer offering health insurance coverage, shall provide, in covering services other than emergency services, for reimbursement with respect to services which are otherwise covered and which are provided to an enrollee other than through the plan or issuer if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable).

“(e) PROHIBITION ON FINANCIAL BARRIERS.—A health insurance issuer in connection with the provision of health insurance coverage may not impose any cost sharing for pediatric specialty services provided under such coverage to enrollee children in amounts that exceed the cost-sharing required for other specialty care under such coverage.

“(f) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—A health insurance issuer in connection with the provision of health insurance coverage shall ensure that such coverage provides special consideration for the provision of services to enrollee children with special health care needs. Appropriate procedures shall be implemented to provide care for children with special health care needs. The development of such procedures shall include participation by the families of such children.

“(g) DEFINITIONS.—In this part:

“(1) CHILD.—The term ‘child’ means an individual who is under 19 years of age.

“(2) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—The term ‘children with special health care needs’ means those children who have or are at elevated risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type and amount not usually required by children.

“SEC. 2771. CONTINUITY OF CARE.

“(a) IN GENERAL.—If a contract between a health insurance issuer, in connection with the provision of health insurance coverage, and a health care provider is terminated (other than by the issuer for failure to meet applicable quality standards or for fraud) and an enrollee is undergoing a course of treatment from the provider at the time of such termination, the issuer shall—

“(1) notify the enrollee of such termination, and

“(2) subject to subsection (c), permit the enrollee to continue the course of treatment with the provider during a transitional period (provided under subsection (b)).

“(b) TRANSITIONAL PERIOD.—

“(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least—

“(A) 60 days from the date of the notice to the enrollee of the provider's termination in the case of a primary care provider, or

“(B) 120 days from such date in the case of another provider.

“(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and shall include reasonable follow-up care related to the institutionalization and shall also include institutional care scheduled prior to the date of termination of the provider status.

“(3) PREGNANCY.—If—

“(A) an enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

“(B) the provider was treating the pregnancy before date of the termination, the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

“(4) TERMINAL ILLNESS.—

“(A) IN GENERAL.—If—

“(i) an enrollee was determined to be terminally ill (as defined in subparagraph (B)) at the time of a provider's termination of participation, and

“(ii) the provider was treating the terminal illness before the date of termination, the transitional period under this subsection shall extend for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

“(B) DEFINITION.—In subparagraph (A), an enrollee is considered to be ‘terminally ill’ if the enrollee has a medical prognosis that the enrollee's life expectancy is 6 months or less.

“(c) PERMISSIBLE TERMS AND CONDITIONS.—

An issuer may condition coverage of continued treatment by a provider under subsection (a)(2) upon the provider agreeing to the following terms and conditions:

“(1) The provider agrees to continue to accept reimbursement from the issuer at the rates applicable prior to the start of the transitional period as payment in full.

“(2) The provider agrees to adhere to the issuer's quality assurance standards and to provide to the issuer necessary medical information related to the care provided.

“(3) The provider agrees otherwise to adhere to the issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the issuer.

“SEC. 2772. CONTINUOUS QUALITY IMPROVEMENT.

“(a) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall establish and maintain an ongoing, internal quality assurance program that at a minimum meets the requirements of subsection (b).

“(b) REQUIREMENTS.—The internal quality assurance program of an issuer under subsection (a) shall—

“(1) establish and measure a set of health care, functional assessments, structure, processes and outcomes, and quality indicators that are unique to children and based on nationally accepted standards or guidelines of care;

“(2) maintain written protocols consistent with recognized clinical guidelines or current consensus on the pediatric field, to be used for purposes of internal utilization review, with periodic updating and evaluation by pediatric specialists to determine effectiveness in controlling utilization;

“(3) provide for peer review by health care professionals of the structure, processes, and outcomes related to the provision of health services, including pediatric review of pediatric cases;

“(4) include in member satisfaction surveys, questions on child and family satisfaction and experience of care, including care to children with special needs;

“(5) monitor and evaluate the continuity of care with respect to children;

“(6) include pediatric measures that are directed at meeting the needs of at-risk children and children with chronic conditions, disabilities and severe illnesses;

“(7) maintain written guidelines to ensure the availability of medications appropriate to children;

“(8) use focused studies of care received by children with certain types of chronic conditions and disabilities and focused studies of specialized services used by children with chronic conditions and disabilities;

“(9) monitor access to pediatric specialty services; and

“(10) monitor child health care professional satisfaction.

“(c) UTILIZATION REVIEW ACTIVITIES.—

“(1) COMPLIANCE WITH REQUIREMENTS.—

“(A) IN GENERAL.—A health insurance issuer that offers health insurance coverage for children shall conduct utilization review activities in connection with the provision of such coverage only in accordance with a utilization review program that meets at a minimum the requirements of this subsection.

“(B) DEFINITIONS.—In this subsection:

“(i) CLINICAL PEERS.—The term ‘clinical peer’ means, with respect to a review, a physician or other health care professional who holds a non-restricted license in a State and in the same or similar specialty as typically manages the pediatric medical condition, procedure, or treatment under review.

“(ii) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ means a physician or other health care practitioner licensed or certified under State law to provide health care services and who is operating within the scope of such licensure or certification.

“(iii) UTILIZATION REVIEW.—The terms ‘utilization review’ and ‘utilization review activities’ mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings for children, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review specific to children.

“(2) WRITTEN POLICIES AND CRITERIA.—

“(A) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

“(B) USE OF WRITTEN CRITERIA.—A utilization review program shall utilize written clinical review criteria specific to children and developed pursuant to the program with the input of appropriate physicians, including pediatricians, nonprimary care pediatric specialists, and other child health professionals.

“(C) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals, including health care professionals with pediatric expertise who shall oversee review decisions.

“(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

“(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate pediatric or child health training in the conduct of such activities under the program.

“(B) PEER REVIEW OF ADVERSE CLINICAL DETERMINATIONS.—A utilization review program shall provide that clinical peers shall evaluate the clinical appropriateness of adverse clinical determinations and divergent clinical options.

“SEC. 2773. APPEALS AND GRIEVANCE MECHANISMS FOR CHILDREN.

“(a) INTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall establish and maintain a system to provide for the resolution of complaints and appeals regarding all aspects of such coverage. Such a system shall include an expedited procedure for appeals on behalf of a child enrollee in situations in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

“(b) EXTERNAL APPEALS PROCESS.—A health insurance issuer in connection with the provision of health insurance coverage for children shall provide for an independent external review process that meets the following requirements:

“(1) External appeal activities shall be conducted through clinical peers, a physician or other health care professional who is appropriately credentialed in pediatrics with the same or similar specialty and typically manages the condition, procedure, or treatment under review or appeal.

“(2) External appeal activities shall be conducted through an entity that has sufficient pediatric expertise, including subspecialty expertise, and staffing to conduct external appeal activities on a timely basis.

“(3) Such a review process shall include an expedited procedure for appeals on behalf of a child enrollee in which the time frame of a standard appeal would jeopardize the life, health, or development of the child.

“SEC. 2774. ACCOUNTABILITY THROUGH DISTRIBUTION OF INFORMATION.

“(a) IN GENERAL.—A health insurance issuer in connection with the provision of health insurance coverage for children shall submit to enrollees (and prospective enrollees), and make available to the public, in writing the health-related information described in subsection (b).

“(b) INFORMATION.—The information to be provided under subsection (a) shall include a report of measures of structures, processes, and outcomes regarding each health insurance product offered to participants and dependents in a manner that is separate for both the adult and child enrollees, using measures that are specific to each group.”

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

“SEC. 2707. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

“(a) IN GENERAL.—Each health insurance issuer shall comply with children's health accountability requirement under part C with respect to group health insurance coverage it offers.

“(b) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

“(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 714 of the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

“(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.”

(2) CONFORMING AMENDMENT.—Section 2792 of the Public Health Service Act (42 U.S.C. 300gg-92) is amended by inserting “and section 2707(b)” after “of 1996”.

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.) is amended by inserting after section 2752 the following:

“SEC. 2753. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

“Each health insurance issuer shall comply with children's health accountability requirements under part C with respect to individual health insurance coverage it offers.”

(d) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg-23) is amended—

(A) in subsection (a)(1), by striking “subsection (b)” and inserting “subsection (b) and (c)”;

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

“(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2707 and part C, and part D insofar as it applies to section 2707 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions.”

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of the Public Health Service Act (42 U.S.C. 300gg-62) is amended—

(A) in subsection (a), by striking “subsection (b), nothing in this part” and inserting “subsections (b) and (c)”;

(B) by adding at the end the following new subsection:

“(c) SPECIAL RULES IN CASE OF CHILDREN'S HEALTH ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (b), the provisions of section 2753 and part C, and part D insofar as it applies to section 2753 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such section.”

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

“SEC. 714. CHILDREN'S HEALTH ACCOUNTABILITY STANDARDS.

“(a) IN GENERAL.—Subject to subsection (b), the provisions of part C of title XXVII of the Public Health Service Act shall apply under this subpart and part to a group health plan (and group health insurance coverage offered in connection with a group health

plan) as if such part were incorporated in this section.

“(b) APPLICATION.—In applying subsection (a) under this subpart and part, any reference in such part C—

“(1) to health insurance coverage is deemed to be a reference only to group health insurance coverage offered in connection with a group health plan and to also be a reference to coverage under a group health plan;

“(2) to a health insurance issuer is deemed to be a reference only to such an issuer in relation to group health insurance coverage or, with respect to a group health plan, to the plan;

“(3) to the Secretary is deemed to be a reference to the Secretary of Labor;

“(4) to an applicable State authority is deemed to be a reference to the Secretary of Labor; and

“(5) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.”

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191) is amended—

(1) in subsection (a)(1), by striking “subsection (b)” and inserting “subsections (b) and (c)”;

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

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

“(c) SPECIAL RULES IN CASE OF PATIENT ACCOUNTABILITY REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 714, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on group health plans and health insurance issuers in connection with group health insurance coverage as the requirements imposed under such provisions.”

(c) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 714”.

(2) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

“Sec. 714. Children’s health accountability standards.”

#### SEC. 4. STUDIES.

(a) BY SECRETARY.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a study, and prepare and submit to Congress a report, concerning—

(1) the unique characteristics of patterns of illness, disability, and injury in children;

(2) the development of measures of quality of care and outcomes related to the health care of children; and

(3) the access of children to primary mental health services and the coordination of managed behavioral health services.

(b) BY GAO.—

(1) MANAGED CARE.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall conduct a study, and prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report, concerning—

(A) an assessment of the structure and performance of non-governmental health plans, medicaid managed care organizations, plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and the program

under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) serving the needs of children with special health care needs;

(B) an assessment of the structure and performance of non-governmental plans in serving the needs of children as compared to medicaid managed care organizations under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(C) the emphasis that private managed care health plans place on primary care and the control of services as it relates to care and services provided to children with special health care needs.

(2) PLAN SURVEY.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains a survey of health plan activities that address the unique health needs of adolescents, including quality measures for adolescents and innovative practice arrangement.

By Mr. INHOFE:

S. 1073. A bill to establish a National Commission to Eliminate Waste in Government; to the Committee on Government Affairs.

Mr. INHOFE. Mr. President, today I rise to bring attention to an issue that affects all Americans, government waste. As we all know, the Federal Government is infamous for its profligate programs and approaches to problem solving. In the last decade, we have seen inefficiency of mammoth proportions within the government.

As a result, I have introduced legislation that would establish a national commission to eliminate government waste. This act would resurrect President Reagan’s work to find an equitable way to enact fiscal responsibility and accountability within the government. During the Reagan Administration, a private sector study of government was commissioned to dispose of Federal waste, mismanagement, and abuse. Led by industrialist J. Peter Grace, the Grace Commission produced 47 reports with 2,478 recommendations. As a result of this study, President Reagan issued executive orders that saved the Federal Government more than \$110 billion.

Today, many Federal agencies still use cumbersome bureaucratic procedures. The National Commission to Eliminate Waste in Government Act would establish a commission to conduct a private sector survey on management and cost control within the government. It would also provide an opportunity for the commission to review existing reports on government waste. Because the commission would be funded, staffed, and equipped by the private sector, it would not cost the government one dime.

I urge my colleagues to support this end to government waste and the beginning of discipline and efficiency within our government.

By Mr. GRASSLEY (for himself, Mr. BIDEN, Mr. SMITH of Oregon, and Mr. DASCHLE):

S. 1075. A bill to extend and modify the Drug-Free Communities Support

Program, to authorize a National Community Antidrug Coalition Institute, and for other purposes; to the Committee on the Judiciary.

Mr. GRASSLEY. Mr. President, I rise today to introduce legislation to re-authorize the Drug Free Communities Act. I am pleased to be joined by my colleagues Senator BIDEN, Senator Smith, and Senator DASCHLE in introducing this legislation which will continue for another 5 years the successes that we have found with Drug Free Communities Program. In addition, it builds upon the successes that coalitions have had by encouraging them to establish a coalition mentoring program for nearby communities. Finally, this act will authorize funding for the National Anti-Drug Coalition Institute, which will provide education, training, and technical assistance to leaders of community coalitions.

Substance abuse remains a problem in communities across the country. Substance abuse is the cause of or associated with many of today’s problems, but is a preventable behavior. Community anti-drug coalitions are implementing long-term strategies to address the problem of substance abuse in their communities. By bringing together a cross-section of the community to address a common problem, community coalitions are discovering and implementing unique community solutions to reduce and prevent the incidence of substance abuse in their communities. And that idea, that communities are best suited to address their own problems, is the underlying premise that has been proven with the success of the Drug Free Communities program.

There are three key features to the Drug Free Communities Act. First, communities must take the initiative. In order to receive support, a community coalition must demonstrate that there is a long-term commitment to address teen-drug use. It must have a sustainable coalition that includes the involvement of representatives from a wide variety of community activists.

In addition, every coalition must show that it can sustain itself. Community coalitions must be in existence for at least 6 months before applying. They are only eligible to receive support if they can match these donations dollar for dollar with non-Federal funding, up to \$100,000 per coalition.

An Advisory Commission, consisting of local community leaders, and State and national experts in the field of substance abuse, has worked closely with the Office of National Drug Control Policy to oversee the successful management and growth of this grant program. Because of this partnership, grants have gone to communities and programs that can make a difference in the lives of our children.

Today, we have better evidence that coalitions are working, that they are making a difference. A recent study sponsored by the Annie E. Casey Foundation documented the difference that

eight community coalitions, all of which have received funding through the Drug Free Communities program, from around the country have made in their communities.

In addition to continuing this successful program, this re-authorization legislation adds the possibility for a supplemental grant to the Drug-Free Communities Grant Program. The supplemental grant is available to any coalition that has been in existence for at least 5 years, achieved measurable results in youth substance abuse prevention and treatment, have staff or Coalition members willing to serve as mentors for persons interested in starting or expanding a Coalition in their community, identified demonstrable support from members of the identified community, and have created a detailed plan for mentoring either newly formed or developing Coalitions.

Coalitions receiving the supplemental grant must use these funds to support and encourage the development of new, self-supporting community coalitions focused on the prevention and treatment of substance abuse in the new coalition's community. This supplemental grant can be renewed provided the recipient coalition continues to meet the underlying criteria and has made progress in the development of new coalitions.

Starting a new anti-drug coalition is a difficult exercise, which makes the success of these coalitions I mentioned earlier all the more remarkable. But I also know this from personal experience. For the past 4 years, I have worked with leaders from across my State of Iowa to start and grow the Face It Together Coalition, a State-wide, anti-drug coalition designed to bring together people from all walks of life, business leaders, doctors and nurses, law enforcement, school professionals, members of the media, and so on, to work together toward a common goal: keeping kids drug free.

In working with FIT, it has become clear that by working together, everyone can accomplish more. This is a solid, grass-roots initiative that can work. But it hasn't been an easy process, and it will continue to require the dedication and commitment of all of our board members. One of the biggest challenges that we face has not been finding ideas of what to do, or even finding effective ongoing projects in the State, but identifying and securing funding to support the expansion of our activities. Much can and has been done by volunteers, and through the networking connections that the Board members are able to bring to the table.

In addition, this legislation will authorize \$2 million in federal funding for two years for the National Community Anti-Drug Coalition Institute. Modeled after the success we have seen from the National Drug Court Institute, this national non-profit organization will represent, provide technical assistance and training, and have special expertise and broad, national-level experi-

ence in community anti-drug coalitions.

The funding for the Institute will be to 1. provide education, training, and technical assistance to key members of community anti-drug coalitions, 2. develop and disseminate evaluation tools, mechanisms, and measures to assess and document coalition performance, and 3. bridge the gap between research and practice by providing community coalitions with practical information based on the most current research on coalition-related issues. The Institute is expected to last for more than 2 years, and to pursue and obtain additional funding from sources other than the Federal Government.

In conclusion, I encourage all of my colleagues to join me in supporting this legislation. It is supported by the Administration. It has the support of communities all across the Nation. The Drug Free Communities Program works. I look forward to working with my colleagues here and in the House to ensure quick passage.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1075

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

**SECTION 1. EXTENSION OF DRUG-FREE COMMUNITIES SUPPORT PROGRAM.**

(a) FINDINGS.—Congress makes the following findings:

(1) In the next 15 years, the youth population in the United States will grow by 21 percent, adding 6,500,000 youth to the population of the United States. Even if drug use rates remain constant, there will be a huge surge in drug-related problems, such as academic failure, drug-related violence, and HIV incidence, simply due to this population increase.

(2) According to the 1994-1996 National Household Survey, 60 percent of students age 12 to 17 who frequently cut classes and who reported delinquent behavior in the past 6 months used marijuana 52 days or more in the previous year.

(3) The 2000 Washington Kids Count survey conducted by the University of Washington reported that students whose peers have little or no involvement with drinking and drugs have higher math and reading scores than students whose peers had low level drinking or drug use.

(4) Substance abuse prevention works. In 1999, only 10 percent of teens saw marijuana users as popular, compared to 17 percent in 1998 and 19 percent in 1997. The rate of past-month use of any drug among 12 to 17 year olds declined 26 percent between 1997 and 1999. Marijuana use for sixth through eighth graders is at the lowest point in 5 years, as is use of cocaine, inhalants, and hallucinogens.

(5) Community Anti-Drug Coalitions throughout the United States are successfully developing and implementing comprehensive, long-term strategies to reduce substance abuse among youth on a sustained basis. For example:

(A) The Boston Coalition brought college and university presidents together to create the Cooperative Agreement on Underage Drinking. This agreement represents the

first coordinated effort of Boston's many institutions of higher education to address issues such as binge drinking, underage drinking, and changing the norms surrounding alcohol abuse that exist on college and university campuses.

(B) The Miami Coalition used a three-part strategy to decrease the percentage of high school seniors who reported using marijuana at least once during the most recent 30-day period. The development of a media strategy, the creation of a network of prevention agencies, and discussions with high school students about the dangers of marijuana all contributed to a decrease in the percentage of seniors who reported using marijuana from more than 22 percent in 1995 to 9 percent in 1997. The Miami Coalition was able to achieve these results while national rates of marijuana use were increasing.

(C) The Nashville Prevention Partnership worked with elementary and middle school children in an attempt to influence them toward positive life goals and discourage them from using substances. The Partnership targeted an area in East Nashville and created after school programs, mentoring opportunities, attendance initiatives, and safe passages to and from school. Attendance and test scores increased as a result of the program.

(D) At a youth-led town meeting sponsored by the Bering Strait Community Partnership in Nome, Alaska, youth identified a need for a safe, substance-free space. With help from a variety of community partners, the Partnership staff and youth members created the Java Hut, a substance-free coffeehouse designed for youth. The Java Hut is helping to change norms in the community by providing a fun, youth-friendly atmosphere and activities that are not centered around alcohol or marijuana.

(E) Portland's Regional Drug Initiative (RDI) has promoted the establishment of drug-free workplaces among the city's large and small employers. More than 3,000 employers have attended an RDI training session, and of those, 92 percent have instituted drug-free workplace policies. As a result, there has been a 5.5 percent decrease in positive workplace drug tests.

(F) San Antonio Fighting Back worked to increase the age at which youth first used illegal substances. Research suggests that the later the age of first use, the lower the risk that a young person will become a regular substance abuser. As a result, the age of first illegal drug use increased from 9.4 years in 1992 to 13.5 years in 1997.

(G) In 1990, multiple data sources confirmed a trend of increased alcohol use by teenagers in the Troy community. Using its "multiple strategies over multiple sectors" approach, the Troy Coalition worked with parents, physicians, students, coaches, and others to address this problem from several angles. As a result, the rate of twelfth grade students who had consumed alcohol in the past month decreased from 62.1 percent to 53.3 percent between 1991 and 1998, and the rate of eighth grade students decreased from 26.3 percent to 17.4 percent. The Troy Coalition believes that this decline represents not only a change in behavior on the part of students, but also a change in the norms of the community.

(H) In 2000, the Coalition for a Drug-Free Greater Cincinnati surveyed more than 47,000 local seventh through twelfth graders. The results provided evidence that the Coalition's initiatives are working. For the first time in a decade, teen drug use in Greater Cincinnati appears to be leveling off. The data collected from the survey has served as a tool to strengthen relationships between

schools and communities, as well as facilitate the growth of anti-drug coalitions in communities where they had not existed.

(6) Despite these successes, drug use continues to be a serious problem facing communities across the United States. For example:

(A) According to the Pulse Check: Trends in Drug Abuse Mid-Year 2000 report—

(i) crack and powder cocaine remains the most serious drug problem;

(ii) marijuana remains the most widely available illicit drug, and its potency is on the rise;

(iii) treatment sources report an increase in admissions with marijuana as the primary drug of abuse—and adolescents outnumber other age groups entering treatment for marijuana;

(iv) 80 percent of Pulse Check sources reported increased availability of club drugs, with ecstasy (MDMA) and ketamine the most widely cited club drugs and seven sources reporting that powder cocaine is being used as a club drug by young adults;

(v) ecstasy abuse and trafficking is expanding, no longer confined to the “rave” scene;

(vi) the sale and use of club drugs has grown from nightclubs and raves to high schools, the streets, neighborhoods, open venues, and younger ages;

(vii) ecstasy users often are unknowingly purchasing adulterated tablets or some other substance sold as MDMA; and

(viii) along with reports of increased heroin snorting as a route of administration for initiates, there is also an increase in injecting initiates and the negative health consequences associated with injection (for example, increases in HIV/AIDS and Hepatitis C) suggesting that there is a generational forgetting of the dangers of injection of the drug.

(B) The 2000 Parent’s Resource Institute for Drug Education study reported that 23.6 percent of children in the sixth through twelfth grades used illicit drugs in the past year. The same study found that monthly usage among this group was 15.3 percent.

(C) According to the 2000 Monitoring the Future study, the use of ecstasy among eighth graders increased from 1.7 percent in 1999 to 3.1 percent in 2000, among tenth graders from 4.4 percent to 5.4 percent, and from 5.6 percent to 8.2 percent among twelfth graders.

(D) A 1999 Mellman Group study found that—

(i) 56 percent of the population in the United States believed that drug use was increasing in 1999;

(ii) 92 percent of the population viewed illegal drug use as a serious problem in the United States; and

(iii) 73 percent of the population viewed illegal drug use as a serious problem in their communities.

(7) According to the 2001 report of the National Center on Addiction and Substance Abuse at Columbia University entitled “Shoveling Up: The Impact of Substance Abuse on State Budgets”, using the most conservative assumption, in 1998 States spent \$77,900,000,000 to shovel up the wreckage of substance abuse, only \$3,000,000,000 to prevent and treat the problem and \$433,000,000 for alcohol and tobacco regulation and compliance. This \$77,900,000,000 burden was distributed as follows:

(A) \$30,700,000,000 in the justice system (77 percent of justice spending).

(B) \$16,500,000,000 in education costs (10 percent of education spending).

(C) \$15,200,000,000 in health costs (25 percent of health spending).

(D) \$7,700,000,000 in child and family assistance (32 percent of child and family assistance spending).

(E) \$5,900,000,000 in mental health and developmental disabilities (31 percent of mental health spending).

(F) \$1,500,000,000 in public safety (26 percent of public safety spending) and \$400,000,000 for the state workforce.

(8) Intergovernmental cooperation and coordination through national, State, and local or tribal leadership and partnerships are critical to facilitate the reduction of substance abuse among youth in communities across the United States.

(9) Substance abuse is perceived as a much greater problem nationally than at the community level. According to a 2001 study sponsored by The Pew Charitable Trusts, between 1994 and 2000—

(A) there was a 43 percent increase in the percentage of Americans who felt progress was being made in the war on drugs at the community level;

(B) only 9 percent of Americans say drug abuse is a “crisis” in their neighborhood, compared to 27 percent who say this about the nation; and

(C) the percentage of those who felt we lost ground in the war on drugs on a community level fell by more than a quarter, from 51 percent in 1994 to 37 percent in 2000.

(b) EXTENSION AND INCREASE OF PROGRAM.—Section 1024(a) of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1524(a)) is amended—

(1) by striking “and” at the end of paragraph (4); and

(2) by striking paragraph (5) and inserting the following new paragraphs:

“(5) \$50,600,000 for fiscal year 2002;

“(6) \$60,000,000 for fiscal year 2003;

“(7) \$70,000,000 for fiscal year 2004;

“(8) \$70,000,000 for fiscal year 2005;

“(9) \$75,000,000 for fiscal year 2006; and

“(10) \$75,000,000 for fiscal year 2007.”.

(c) EXTENSION OF LIMITATION ON ADMINISTRATIVE COSTS.—Section 1024(b) of that Act (21 U.S.C. 1524(b)) is amended by striking paragraph (5) and inserting the following new paragraph (5):

“(5) 8 percent for each of fiscal years 2002 through 2007.”.

(d) ADDITIONAL GRANTS.—Section 1032(b) of that Act (21 U.S.C. 1532(b)) is amended by adding at the end the following new paragraph (3):

“(3) ADDITIONAL GRANTS.—

“(A) IN GENERAL.—Subject to subparagraph (F), the Administrator may award an additional grant under this paragraph to an eligible coalition awarded a grant under paragraph (1) or (2) for any first fiscal year after the end of the 4-year period following the period of the initial grant under paragraph (1) or (2), as the case may be.

“(B) SCOPE OF GRANTS.—A coalition awarded a grant under paragraph (1) or (2), including a renewal grant under such paragraph, may not be awarded another grant under such paragraph, and is eligible for an additional grant under this section only under this paragraph.

“(C) NO PRIORITY FOR APPLICATIONS.—The Administrator may not afford a higher priority in the award of an additional grant under this paragraph than the Administrator would afford the applicant for the grant if the applicant were submitting an application for an initial grant under paragraph (1) or (2) rather than an application for a grant under this paragraph.

“(D) RENEWAL GRANTS.—Subject to subparagraph (F), the Administrator may award a renewal grant to a grant recipient under this paragraph for each of the fiscal years of the 4-fiscal year period following the fiscal year for which the initial additional grant under subparagraph (A) is awarded in an amount not to exceed amounts as follows:

“(i) For the first and second fiscal years of that 4-fiscal year period, the amount equal to 80 percent of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year.

“(ii) For the second, third, and fourth fiscal years of that 4-fiscal year period, the amount equal to 67 percent of the non-Federal funds, including in-kind contributions, raised by the coalition for the applicable fiscal year.

“(E) SUSPENSION.—If a grant recipient under this paragraph fails to continue to meet the criteria specified in subsection (a), the Administrator may suspend the grant, after providing written notice to the grant recipient and an opportunity to appeal.

“(F) LIMITATION.—The amount of a grant award under this paragraph may not exceed \$100,000 for a fiscal year.”.

(e) DATA COLLECTION AND DISSEMINATION.—Section 1033(b) of that Act (21 U.S.C. 1533(b)) is amended by adding at the end the following new paragraph:

“(3) CONSULTATION.—The Administrator shall carry out activities under this subsection in consultation with the Advisory Commission and the National Community Antidrug Coalition Institute.”.

(f) LIMITATION ON USE OF CERTAIN FUNDS FOR EVALUATION OF PROGRAM.—Section 1033(b) of that Act, as amended by subsection (e) of this section, is further amended by adding at the end the following new paragraph:

“(4) LIMITATION ON USE OF CERTAIN FUNDS FOR EVALUATION OF PROGRAM.—Amounts for activities under paragraph (2)(B) may not be derived from amounts under section 1024(a), except for amounts that are available under section 1024(b) for administrative costs.”.

## SEC. 2. SUPPLEMENTAL GRANTS FOR COALITION MENTORING ACTIVITIES UNDER DRUG-FREE COMMUNITIES SUPPORT PROGRAM.

Subchapter I of chapter 2 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1531 et seq.) is amended by adding at the end the following new section:

### “SEC. 1035. SUPPLEMENTAL GRANTS FOR COALITION MENTORING ACTIVITIES.

“(a) AUTHORITY TO MAKE GRANTS.—As part of the program established under section 1031, the Director may award an initial grant under this subsection, and renewal grants under subsection (f), to any coalition awarded a grant under section 1032 that meets the criteria specified in subsection (d) in order to fund coalition mentoring activities by such coalition in support of the program.

“(b) TREATMENT WITH OTHER GRANTS.—

“(1) SUPPLEMENT.—A grant awarded to a coalition under this section is in addition to any grant awarded to the coalition under section 1032.

“(2) REQUIREMENT FOR BASIC GRANT.—A coalition may not be awarded a grant under this section for a fiscal year unless the coalition was awarded a grant or renewal grant under section 1032(b) for that fiscal year.

“(c) APPLICATION.—A coalition seeking a grant under this section shall submit to the Administrator an application for the grant in such form and manner as the Administrator may require.

“(d) CRITERIA.—A coalition meets the criteria specified in this subsection if the coalition—

“(1) has been in existence for at least 5 years;

“(2) has achieved, by or through its own efforts, measurable results in the prevention and treatment of substance abuse among youth;

“(3) has staff or members willing to serve as mentors for persons seeking to start or expand the activities of other coalitions in the prevention and treatment of substance abuse;

“(4) has demonstrable support from some members of the community in which the coalition mentoring activities to be supported by the grant under this section are to be carried out; and

“(5) submits to the Administrator a detailed plan for the coalition mentoring activities to be supported by the grant under this section.

“(e) USE OF GRANT FUNDS.—A coalition awarded a grant under this section shall use the grant amount for mentoring activities to support and encourage the development of new, self-supporting community coalitions that are focused on the prevention and treatment of substance abuse in such new coalitions’ communities. The mentoring coalition shall encourage such development in accordance with the plan submitted by the mentoring coalition under subsection (d)(5).

“(f) RENEWAL GRANTS.—The Administrator may make a renewal grant to any coalition awarded a grant under subsection (a), or a previous renewal grant under this subsection, if the coalition, at the time of application for such renewal grant—

“(1) continues to meet the criteria specified in subsection (d); and

“(2) has made demonstrable progress in the development of one or more new, self-supporting community coalitions that are focused on the prevention and treatment of substance abuse.

“(g) GRANT AMOUNTS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the total amount of grants awarded to a coalition under this section for a fiscal year may not exceed the amount of non-Federal funds raised by the coalition, including in-kind contributions, for that fiscal year.

“(2) INITIAL GRANTS.—The amount of the initial grant awarded to a coalition under subsection (a) may not exceed \$75,000.

“(3) RENEWAL GRANTS.—The total amount of renewal grants awarded to a coalition under subsection (f) for any fiscal year may not exceed \$75,000.

“(h) FISCAL YEAR LIMITATION ON AMOUNT AVAILABLE FOR GRANTS.—The total amount available for grants under this section, including renewal grants under subsection (f), in any fiscal year may not exceed the amount equal to five percent of the amount authorized to be appropriated by section 1024(a) for that fiscal year.”

### SEC. 3. FIVE-YEAR EXTENSION OF ADVISORY COMMISSION ON DRUG-FREE COMMUNITIES.

Section 1048 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1548) is amended by striking “2002” and inserting “2007”.

### SEC. 4. AUTHORIZATION FOR NATIONAL COMMUNITY ANTIDRUG COALITION INSTITUTE.

(a) IN GENERAL.—The Director of the Office of National Drug Control Policy may, using amounts authorized to be appropriated by subsection (d), make a grant to an eligible organization to provide for the establishment of a National Community Antidrug Coalition Institute.

(b) ELIGIBLE ORGANIZATIONS.—An organization eligible for the grant under subsection (a) is any national nonprofit organization that represents, provides technical assistance and training to, and has special expertise and broad, national-level experience in community antidrug coalitions under section 1032 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1532).

(c) USE OF GRANT AMOUNT.—The organization receiving the grant under subsection (a) shall establish a National Community Antidrug Coalition Institute to—

(1) provide education, training, and technical assistance for coalition leaders and community teams;

(2) develop and disseminate evaluation tools, mechanisms, and measures to better assess and document coalition performance measures and outcomes; and

(3) bridge the gap between research and practice by translating knowledge from research into practical information.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for purposes of activities under this section, including the grant under subsection (a), amounts as follows:

(1) For each of fiscal years 2002 and 2003, \$2,000,000.

(2) For each of fiscal years 2004, 2005, 2006, and 2007, such sums as may be necessary for such activities.

Mr. BIDEN, Mr. President, today I introduce legislation to reauthorize the Drug Free Communities Act, a program which currently funds more than 300 community coalitions across the country that work to reduce drug, alcohol, and tobacco use.

Four years ago, I worked with Senator GRASSLEY, Representatives Sandy Levin and Rob Portman, and others to create this important program to fund coalitions of citizens—parents, youth, businesses, media, law enforcement, religious organizations, civic groups, doctors, nurses, and others—working to reduce youth substance abuse.

Community coalitions across the country—including two in my home State of Delaware—are galvanizing tremendous support for prevention efforts. They are helping fellow citizens make a difference in their communities. And they are helping all sectors of the community send a consistent message about alcohol, drugs, and tobacco.

I have been fighting for this type of anti-drug program for local communities for over a decade because I believe that prevention is a critical—but too often overlooked—part of an effective drug strategy.

Substance abuse is one of our Nation’s most pervasive problems. Addiction is a disease that does not discriminate on the basis of age, gender, socioeconomic status, race or creed. And while we tend to stereotype drug abuse as an urban problem, the steadily growing number of heroin and methamphetamine addicts in rural villages and suburban towns shows that is simply not the case.

We have nearly 15 million drug users in this country, 4 million of whom are hard-core addicts. We all know someone—a family member, neighbor, colleague or friend—who has become addicted to drugs or alcohol. And we are all affected by the undeniable correlation between substance abuse and crime—an overwhelming 80 percent of the 2 million men and women behind bars today have a history of drug and alcohol abuse or addiction or were arrested for a drug-related crime.

All of this comes at a hefty price. Drug abuse and addiction cost this Nation \$110 billion in law enforcement and other criminal justice expenses, medical bills, lost earnings and other costs each year. Illegal drugs are responsible for thousands of deaths each year and for the spread of a number of

communicable diseases, including AIDS and Hepatitis C. And a study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) shows that 7 out of 10 cases of child abuse and neglect are caused or exacerbated by substance abuse and addiction.

Another CASA study recently revealed that for each dollar that States spend on substance-abuse related programs, 96 cents goes to dealing with the consequences of substance abuse and only 4 cents to preventing and treating it. Investing more in prevention and treatment is cost-effective because it will decrease much of the street crime, child abuse, domestic violence, and other social ills that can result from substance abuse.

If we can get kids through age 21 without smoking, abusing alcohol, or using drugs, they are unlikely to have a substance abuse problem in the future. But there are still those who shrug their shoulders and say “kids are kids—they are going to experiment.” Others find the thought of keeping kids drug-free too daunting a task, and they give up too soon.

But the truth is that we are learning more and more about drug prevention as researchers isolate the so-called “risk” and “protective” factors for drug use. In other words, we now know that if a child has low self-esteem or emotional problems; has a substance abuser for a parent; is a victim of child abuse; or is exposed to pro-drug media messages, that child is at a higher risk of smoking, drinking and using illegal drugs. But the good news is that we are also learning what decreases a child’s risk of substance abuse.

The Drug Free Communities program allows coalitions to put prevention research into action in cities and towns nationwide by funding initiatives tailored to a community’s individual needs.

In my home State of Delaware, both the New Castle County Community Partnership and the Delaware Prevention Coalition’s Southern Partnership are working to prevent youth substance abuse by helping kids do better in school, addressing their behavioral problems, and teaching them the dangers associated with drug, alcohol, and tobacco use. The Delaware coalitions know that teachers who have high expectations of their students and help them develop good social skills also help to prevent substance use. And they know that if kids think that drugs, alcohol, and tobacco are bad for them, they will be less likely to use them.

Other coalitions are working to engage the religious community. In Florida, the Miami Coalition for a Safe and Drug Free Community has developed a substance abuse manual for religious leaders so that they will know how to identify substance abuse and help people who need treatment find it. They are also teaching religious leaders how to incorporate messages about substance abuse into their sermons.

Still other groups are working with the business community. A coalition in Troy, MI, is working with the Chamber of Commerce to form an Employee Assistance Program for a consortium of small businesses who could not otherwise afford to have one.

These are just a few examples of the efforts that are making a difference and just a few of the reasons why I am proud to support community coalitions.

Drug abuse plagues the entire community. We all feel the consequences—crime, homelessness, domestic violence, child abuse, despair—and we all need to do something about it. Prevention messages must come from all sectors of the community, from a number of different voices. Coalitions bring those groups together, give them information they need, help develop programs that work, and nurture them to success.

I believe that the Drug Free Communities program is a powerful prevention initiative and I urge my colleagues to support its reauthorization.

I ask unanimous consent that the full text of the bill be printed in the RECORD.

Mr. SMITH of Oregon. Mr. President, I rise today to join my distinguished colleagues to support the reauthorization of the Drug-Free Communities Support Program. Drug-Free Community grants have had an extremely positive impact on my home State of Oregon, and I know that the program has benefitted a great number of communities all across this country. I am proud to be an original cosponsor of this important bill.

Federal Drug-Free Community grants serve programs in 14 Oregon communities in urban, suburban, and rural areas alike. All Drug-Free Community grants go directly to communities to support a wide variety of innovative drug-abuse prevention programs, ranging from community education programs and after-school programs to parenting classes and youth camps. Communities are invested in the process through a dollar-for-dollar match requirement, ensuring their interest in getting results, and they are getting results. With help from Federal Drug-Free Community dollars, Oregon drug abuse prevention groups are increasing citizen participation and they have produced a measurable decrease in both adult and youth substance abuse.

Portland's Regional Drug Initiative, RDI, for example, has promoted the establishment of drug-free workplaces among the city's large and small employers. Over 3,000 employers have attended an RDI training session, and of those, 92 percent have instituted drug-free workplace policies, resulting in a 5.5 percent decrease in positive workplace drug tests. At the Southern Oregon Drug Awareness program in Medford, OR, 320 young people have participated in its violence prevention course, and upon completion, two-thirds of

those students report having no additional discipline referrals in school. These are two fine examples of how the Drug-Free Communities Support Program is directly responsible for positively impacting lives in Oregon and all across our Nation.

This bill will reauthorize the Drug-Free Communities Support Program to provide grants for an additional five years. The bill will also authorize the creation of a National Community Anti-Drug Coalition Institute, which will serve as a valuable information clearing house for programs seeking to improve themselves by using the best practices of other successful community programs. The bill also establishes a new coalition mentoring program which will enable established coalitions like the Oregon Partnership to help communities develop their own local drug prevention coalitions.

Substance prevention works, and drug abuse is becoming less common through community prevention efforts, but this is no time to rest on our laurels. Over the next fifteen years, the youth population in the United States will grow by 21 percent, and we must ensure that the programs are in place to prevent these youths from succumbing to drug-related problems, such as academic failure, drug-related violence, and HIV infection. The Drug-Free Communities Support Program is an important partner in local efforts to prevent these problems, and I urge my colleagues to join me in supporting its reauthorization.

#### NOTICES OF HEARINGS

##### COMMITTEE ON INDIAN AFFAIRS

Mr. INOUE. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on June 26, 2001, at 10:30 a.m. in room 485 Russell Senate Building to conduct a hearing to receive testimony on the goals and priorities of the Great Plains Tribes for the 107th session of the Congress.

Those wishing additional information may contact committee staff at 202/224-2251.

##### COMMITTEE ON INDIAN AFFAIRS

Mr. INOUE. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on June 28, 2001, at 10:00 a.m. in room 485 Russell Senate Building to conduct a hearing to receive testimony on the goals and priorities of the Montana Wyoming Tribal Leaders Council for the 107th session of the Congress.

Those wishing additional information may contact committee staff at 202/224-2251.

#### AUTHORITY FOR COMMITTEES TO MEET

##### COMMITTEE ON ARMED SERVICES

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the

Senate on Wednesday, June 20, 2001, at 4 p.m., in executive session to meet with NATO Secretary General the Right Honorable Lord Robertson of Port Ellen to discuss alliance matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

##### COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 20, 2001, to conduct a hearing on "The Condition of the U.S. Banking System."

The PRESIDING OFFICER. Without objection, it is so ordered.

##### COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, June 20 at 9:30 a.m. to conduct a hearing. The committee will consider the nominations of Patricia Lynn Scarlett to be an Assistant Secretary of the Interior (for Policy, Management, and Budget); William Gerry Myers III to be the Solicitor of the Department of the Interior; and Bennett William Raley to be an Assistant Secretary of the Interior (for Water and Science).

The PRESIDING OFFICER. Without objection, it is so ordered.

##### COMMITTEE ON FINANCE

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Wednesday, June 20, 2001, to hear testimony regarding Trade Promotion Authority.

The PRESIDING OFFICER. Without objection, it is so ordered.

##### COMMITTEE ON FOREIGN RELATIONS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 20, 2001 at 10 a.m. to hold a hearing titled, "U.S. Security Interests in Europe" as follows:

"U.S. Security Interests in Europe," Wednesday, June 20, 2001, 10 a.m., SD-419.

Witness: The Honorable Colin Powell, Secretary of State, Department of State, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

##### COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. TORRICELLI. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Wednesday, June 20, 2001 at 9:30 a.m. for a hearing to examine the Role of the Federal Energy Regulatory Commission Associated with the Restructuring of Energy Industries.

The PRESIDING OFFICER. Without objection, it is so ordered.