and by following up a screening with medical treatment, fewer women will succumb to these devastating diseases.

Mr. Speaker, this issue is especially important to me and to my constituents, especially those in Rockland county. Recent studies have found that Rockland county has the highest rate of breast cancer in New York State and according to some studies, in the Nation. This legislation will help many of my constituents during a very difficult time in their lives. Providing medical treatment to those women who have been screened by the CDC will vastly improve their chances of survival and reduce the rate of mortality due to these cancers. I strongly support this legislation.

Accordingly, I urge my colleagues to support this important measure.

Mr. DINGELL. Mr. Speaker, I am in support of a bill that will make a big difference in the lives of low-income women with cancer, H.R. 4386, the Breast and Cervical Cancer Treatment Act.

Two individuals have campaigned tirelessly for this bill and the rights of low-income women. First, I commend Representative ANNA ESHOO. Were it not for the energy and attention that Ms. ESHOO brought to this issue, this bill would not be on the floor today. Secondly, I would like to remember Senator John Chafee, the original cosponsor of the companion bill in the Senate. The late Senator Chafee's advocacy for women, children, the poor, and the disabled will continue with the passage of this bill.

We all know that early detection and treatment are the key to surviving cancer. This is the reason why the Centers for Disease Control (CDC) uses Federal funds to provide free diagnostic tests for breast and cervical cancer for low-income uninsured women, many of whom are minorities.

With this bill, the Federal Government will complete its commitment to the low-income women who are diagnosed with cancer through the CDC's screening program. No longer will women diagnosed through the program have to scramble to find state funds, rely on charity care, or incur enormous debts in order to pay for radiation or chemotherapy. H.R. 4386 will allow women to enroll in the Medicaid program for the duration of their cancer treatment, so that they can focus their energies on fighting cancer instead of the health care system.

I hope that my colleagues will join me in voting for H.R. 4386. Advocates of this bill have waited a long time for this day. Let's not make women with breast and cervical cancer wait any longer.

Mr. BLILEY. Mr. Speaker, I commend the gentlelady from North Carolina, Mrs. MYRICK, for her personal courage in the face of breast cancer and for her many hours of work in persuading the House Leadership to bring this important bill to the floor today.

I also wish to recognize one of the original cosponsors of H.R. 4386, Mr. LAZIO of New York for his many months of hard work on the Commerce Committee persuading members and forging alliances with the American Cancer Society, the National Women's Health Network, the National Cervical Cancer Coalition, the National Breast Cancer Coalition, the Cancer Research Foundation of America, and so many others to make this day possible.

Like so many women with whom I have met over the last few years advocating for this legislation, my own wife is a breast cancer survivor. I know firsthand the fears that families face when they first hear that word. It is with those memories in my mind that I work in Congress to help find new ways that we can help more women from falling victim to cancer.

In the closing days of the last session, the Committee I chair reported out H.R. 1070, the Lazio ''Breast and Cervical Cancer Prevention and Treatment Act of 1999.'' I am very pleased that we are now on the floor debating a bill based on the Committee's work, which addresses both breast cancer, the leading cause of cancer deaths among women, and cervical cancer, a form of cancer caused by a viral infection that kills more women in America than AIDS.

Again, I thank Congresswoman MYRICK, my Commerce Committee colleagues, and many other Members who have contributed to bringing this legislation to the floor today.

Mr. LAZIO. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. LAZIO) that the House suspend the rules and pass the bill, H.R. 4386, as amended.

The question was taken.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CHILDREN'S HEALTH ACT OF 2000

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4365) to amend the Public Health Service Act with respect to children's health, as amended.

The Clerk read as follows:

H.R. 4365

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 Act of 2000''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—AUTISM

Subtitle A—Surveillance and Research Regarding Prevalence and Pattern of Autism

SEC. 101. SHORT TITLE.

This subtitle may be cited as the ''Autism Statistics, Surveillance, Research, and Epidemiology Act of 2000 (ASSURE)''.

SEC. 102. SURVEILLANCE AND RESEARCH PROGRAMS; CLEARINGHOUSE; ADVISORY COMMITTEE.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317G the following section:

''SURVEILLANCE AND RESEARCH REGARDING AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS

''SEC. 317H. (a) IN GENERAL.—The Secretary , acting through the Director of the Centers for Disease Control and Prevention, may make awards of grants and cooperative agreements for the collection, analysis, and reporting of data on autism and pervasive developmental disorders. An entity may receive such an award only if the entity is a public or nonprofit private entity ''(including health departments of States and political subdivisions of States, and including universities and other educational entities). In making such awards, the Secretary may provide direct technical assistance in lieu of cash.

''(b) CENTERS OF EXCELLENCE IN AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS EPIDEMIOLOGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall (subject to the extent of amounts made available in appropriations Acts) establish not less than three, and not more than five, regional centers of excellence in autism and pervasive developmental disorders epidemiology for the purpose of collecting and analyzing information on the number, incidence, correlates, and causes of autism and related developmental disorders.

''(2) RECIPIENTS OF AWARDS FOR ESTABLISHMENT OF CENTERS.—Centers under paragraph (1) shall be established and operated through the award of grants or cooperative agreements to public or nonprofit private entities that conduct research, including health departments of States and political subdivisions of States, and including universities and other educational entities.

''(3) CERTAIN REQUIREMENTS.—An award for a center under paragraph (1) may be made only if the entity involved submits to the Secretary an application containing such agreements and information as the Secretary may require, including an agreement that the center involved will operate in accordance with the following:

''(A) The center will collect, analyze, and report autism and pervasive developmental disorders data according to guidelines prescribed by the Director, after consultation with relevant State and local public health officials, private sector developmental disorder researchers, and advocates for those with developmental disorders;

''(B) The center will assist with the development and coordination of State autism and pervasive developmental disorders surveillance efforts within a region;

''(C) The center will provide education, training, and clinical skills improvement for health professionals aimed at better understanding and treatment of autism and related developmental disorders; and

''(D) The center will identify eligible cases and controls through its surveillance systems and conduct research into factors which may cause autism and related developmental disorders; each program will develop or extend an area of special research expertise (including, but not limited to, genetics, environmental exposure to contaminants, immunology, and other relevant research specialty areas).

''(c) CLEARINGHOUSE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out the following:

''(1) The Centers for Disease Control and Prevention shall serve as the coordinating agency for autism and pervasive developmental disorders surveillance activities through the establishment of a clearinghouse for the collection and storage of data generated from the monitoring programs created by this section. The functions of such a clearinghouse shall include facilitating the coordination of research and policy development relating to the epidemiology of autism and other pervasive developmental disorders.

''(2) The Secretary shall coordinate the Federal response to requests for assistance from State health department officials regarding potential or alleged autism or developmental disorder clusters.

''(d) ADVISORY COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall establish an Advisory Committee for Autism and Pervasive developmental disorders Epidemiology Research (in this section referred to as the 'Committee'). The Committee shall provide advice and recommendations to the Director of the Centers for Disease Control and Prevention on—

''(A) the establishment of a national autism and pervasive developmental disorders surveillance program;

''(B) the establishment of centers of excellence in autism and pervasive developmental disorders epidemiology;

''(C) methods and procedures to more effectively coordinate government and non-government programs and research on autism and pervasive developmental disorders epidemiology; and

''(D) the effective operation of autism and pervasive developmental disorders epidemiology research activities.

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Committee shall be composed of ex officio members in accordance with subparagraph (B) and 11 appointed members in accordance with subparagraph (C).

''(B) EX OFFICIO MEMBERS.—The following officials shall serve as ex officio members of the Committee:

''(i) The Director of the National Center for Environmental Health.

''(ii) The Assistant Administrator of the Agency for Toxic Substances and Disease Registry.

''(iii) The Director of the National Institute of Child Health and Human Development.

''(iv) The Director of the National Institute of Neurological Disorders and Stroke.

''(C) APPOINTED MEMBERS.—Appointments to the Committee shall be made in accordance with the following:

''(i) Two members shall be research scientists with demonstrated achievements in research related to autism and related developmental disorders. The scientists shall be appointed by the Secretary in consultation with the National Academy of Sciences.

''(ii) Five members shall be representatives of the five national organizations whose primary emphasis is on research into autism and other pervasive developmental disorders. One representative from each of such organizations shall be appointed by the Secretary in consultation with the National Academy of Sciences.

''(iii) Two members shall be clinicians whose practice is primarily devoted to the treatment of individuals with autism and other pervasive developmental disorders. The clinicians shall be appointed by the Secretary in consultation with the Institute of Medicine and the National Academy of Sciences.

''(iv) Two members shall be individuals who are the parents or legal guardians of a person or persons with autism or other pervasive developmental disorders. The individuals shall be appointed by the Secretary in consultation with the ex officio members under subparagraph (B) and the five national organizations referred to in clause (ii).

''(3) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following apply with respect to the Committee:

''(A) The Committee shall receive necessary and appropriate administrative support from the Department of Health and Human Services.

''(B) Members of the Committee shall be appointed for a term of three years, and may serve for an unlimited number of terms if reappointed.

''(C) The Committee shall meet no less than two times per year.

''(D) Members of the Committee shall not receive additional compensation for their service. Such members may receive reimbursement for appropriate and additional expenses that are incurred through service on the Committee which would not have incurred had they not been a member of the Committee.

''(e) REPORT TO CONGRESS.—The Secretary shall prepare and submit to the Congress, after consultation with and comment by the advisory committee under subsection (d), an annual report regarding the prevalence and incidence of autism and other pervasive developmental disorders, the results of research into the etiology of autism and other pervasive developmental disorders, public health responses to known or preventable causes of autism and other pervasive developmental disorders, and the need for additional research into promising lines of scientific inquiry.

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

Subtitle B—Expansion, Intensification, and Coordination of Autism Activities of National Institutes of Health With Respect to Autism

SEC. 111. SHORT TITLE.

This subtitle may be cited as the ''Advancement in Pediatric Autism Research Act of 2000''.

SEC. 112. EXPANSION, INTENSIFICATION, AND COORDINATION; INFORMATION AND EDUCATION; INTERAGENCY COORDINATING COMMITTEE.

Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following section:

''AUTISM

''SEC. 409C. (a) IN GENERAL.—

''(1) EXPANSION OF ACTIVITIES.—The Director of NIH (in this section referred to as the 'Director') shall expand, intensify, and coordinate the activities of the National Institutes of Health with respect to research on autism.

''(2) ADMINISTRATION OF PROGRAM; COLLABORATION AMONG AGENCIES.—The Director shall carry out this section (other than subsection (b)) acting through the Director of the National Institute of Mental Health and in collaboration with any other agencies that the Director determines appropriate.

''(b) INTERAGENCY COORDINATING COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall ensure that there is in operation an interagency committee to be known as the 'Autism Coordinating Committee' (referred to in this subsection as the 'Committee') to coordinate all efforts within the Department of Health and Human Services concerning autism, including activities carried out through the National Institutes of Health under this section and activities carried out through the Centers for Disease Control and Prevention under section 317H.

''(2) MEMBERSHIP.—The Committee shall be composed of such directors of the national research institutes, such directors of centers within the Centers for Disease Control and Prevention, and such other officials within the Department of Health and Human Services as the Secretary determines to be appropriate. The Committee may include representatives of other Federal agencies that serve children with autism, such as the Department of Education.

''(3) MEETINGS.—The Committee shall meet not less than twice per year.

''(c) CENTERS OF EXCELLENCE.—

''(1) IN GENERAL.—The Director shall under subsection (a)(1) make awards of grants and contracts to public or nonprofit private entities to pay all or part of the cost of planning, establishing, improving, and providing basic operating support for centers of excellence regarding research on autism.

''(2) RESEARCH.—Each center under paragraph (1) shall conduct basic and clinical research into autism. Such research should include investigations into the cause, diagnosis, early detection, prevention, control, and treatment of autism. These centers, as a group, shall conduct research including but not limited to the fields of developmental neurobiology, genetics, and psychopharmacology.

''(3) SERVICES FOR PATIENTS.—A center under paragraph (1) may expend amounts provided under such paragraph to carry out a program to make individuals aware of opportunities to participate as subjects in research conducted by the centers. The program may, in accordance with such criteria as the Director may establish, provide to such subjects referrals for health and other services, and such patient care costs as are required for research. The extent to which the center can demonstrate availability and access to clinical services shall be considered by the Director in decisions about awarding the grants to applicants which meet the scientific criteria for funding.

''(4) COORDINATION OF CENTERS; REPORTS.—The Director shall, as appropriate, provide for the coordination of information among centers under paragraph (1) and ensure regular communication between such centers, and may require the periodic preparation of reports on the activities of the centers and the submission of the reports to the Director.

''(5) ORGANIZATION OF CENTERS.—Each center under paragraph (1) shall use the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such requirements as may be prescribed by the Director.

''(6) NUMBER OF CENTERS; DURATION OF SUPPORT.—The Director shall provide for the establishment of not less than five centers under paragraph (1), subject to the extent of amounts made available in appropriations Acts. Support of such a center may be for a period not exceeding 5 years. Such period may be extended for one or more additional periods not exceeding 5 years if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period should be extended.

''(d) FACILITATION OF RESEARCH.—The Director shall under subsection (a)(1) provide for a program under which samples of tissues and genetic materials that are of use in research on autism are donated, collected, preserved, and made available for such research. The program shall be carried out in accordance with accepted scientific and medical standards for the donation, collection, and preservation of such samples.

''(e) INFORMATION AND EDUCATION.—

''(1) IN GENERAL.—The Director shall establish and implement a program to provide information and education on autism to health professionals and the general public, including information and education on advances in the diagnosis and treatment of autism and training and continuing education through programs for scientists, physicians, and other health professionals who provide care for patients with autism.

''(2) STIPENDS.—The Director may use amounts made available under this section to provide stipends for health professionals who are enrolled in training programs under this section.

''(f) PUBLIC INPUT.—The Director shall under subsection (a)(1) provide for means through which the public can obtain information on the existing and planned programs and activities of the National Institutes of Health with respect to autism and through which the Director can receive comments from the public regarding such programs and activities.

''(g) ANNUAL REPORT TO CONGRESS.—The Director shall prepare and submit to the appropriate committees of the Congress reports regarding the activities carried out under this section. The first report shall be submitted not later than January 10, 2002, and subsequent reports shall be submitted annually thereafter.

''(h) FUNDING.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorizations of appropriations are in addition to any other authorizations of appropriations that are available for such purpose.''.

TITLE II—RESEARCH AND DEVELOPMENT REGARDING FRAGILE X

SEC. 201. SHORT TITLE.

This title may be cited as the ''Fragile X Research Breakthrough Act of 2000''.

SEC. 202. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT; RESEARCH ON FRAGILE X.

Subpart 7 of part C of title IV of the Public Health Service Act is amended by adding at the end the following section:

''FRAGILE X

''SEC. 452E. (a) EXPANSION AND COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute, after consultation with the advisory council for the Institute, shall expand, intensify, and coordinate the activities of the Institute with respect to research on the disease known as fragile X.

''(b) RESEARCH CENTERS.—

''(1) IN GENERAL.—The Director of the Institute, after consultation with the advisory council for the Institute, shall make grants to, or enter into contracts with, public or nonprofit private entities for the development and operation of centers to conduct research for the purposes of improving the diagnosis and treatment of, and finding the cure for, fragile X.

''(2) NUMBER OF CENTERS.—In carrying out paragraph (1), the Director of the Institute shall, to the extent that amounts are appropriated, provide for the establishment of at least three fragile X research centers.

''(3) ACTIVITIES.—

''(A) IN GENERAL.—Each center assisted under paragraph (1) shall, with respect to fragile X—

''(i) conduct basic and clinical research, which may include clinical trials of—

''(I) new or improved diagnostic methods; and

''(II) drugs or other treatment approaches; and

''(ii) conduct research to find a cure.

''(B) FEES.—A center may use funds provided under paragraph (1) to provide fees to individuals serving as subjects in clinical trials conducted under subparagraph (A).

''(4) COORDINATION AMONG CENTERS.—The Director of the Institute shall, as appropriate, provide for the coordination of the activities of the centers assisted under this section, including providing for the exchange of information among the centers.

''(5) CERTAIN ADMINISTRATIVE REQUIREMENTS.—Each center assisted under paragraph (1) shall use the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such requirements as may be prescribed by the Director of the Institute.

''(6) DURATION OF SUPPORT.—Support may be provided to a center under paragraph (1) for a period not exceeding 5 years. Such period may be extended for one or more additional periods, each of which may not exceed 5 years, if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period be extended.

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

SEC. 203. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT; LOAN REPAYMENT PROGRAM REGARDING RESEARCH ON FRAGILE X.

Part G of title IV of the Public Health Service Act (42 U.S.C. 288 et seq.) is amended by inserting after section 487E the following section:

''LOAN REPAYMENT PROGRAM REGARDING RESEARCH ON FRAGILE X

''SEC. 487F. (a) IN GENERAL.—The Secretary, in consultation with the Director of the National Institute of Child Health and Human Development, shall establish a program under which the Federal Government enters into contracts with qualified health professionals (including graduate students) who agree to conduct research regarding fragile X in consideration of the Federal Government's agreement to repay, for each year of such service, not more than $35,000 of the principal and interest of the educational loans owed by such health professionals.

''(b) APPLICABILITY OF CERTAIN PROVISIONS.—With respect to the National Health Service Corps Loan Repayment Program established in subpart III of part D of title III, the provisions of such subpart (including section 338B(g)(3)) shall, except as inconsistent with subsection (a) of this section, apply to the program established in such subsection in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established in such subpart.

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

TITLE III—JUVENILE ARTHRITIS AND RELATED CONDITIONS

SEC. 301. NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES; RESEARCH ON JUVENILE ARTHRITIS AND RELATED CONDITIONS.

Subpart 4 of part C of title IV of the Public Health Service Act (42 U.S.C. 285d et seq.) is amended by inserting after section 442 the following section:

''JUVENILE ARTHRITIS AND RELATED CONDITIONS

''SEC. 442A. (a) EXPANSION AND COORDINATION OF ACTIVITIES.—The Director of the Institute, in coordination with the Director of the National Institute of Allergy and Infectious Diseases, shall expand and intensify the programs of such Institutes with respect to research and related activities concerning juvenile arthritis and related conditions.

''(b) COORDINATION.—The Directors referred to in subsection (a) shall jointly coordinate the programs referred to in such subsection and consult with the Arthritis and Musculoskeletal Diseases Interagency Coordinating Committee.

''(c) PEDIATRIC RHEUMATOLOGY.—The Secretary, acting through the appropriate agencies of the Public Health Service, shall develop a coordinated effort to help ensure that a national infrastructure is in place to train and develop pediatric rheumatologists to address the health care services requirements of children with arthritis and related conditions.

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

SEC. 302. INFORMATION CLEARINGHOUSE.

Section 438(b) of the Public Health Service Act (42 U.S.C. 285d–3(b)) is amended by inserting '', including juvenile arthritis and related conditions,'' after ''diseases''.

TITLE IV—REDUCING BURDEN OF DIABETES AMONG CHILDREN AND YOUTH

SEC. 401. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part B of title III of the Public Health Service Act, as amended by section 102 of this Act, is amended by inserting after section 317H the following section:

''DIABETES IN CHILDREN AND YOUTH

''SEC. 317I. (a) NATIONAL REGISTRY ON JUVENILE DIABETES.—The Secretary , acting through the Director of the Centers for Disease Control and Prevention, shall develop a system to collect data on juvenile diabetes, including with respect to incidence and prevalence, and shall establish a national database for such data.

''(b) TYPE 2 DIABETES IN YOUTH.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the Administrator of the Health Resources and Services Administration, shall implement a national public health effort to address type 2 diabetes in youth, including—

''(1) enhancing surveillance systems and expanding research to better assess the prevalence of type 2 diabetes in youth and determine the extent to which type 2 diabetes is incorrectly diagnosed as type 1 diabetes among children;

''(2) assisting States in establishing coordinated school health programs and physical activity and nutrition demonstration programs to control weight and increase physical activity among youth; and

''(3) developing and improving laboratory methods to assist in diagnosis, treatment, and prevention of diabetes including, but not limited to, developing noninvasive ways to monitor blood glucose to prevent hypoglycema and improving existing glucometers that measure blood glucose.

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

SEC. 402. PROGRAMS OF NATIONAL INSTITUTES OF HEALTH.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by inserting after section 434 the following section:

''JUVENILE DIABETES

''SEC. 434A. (a) LONG-TERM EPIDEMIOLOGY STUDIES.—

''(1) IN GENERAL.—The Director of the Institute shall conduct or support long-term epidemiology studies in which individuals with type 1, or juvenile, diabetes are followed for 10 years or more. Such studies shall, in order to provide a valuable resource for the purposes specified in paragraph (2), provide for complete characterization of disease manifestations, appropriate medical history, elucidation of environmental factors, delineation of complications, results of usual medical treatment and a variety of other potential valuable (such as samples of blood).

''(2) PURPOSES.—The purposes referred to in paragraph (1) with respect to type 1 diabetes are the following:

''(A) Delineation of potential environmental triggers thought precipitating or causing type 1 diabetes.

''(B) Delineation of those clinical characteristics or lab measures associated with complications of the disease.

''(C) Potential study population to enter into clinical trials for prevention and treatment, as well as genetic studies.

''(b) CLINICAL TRIAL INFRASTRUCTURE/INNOVATIVE TREATMENTS FOR JUVENILE DIABETES.—The Secretary, acting through the Director of the National Institutes of Health, shall support regional clinical centers for the cure of juvenile diabetes and shall through such centers provide for—

''(1) well-characterized population of children appropriate for study;

''(2) well-trained clinical scientists able to conduct such trials;

''(3) appropriate clinical settings able to house such studies; and

''(4) appropriate statistical capability, data, safety and other monitoring capacity.

''(c) DEVELOPMENT OF VACCINE.—The Secretary, acting through the appropriate agencies of the Public Health Service, shall provide for a national effort to develop a vaccine for type 1 diabetes. Such effort shall provide for a combination of increased efforts in research and development of candidate vaccines, coupled with appropriate ability to conduct large clinical trials in children.

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

TITLE V—ASTHMA TREATMENT SERVICES FOR CHILDREN

SEC. 501. SHORT TITLE.

This title may be cited as the ''Children's Asthma Relief Act of 2000''.

Subtitle A—Treatment

SEC. 511. GRANTS FOR CHILDREN'S ASTHMA RELIEF.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following part:

''PART P—ADDITIONAL PROGRAMS

''SEC. 399L. CHILDREN'S ASTHMA TREATMENT GRANTS PROGRAM.

''(a) AUTHORITY TO MAKE GRANTS.—

''(1) IN GENERAL.—In addition to any other payments made under this Act or title V of the Social Security Act, the Secretary shall award grants to eligible entities to carry out the following purposes:

''(A) To provide access to quality medical care for children who live in areas that have a high prevalence of asthma and who lack access to medical care.

''(B) To provide on-site education to parents, children, health care providers, and medical teams to recognize the signs and symptoms of asthma, and to train them in the use of medications to treat asthma and prevent its exacerbations.

''(C) To decrease preventable trips to the emergency room by making medication available to individuals who have not previously had access to treatment or education in the management of asthma.

''(D) To provide other services, such as smoking cessation programs, home modification, and other direct and support services that ameliorate conditions that exacerbate or induce asthma.

''(2) CERTAIN PROJECTS.—In making grants under paragraph (1), the Secretary may make grants designed to develop and expand the following projects:

''(A) Projects to provide comprehensive asthma services to children in accordance with the guidelines of the National Asthma Education and Prevention Program (through the National Heart, Lung and Blood Institute), including access to care and treatment for asthma in a community-based setting;

''(B) Projects to demonstrate mobile health care clinics that in accordance with such guidelines provide preventive asthma care. Such projects shall be evaluated and reports describing the findings of the evaluations shall be submitted to the Congress.

''(C) Projects to conduct validated asthma management education programs for patients with asthma and their families, including patient education regarding asthma management, family education on asthma management, and the distribution of materials, including displays and videos, to reinforce concepts presented by medical teams.

''(2) AWARD OF GRANTS.—

''(A) APPLICATION.—

''(i) IN GENERAL.—An eligible entity shall submit an application to the Secretary for a grant under this section in such form and manner as the Secretary may require.

''(ii) REQUIRED INFORMATION.—An application submitted under this subparagraph shall include a plan for the use of funds awarded under the grant and such other information as the Secretary may require.

''(B) REQUIREMENT.—In awarding grants under this section, the Secretary shall give preference to eligible entities that demonstrate that the activities to be carried out under this section shall be in localities within areas of known or suspected high prevalence of childhood asthma or high asthma-related mortality (relative to the average asthma prevalence rates and associated mortality rates in the United States). Acceptable data sets to demonstrate a high prevalence of childhood asthma or high asthma-related mortality may include data from Federal, State, or local vital statistics, claims data under title XIX or XXI of the Social Security Act, other public health statistics or surveys, or other data that the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, deems appropriate.

''(3) DEFINITION OF ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' means a State agency or other entity receiving funds under title V of the Social Security Act, a local community, a nonprofit children's hospital or foundation, or a nonprofit community-based organization.

''(b) COORDINATION WITH OTHER CHILDREN'S PROGRAMS.—An eligible entity shall identify in the plan submitted as part of an application for a grant under this section how the entity will coordinate operations and activities under the grant with—

''(1) other programs operated in the State that serve children with asthma, including any such programs operated under titles V, XIX, or XXI of the Social Security Act; and

''(2) one or more of the following—

''(A) the child welfare and foster care and adoption assistance programs under parts B and E of title IV of such Act;

''(B) the head start program established under the Head Start Act (42 U.S.C. 9831 et seq.);

''(C) the program of assistance under the special supplemental nutrition program for women, infants and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786);

''(D) local public and private elementary or secondary schools; or

''(E) public housing agencies, as defined in section 3 of the United States Housing Act of 1937 (42 U.S.C. 1437a).

''(c) EVALUATION.—An eligible entity that receives a grant under this section shall submit to the Secretary an evaluation of the operations and activities carried out under the grant that includes—

''(1) a description of the health status outcomes of children assisted under the grant;

''(2) an assessment of the utilization of asthma-related health care services as a result of activities carried out under the grant;

''(3) the collection, analysis, and reporting of asthma data according to guidelines prescribed by the Director of the Centers for Disease Control and Prevention; and

''(4) such other information as the Secretary may require.

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

SEC. 512. TECHNICAL AND CONFORMING AMENDMENTS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended—

(1) in part L, by redesignating section 399D as section 399A;

(2) in part M—

(A) by redesignating sections 399H through 399L as sections 399B through 399F, respectively;

(B) in section 399B (as so redesignated), in subsection (e)—

(i) by striking ''section 399K(b)'' and inserting ''subsection (b) of section 399E''; and

(ii) by striking ''section 399C'' and inserting ''such section'';

(C) in section 399E (as so redesignated), in subsection (c), by striking ''section 399H(a)'' and inserting ''section 399B(a)''; and

(D) in section 399F (as so redesignated)—

(i) in subsection (a), by striking ''section 399I'' and inserting ''section 399C'';

(ii) in subsection (a), by striking ''subsection 399J'' and inserting ''section 399D''; and

(iii) in subsection (b), by striking ''subsection 399K'' and inserting ''section 399E'';

(3) in part N, by redesignating section 399F as section 399G; and

(4) in part O—

(A) by redesignating sections 399G through 399J as sections 399H through 399K, respectively;

(B) in section 399H (as so redesignated), in subsection (b), by striking ''section 399H'' and inserting ''section 399I'';

(C) in section 399J (as so redesignated), in subsection (b), by striking ''section 399G(d)'' and inserting ''section 399H(d)''; and

(D) in section 399K (as so redesignated), by striking ''section 399G(d)(1)'' and inserting ''section 399H(d)(1)''.

Subtitle B—Prevention Activities

SEC. 521. PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT; SYSTEMS FOR REDUCING ASTHMA-RELATED ILLNESSES THROUGH URBAN COCKROACH MANAGEMENT.

Section 1904(a)(1) of the Public Health Service Act (42 U.S.C. 300w–3(a)(1)) is amended—

(1) by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively;

(2) by adding a period at the end of subparagraph (G) (as so redesignated);

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

''(E) The establishment, operation, and coordination of effective and cost-efficient systems to reduce the prevalence of asthma and asthma-related illnesses among urban populations, especially children, by reducing the level of exposure to cockroach allergen through the use of integrated pest management, as applied to cockroaches. Amounts expended for such systems may include the costs of building maintenance and the costs of programs to promote community participation in the carrying out at such sites of integrated pest management, as applied to cockroaches. For purposes of this subparagraph, the term 'integrated pest management' means an approach to the management of pests in public facilities that combines biological, cultural, physical, and chemical tools in a way that minimizes economic, health, and environmental risks.'';

(4) in subparagraph (F) (as so redesignated), by striking ''subparagraphs (A) through (D)'' and inserting ''subparagraphs (A) through (E)''; and

(5) in subparagraph (G) (as so redesignated), by striking ''subparagraphs (A) through (E)'' and inserting ''subparagraphs (A) through (F)''.

Subtitle C—Coordination of Federal Activities

SEC. 531. COORDINATION THROUGH NATIONAL INSTITUTES OF HEALTH.

Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by inserting after section 424A the following section:

''COORDINATION OF FEDERAL ASTHMA ACTIVITIES

''SEC. 424B (a) IN GENERAL.—The Director of Institute shall, through the National Asthma Education Prevention Program Coordinating Committee—

''(1) identify all Federal programs that carry out asthma-related activities;

''(2) develop, in consultation with appropriate Federal agencies and professional and voluntary health organizations, a Federal plan for responding to asthma; and

''(3) not later than 12 months after the date of the enactment of the Children's Health Act of 2000, submit recommendations to the appropriate committees of the Congress on ways to strengthen and improve the coordination of asthma-related activities of the Federal Government.

''(b) REPRESENTATION OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT.—A representative of the Department of Housing and Urban Development shall be included on the National Asthma Education Prevention Program Coordinating Committee for the purpose of performing the tasks described in subsection (a).

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

Subtitle D—Compilation of Data

SEC. 541. COMPILATION OF DATA BY CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part B of title III of the Public Health Service Act, as amended by section 401 of this Act, is amended by inserting after section 317I the following section:

''COMPILATION OF DATA ON ASTHMA

''SEC. 317J. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the Director of the National Heart, Lung, and Blood Institute, shall—

''(1) conduct local asthma surveillance activities to collect data on the prevalence and severity of asthma and the quality of asthma management;

''(2) compile and annually publish data on the prevalence of children suffering from asthma in each State; and

''(3) to the extent practicable, compile and publish data on the childhood mortality rate associated with asthma nationally.

''(b) NATIONAL COORDINATING COMMITTEE.—The Director of the National Heart, Lung, and Blood Institute shall in carrying out subsection (a) consult with the National Asthma Education Prevention Program Coordinating Committee.

''(c) COLLABORATIVE EFFORTS.—The activities described in subsection (a)(1) may be conducted in collaboration with eligible entities awarded a grant under section 399L.''.

TITLE VI—BIRTH DEFECTS PREVENTION ACTIVITIES

Subtitle A—Folic Acid

SEC. 601. SHORT TITLE.

This subtitle may be cited as the ''Folic Acid Promotion and Birth Defects Prevention Act of 2000''.

SEC. 602. PROGRAM REGARDING EFFECTS OF FOLIC ACID IN PREVENTION OF BIRTH DEFECTS.

Part B of title III of the Public Health Service Act, as amended by section 541 of this Act, is amended by inserting after section 317J the following section:

''EFFECTS OF FOLIC ACID IN PREVENTION OF BIRTH DEFECTS

''SEC. 317K. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out a program (directly or through grants or contracts) for the following purposes:

''(1) To provide education and training for health professionals and the general public for purposes of explaining the effects of folic acid in preventing birth defects and for purposes of encouraging each woman of reproductive capacity (whether or not planning a pregnancy) to consume on a daily basis a dietary supplement that provides an appropriate level of folic acid.

''(2) To conduct research with respect to such education and training, including identifying effective strategies for increasing the rate of consumption of folic acid by women of reproductive capacity.

''(3) To conduct research to increase the understanding of the effects of folic acid in preventing birth defects, including understanding with respect to cleft lip, cleft palate, and heart defects.

''(4) To provide for appropriate epidemiological activities regarding folic acid and birth defects, including epidemiological activities regarding neural tube defects.

''(b) CONSULTATIONS WITH STATES AND PRIVATE ENTITIES.—In carrying out subsection (a), the Secretary shall consult with the States and with other appropriate public or private entities, including national nonprofit private organizations, health professionals, and providers of health insurance and health plans.

''(c) TECHNICAL ASSISTANCE.—The Secretary may (directly or through grants or contracts) provide technical assistance to public and nonprofit private entities in carrying out the activities described in subsection (a).

''(d) EVALUATIONS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of activities under subsection (a) in order to determine the extent to which such activities have been effective in carrying out the purposes of the program under such subsection, including the effects on various demographic populations. Methods of evaluation under the preceding sentence may include surveys of knowledge and attitudes on the consumption of folic acid and on blood folate levels. Such methods may include complete and timely monitoring of infants who are born with neural tube defects.

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

Subtitle B—National Center on Birth Defects and Developmental Disabilities

SEC. 611. NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.

Section 317C of the Public Health Service Act (42 U.S.C. 247b–4) is amended—

(1) by striking the heading for the section and inserting the following:

''NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES'';

(2) by striking ''SEC. 317C. (a)'' and all that follows through the end of subsection (a) and inserting the following:

''SEC. 317C. (a) IN GENERAL.—

''(1) NATIONAL CENTER.—There is established within the Centers for Disease Control and Prevention a center to be known as the National Center on Birth Defects and Developmental Disabilities (referred to in this section as the 'Center'), which shall be headed by a director appointed by the Director of the Centers for Disease Control and Prevention.

''(2) GENERAL DUTIES.—The Secretary shall carry out programs—

(A) to collect, analyze, and make available data on birth defects (in a manner that facilitates compliance with subsection (d)(2)), including data on the causes of such defects and on the incidence and prevalence of such defects;

(B) to operate regional centers for the conduct of applied epidemiological research on the prevention of such defects; and

(C) to provide information and education to the public on the prevention of such defects.

''(3) FOLIC ACID.—The Secretary shall carry out section 317K through the Center.

''(4) CERTAIN PROGRAMS.—

''(A) TRANSFERS.—All programs and functions described in subparagraph (B) are transferred to the Center, effective on the date of the enactment of the Children's Health Act of 2000.

''(B) RELEVANT PROGRAMS.—The programs and functions described in this subparagraph are all programs and functions that—

''(i) relate to birth defects, folic acid, cerebral palsy, mental retardation, child development, newborn screening, autism, fragile X syndrome, fetal alcohol syndrome, pediatric genetics, or disability prevention; and

''(ii) were carried out through the National Center for Environmental Health as of the day before the date of the enactment of the Act referred to in subparagraph (A).

''(C) RELATED TRANSFERS.—Personnel employed in connection with the programs and functions specified in subparagraph (B), and amounts available for carrying out the programs and functions, are transferred to the Center, effective on the date of the enactment of the Act referred to in subparagraph (A). Such transfer of amounts does not affect the period of availability of the amounts, or the availability of the amounts with respect to the purposes for which the amounts may be expended.''; and

(3) in subsection (b)(1), in the matter preceding subparagraph (A), by striking ''(a)(1)'' and inserting ''(a)(2)(A)''.

TITLE VII—EARLY DETECTION, DIAGNOSIS, AND TREATMENT REGARDING HEARING LOSS IN INFANTS

SEC. 701. SHORT TITLE.

This title may be cited as the ''Newborn and Infant Hearing Screening and Intervention Act of 2000''.

SEC. 702. PURPOSES.

The purposes of this title are to clarify the authority within the Public Health Service Act to authorize statewide newborn and infant hearing screening, evaluation and intervention programs and systems, technical assistance, a national applied research program, and interagency and private sector collaboration for policy development, in order to assist the States in making progress toward the following goals:

(1) All babies born in hospitals in the United States and its territories should have a hearing screening before leaving the birthing facility. Babies born in other countries and residing in the United States via immigration or adoption should have a hearing screening as early as possible.

(2) All babies who are not born in hospitals in the United States and its territories should have a hearing screening within the first 3 months of life.

(3) Appropriate audiologic and medical evaluations should be conducted by 3 months for all newborns and infants suspected of having hearing loss to allow appropriate referral and provisions for audiologic rehabilitation, medical and early intervention before the age of 6 months.

(4) All newborn and infant hearing screening programs and systems should include a component for audiologic rehabilitation, medical and early intervention options that ensures linkage to any new and existing state-wide systems of intervention and rehabilitative services for newborns and infants with hearing loss.

(5) Public policy in regard to newborn and infant hearing screening and intervention should be based on applied research and the recognition that newborns, infants, toddlers, and children who are deaf or hard-of-hearing have unique language, learning, and communication needs, and should be the result of consultation with pertinent public and private sectors.

SEC. 703. PROGRAMS OF HEALTH RESOURCES AND SERVICES ADMINISTRATION, CENTERS FOR DISEASE CONTROL AND PREVENTION, AND NATIONAL INSTITUTES OF HEALTH.

Part P of title III of the Public Health Service Act, as added by section 511 of this Act, is amended by adding at the end the following section:

''SEC. 399M. EARLY DETECTION, DIAGNOSIS, AND TREATMENT REGARDING HEARING LOSS IN INFANTS.

''(a) STATEWIDE NEWBORN AND INFANT HEARING SCREENING, EVALUATION AND INTERVENTION PROGRAMS AND SYSTEMS.—The Secretary, acting through the Administrator of

the Health Resources and Services Administration, shall make awards of grants or cooperative agreements to develop statewide newborn and infant hearing screening, evaluation and intervention programs and systems for the following purposes:

''(1) To develop and monitor the efficacy of state-wide newborn and infant hearing screening, evaluation and intervention programs and systems. Early intervention includes referral to schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated by part C of the Individuals with Disabilities Education Act, which offer programs specifically designed to meet the unique language and communication needs of deaf and hard of hearing newborns, infants, toddlers, and children.

''(2) To collect data on statewide newborn and infant hearing screening, evaluation and intervention programs and systems that can be used for applied research, program evaluation and policy development.

''(b) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH.—

''(1) CENTERS FOR DISEASE CONTROL AND PREVENTION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an intramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems. The program shall develop standardized procedures for data management and program effectiveness and costs, such as—

''(A) to ensure quality monitoring of newborn and infant hearing loss screening, evaluation, and intervention programs and systems;

''(B) to provide technical assistance on data collection and management;

''(C) to study the costs and effectiveness of newborn and infant hearing screening, evaluation and intervention programs and systems conducted by State-based programs in order to answer issues of importance to state and national policymakers;

''(D) to identify the causes and risk factors for congenital hearing loss;

''(E) to study the effectiveness of newborn and infant hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and language status of these children at school age; and

''(F) to promote the sharing of data regarding early hearing loss with State-based birth defects and developmental disabilities monitoring programs for the purpose of identifying previously unknown causes of hearing loss.

''(2) NATIONAL INSTITUTES OF HEALTH.—The Director of the National Institutes of Health, acting through the Director of the National Institute on Deafness and Other Communication Disorders, shall for purposes of this section, continue a program of research and development on the efficacy of new screening techniques and technology, including clinical studies of screening methods, studies on efficacy of intervention, and related research.

''(c) COORDINATION AND COLLABORATION.—

''(1) IN GENERAL.—In carrying out programs under this section, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall collaborate and consult with other Federal agencies; State and local agencies, including those responsible for early intervention services pursuant to title XIX of the Social Security Act (Medicaid Early and Periodic Screening, Diagnosis and Treatment Program); title XXI of the Social Security Act (State Children's Health Insurance Program); title V of the Social Security Act (Maternal and Child Health Block Grant Program); and part C of the Individuals with Disabilities Education Act; consumer groups of and that serve individuals who are deaf and hard-of-hearing and their families; appropriate national medical and other health and education specialty organizations; persons who are deaf and hard-of-hearing and their families; other qualified professional personnel who are proficient in deaf or hard-of-hearing children's language and who possess the specialized knowledge, skills, and attributes needed to serve deaf and hard-of-hearing newborns, infants, toddlers, children, and their families; third-party payers and managed care organizations; and related commercial industries.

''(2) POLICY DEVELOPMENT.—The Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall coordinate and collaborate on recommendations for policy development at the Federal and State levels and with the private sector, including consumer, medical and other health and education professional-based organizations, with respect to newborn and infant hearing screening, evaluation and intervention programs and systems.

''(3) STATE EARLY DETECTION, DIAGNOSIS, AND INTERVENTION PROGRAMS AND SYSTEMS; DATA COLLECTION.—The Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention shall coordinate and collaborate in assisting States to establish newborn and infant hearing screening, evaluation and intervention programs and systems under subsection (a) and to develop a data collection system under subsection (b).

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to preempt any State law.

''(e) DEFINITIONS.—For purposes of this section:

''(1) The term 'audiologic evaluation' refers to procedures to assess the status of the auditory system; to establish the site of the auditory disorder; the type and degree of hearing loss, and the potential effects of hearing loss on communication; and to identify appropriate treatment and referral options. Referral options should include linkage to State coordinating agencies under part C of the Individuals with Disabilities Education Act or other appropriate agencies, medical evaluation, hearing aid/sensory aid assessment, audiologic rehabilitation treatment, national and local consumer, self-help, parent, and education organizations, and other family-centered services.

''(2) The terms 'audiologic rehabilitation' and 'audiologic intervention' refer to procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.

''(3) The term 'early intervention' refers to providing appropriate services for the child with hearing loss, including nonmedical services, and ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, communication options and are given the opportunity to consider the full range of educational and program placements and options for their child.

''(4) The term 'medical evaluation by a physician' refers to key components including history, examination, and medical decision making focused on symptomatic and related body systems for the purpose of diagnosing the etiology of hearing loss and related physical conditions, and for identifying appropriate treatment and referral options.

''(5) The term 'medical intervention' refers to the process by which a physician provides medical diagnosis and direction for medical and/or surgical treatment options of hearing loss and/or related medical disorder associated with hearing loss.

''(6) The term 'newborn and infant hearing screening' refers to objective physiologic procedures to detect possible hearing loss and to identify newborns and infants who, after rescreening, require further audiologic and medical evaluations.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) STATEWIDE NEWBORN AND INFANT HEARING SCREENING, EVALUATION AND INTERVENTION PROGRAMS AND SYSTEMS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated to the Health Resources and Services Administration such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(2) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH; CENTERS FOR DISEASE CONTROL AND PREVENTION.—For the purpose of carrying out subsection (b)(1), there are authorized to be appropriated to the Centers for Disease Control and Prevention such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(3) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH; NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS.—For the purpose of carrying out subsection (b)(2), there are authorized to be appropriated to the National Institute on Deafness and Other Communication Disorders such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE VIII—CHILDREN AND EPILEPSY

SEC. 801. NATIONAL PUBLIC HEALTH CAMPAIGN ON EPILEPSY; SEIZURE DISORDER DEMONSTRATION PROJECTS IN MEDICALLY UNDERSERVED AREAS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following section:

''SEC. 330E. EPILEPSY; SEIZURE DISORDER.

''(a) NATIONAL PUBLIC HEALTH CAMPAIGN.—

''(1) IN GENERAL.—The Secretary shall develop and implement public health surveillance, education, research, and intervention strategies to improve the lives of persons with epilepsy, with a particular emphasis on children. Such projects may be carried out by the Secretary directly and through awards of grants or contracts to public or nonprofit private entities. The Secretary may directly or through such awards provide technical assistance with respect to the planning, development, and operation of such projects.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) shall include—

''(A) expanding current surveillance activities through existing monitoring systems and improving registries that maintain data on individuals with epilepsy, including children;

''(B) enhancing research activities on patient management and control of epilepsy;

''(C) implementing public and professional information and education programs regarding epilepsy, including initiatives which promote effective management and control of the disease through children's programs which are targeted to parents, schools, daycare providers, patients;

''(D) undertaking educational efforts with the media, providers of health care, schools and others regarding stigmas and secondary disabilities related to epilepsy and seizures, and also its affects on youth;

''(E) utilizing and expanding partnerships with organizations with experience addressing the health and related needs of people with disabilities; and

''(F) other activities the Secretary deems appropriate.

''(3) COORDINATION OF ACTIVITIES.—The Secretary shall ensure that activities under this subsection are coordinated as appropriate with other agencies of the Public Health Service that carry out activities regarding epilepsy and seizure.

''(b) SEIZURE DISORDER; DEMONSTRATION PROJECTS IN MEDICALLY UNDERSERVED AREAS.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States and local governments for the purpose of carrying out demonstration projects to improve access to health and other services regarding seizures to encourage early detection and treatment in children and others residing in medically underserved areas.

''(2) APPLICATION FOR GRANT.—The Secretary may make a grant under paragraph (1) only if the application for the grant is submitted to the Secretary and the application is in such form, is made in such matter, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subsection.

''(c) DEFINITIONS.—For purposes of this section:

''(1) The term ''epilepsy'' refers to a chronic and serious neurological condition which produces excessive electrical discharges in the brain causing recurring seizures affecting all life activities. The Secretary may revise the definition of such term as the Secretary.

''(2) The term ''medically underserved'' has the meaning applicable under section 799B(6).

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

TITLE IX—SAFE MOTHERHOOD; INFANT HEALTH PROMOTION

Subtitle A—Safe Motherhood Monitoring and Prevention Research

SEC. 901. SHORT TITLE.

This title may be cited as the ''Safe Motherhood Monitoring and Prevention Research Act''.

SEC. 902. MONITORING; PREVENTION RESEARCH AND OTHER ACTIVITIES.

Part B of title III of the Public Health Service Act, as amended by section 602 of this Act, is amended by inserting after section 317K the following section:

''SAFE MOTHERHOOD

''SEC. 317L. (a) MONITORING.—

''(1) PURPOSE.—The purpose of this subsection is to develop monitoring systems at the local, State, and national level to better understand the burden of maternal complications and mortality and to decrease the disparities among population at risk of death and complications from pregnancy.

''(2) ACTIVITIES.—For the purpose described in paragraph (1), the Secretary may carry out the following activities:

''(A) the Secretary may establish and implement a national monitoring and surveillance program to identify and promote the investigation of deaths and severe complications that occur during pregnancy.

''(B) The Secretary may expand the Pregnancy Risk Assessment Monitoring System to provide surveillance and collect data in each of the 50 States.

''(C) The Secretary may expand the Maternal and Child Health Epidemiology Program to provide technical support, financial assistance, or the time-limited assignment of senior epidemiologists to maternal and child health programs in each of the 50 States.

''(b) PREVENTION RESEARCH.—

''(1) PURPOSE.—The purpose of this subsection is to provide the Secretary with the authority to further expand research concerning risk factors, prevention strategies, and the roles of the family, health care providers and the community in safe motherhood.

''(2) RESEARCH.—The Secretary may carry out activities to expand research relating to—

''(A) encouraging preconception counseling, especially for at risk populations such as diabetics;

''(B) the identification of critical components of prenatal delivery and postpartum care;

''(C) the identification of outreach and support services, such as folic acid education, that are available for pregnant women;

''(D) the identification of women who are at high risk for complications;

''(E) preventing preterm delivery;

''(F) preventing urinary tract infections;

''(G) preventing unnecessary caesarean sections;

''(H) an examination of the higher rates of maternal mortality among African American women;

''(I) an examination of the relationship between domestic violence and maternal complications and mortality;

''(J) preventing smoking, alcohol and illegal drug usage before, during and after pregnancy;

''(K) preventing infections that cause maternal and infant complications; and

''(L) other areas determined appropriate by the Secretary.

''(c) PREVENTION PROGRAMS.—

''(1) IN GENERAL.—The Secretary may carry out activities to promote safe motherhood, including—

''(A) public education campaigns on healthy pregnancies and the building of partnerships with outside organizations concerned about safe motherhood;

''(B) education programs for physicians, nurses and other health care providers; and

''(C) activities to promote community support services for pregnant women.

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

Subtitle B—Pregnant Mothers and Infants Health Promotion

SEC. 911. SHORT TITLE.

This subtitle may be cited as the ''Pregnant Mothers and Infants Health Protection Act''.

SEC. 912. PROGRAMS REGARDING PRENATAL AND POSTNATAL HEALTH.

Part B of title III of the Public Health Service Act, as amended by section 902 of this Act, is amended by inserting after section 317L the following section:

''PRENATAL AND POSTNATAL HEALTH

''SEC. 317M. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out programs—

''(1) to collect, analyze, and make available data on prenatal smoking, alcohol and illegal drug usage, including data on the implications of such activities and on the incidence and prevalence of such activities and their implications;

''(2) to conduct applied epidemiological research on the prevention of prenatal and postnatal smoking, alcohol and illegal drug usage;

''(3) to support, conduct, and evaluate the effectiveness of educational and cessation programs; and

''(4) to provide information and education to the public on the prevention and implications of prenatal and postnatal smoking, alcohol and illegal drug usage.

''(b) GRANTS.—In carrying out subsection (a), the Secretary may award grants to and enter into contracts with States, local governments, scientific and academic institutions, Federally qualified health centers, and other public and nonprofit entities, and may provide technical and consultative assistance to such entities.

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

TITLE X—REVISION AND EXTENSION OF PROGRAMS

Subtitle A—Pediatric Research Initiative

SEC. 1001. SHORT TITLE.

This subtitle may be cited as the ''Pediatric Research Initiative Act of 2000''.

SEC. 1002. ESTABLISHMENT OF PEDIATRIC RESEARCH INITIATIVE.

Part B of title IV of the Public Health Service Act, as amended by section 112 of this Act, is amended by adding at the end the following:

''PEDIATRIC RESEARCH INITIATIVE

''SEC. 409D. (a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Director of NIH a Pediatric Research Initiative (referred to in this section as the 'Initiative'). The Initiative shall be headed by the Director of NIH.

''(b) PURPOSE.—The purpose of the Initiative is to provide funds to enable the Director of NIH to provide—

''(1) increased support for pediatric biomedical research within the National Institutes of Health to ensure that the expanding opportunities for advancement in scientific investigations and care for children are realized;

''(2) enhanced collaborative efforts among the Institutes to support multidisciplinary research in the areas that the Director deems most promising; and

''(3) the development of adequate pediatric clinical trials and pediatric use information to promote the safer and more effective use of prescription drugs in the pediatric population.

''(c) DUTIES.—In carrying out subsection (b), the Director of NIH shall—

''(1) consult with the Director of the National Institute of Child Health and Human Development and the Directors of the other national research institutes, in considering their requests for new or expanded pediatric research efforts, and consult with the Administrator of the Health Resources and Services Administration and other advisors as the Director determines to be appropriate;

''(2) have broad discretion in the allocation of any Initiative assistance among the Institutes, among types of grants, and between basic and clinical research so long as the—

''(A) assistance is directly related to the illnesses and conditions of children; and

''(B) assistance is extramural in nature; and

''(3) be responsible for the oversight of any newly appropriated Initiative funds and annually report to Congress and the public on the extent of the total extramural support for pediatric research across the NIH, including the specific support and research awards allocated through the Initiative.

''(d) AUTHORIZATION.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be

necessary for each of the fiscal years 2001 through 2005.

''(e) TRANSFER OF FUNDS.—The Director of NIH may transfer amounts appropriated under this section to any of the Institutes for a fiscal year to carry out the purposes of the Initiative under this section.''.

SEC. 1003. INVESTMENT IN TOMORROW'S PEDIATRIC RESEARCHERS.

Subpart 7 of part C of title IV of the Public Health Service Act, as amended by section 921 of this Act, is amended by adding at the end the following:

''INVESTMENT IN TOMORROW'S PEDIATRIC RESEARCHERS

''SEC. 452G. (a) IN GENERAL.—In order to ensure the future supply of researchers dedicated to the care and research needs of children, the Director of the Institute, after consultation with the Administrator of the Health Resources and Services Administration, shall support activities to provide for—

''(1) an increase in the number and size of institutional training grants to pediatric departments of medical schools and to children's hospitals; and

''(2) an increase in the number of career development awards for health professionals who are in pediatric specialties or subspecialties and intend to build careers in pediatric basic and clinical research.

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

Subtitle B—Other Programs

SEC. 1011. CHILDHOOD IMMUNIZATIONS.

Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended in the first sentence by striking ''1998'' and all that follows and inserting ''1998 through 2003.''.

SEC. 1012. SCREENINGS, REFERRALS, AND EDUCATION REGARDING LEAD POISONING.

Section 317A(l)(1) of the Public Health Service Act (42 U.S.C. 247b–1(l)(1)) is amended by striking ''1994'' and all that follows and inserting ''1994 through 2003.''.

TITLE XI—CHILDHOOD SKELETAL MALIGNANCIES

SEC. 1101. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION AND NATIONAL INSTITUTES OF HEALTH.

Part P of title III of the Public Health Service Act, as amended by section 703 of this Act, is amended by adding at the end the following section:

''SEC. 399N. CHILDHOOD SKELETAL MALIGNANCIES.

''(a) IN GENERAL.—The Secretary, acting as appropriate through the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall study environmental and other risk factors for childhood skeletal cancers, and carry out projects to improve outcomes among children with childhood skeletal cancers and resultant secondary conditions, including limb loss. Such projects shall be carried out by the Secretary directly and through awards of grants or contracts to public or nonprofit entities.

''(b) CERTAIN ACTIVITIES.—Activities under subsection (a) include—

''(1) the expansion of current demographic data collection and population surveillance efforts to include childhood skeletal cancers nationally;

''(2) the development of a uniform reporting system under which treating physicians, hospitals, clinics, and states report the diagnosis of childhood skeletal cancers, including relevant associated epidemiological data; and

''(3) support for the National Limb Loss Information Center to address, in part, the primary and secondary needs of persons who experience childhood skeletal cancers in order to prevent or minimize the disabling nature of these cancers.

''(c) COORDINATION OF ACTIVITIES.—The Secretary shall assure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities focused on childhood cancers and limb loss.

''(d) DEFINITION.—For purposes of this section, the term 'childhood skeletal cancer' refers to any malignancy originating in the connective tissue of a person before skeletal maturity including the appendicular and axial skeleton. The Secretary may for purposes of this section revise the definition of such term to the extent determined by the Secretary to be appropriate.

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

TITLE XII—ADOPTION AWARENESS

Subtitle A—Infant Adoption Awareness

SEC. 1201. SHORT TITLE.

This subtitle may be cited as the ''Infant Adoption Awareness Act of 2000''.

SEC. 1202. GRANTS REGARDING INFANT ADOPTION AWARENESS.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 801 of this Act, is amended by adding at the end the following section:

''SEC. 330F. CERTAIN SERVICES FOR PREGNANT WOMEN.

''(a) INFANT ADOPTION AWARENESS.—

''(1) IN GENERAL.—The Secretary shall make grants to national, regional, or local adoption organizations for the purpose of developing and implementing programs to train the designated staff of eligible health centers in providing adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling.

''(2) BEST-PRACTICES GUIDELINES.—

''(A) IN GENERAL.—A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree that, in providing training under such paragraph, the organization will follow the guidelines developed under subparagraph (B).

''(B) PROCESS FOR DEVELOPMENT OF GUIDELINES.—

''(i) IN GENERAL.—The Secretary shall establish and supervise a process described in clause (ii) in which the participants are—

''(I) an appropriate number and variety of adoption organizations that, as a group, have expertise in all models of adoption practice and that represent all members of the adoption triad (birth mother, infant, and adoptive parent); and

''(II) affected public health entities.

''(ii) DESCRIPTION OF PROCESS.—The process referred to in clause (i) is a process in which the participants described in such clause collaborate to develop best-practices guidelines on the provision of adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling.

''(iii) DATE CERTAIN FOR DEVELOPMENT.—The Secretary shall ensure that the guidelines described in clause (ii) are developed not later than 180 days after the date of the enactment of the Children's Health Act of 2000.

''(C) RELATION TO AUTHORITY FOR GRANTS.—The Secretary may not make any grant under paragraph (1) before the date on which the guidelines under subparagraph (B) are developed.

''(3) USE OF GRANT.—

''(A) IN GENERAL.—With respect to a grant under paragraph (1)—

''(i) an adoption organization may expend the grant to carry out the programs directly or through grants to or contracts with other adoption organizations;

''(ii) the purposes for which the adoption organization expends the grant may include the development of a training curriculum, consistent with the guidelines developed under paragraph (2)(B); and

''(iii) a condition for the receipt of the grant is that the adoption organization agree that, in providing training for the designated staff of eligible health centers, such organization will make reasonable efforts to ensure that the individuals who provide the training are individuals who are knowledgeable on the process for adopting a child and are experienced in providing adoption information and referrals in the geographic areas in which the eligible health centers are located, and that the designated staff receive the training in such areas.

''(B) RULE OF CONSTRUCTION REGARDING TRAINING OF TRAINERS.—With respect to individuals who under a grant under paragraph (1) provide training for the designated staff of eligible health centers (referred to in this subparagraph as 'trainers'), subparagraph (A)(iii) may not be construed as establishing any limitation regarding the geographic area in which the trainers receive instruction in being such trainers. A trainer may receive such instruction in a different geographic area than the area in which the trainer trains (or will train) the designated staff of eligible health centers.

''(4) ADOPTION ORGANIZATIONS; ELIGIBLE HEALTH CENTERS; OTHER DEFINITIONS.—For purposes of this section:

''(A) The term 'adoption organization' means a national, regional, or local organization—

''(i) among whose primary purposes are adoption;

''(ii) that is knowledgeable on the process for adopting a child and on providing adoption information and referrals to pregnant women; and

''(iii) that is a nonprofit private entity.

''(B) The term 'designated staff', with respect to an eligible health center, means staff of the center who provide pregnancy or adoption information and referrals (or will provide such information and referrals after receiving training under a grant under paragraph (1)).

''(C) The term 'eligible health centers' means public and nonprofit private entities that provide health-related services to pregnant women.

''(5) TRAINING FOR CERTAIN ELIGIBLE HEALTH CENTERS.—A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree to make reasonable efforts to ensure that the eligible health centers with respect to which training under the grant is provided include—

''(A) eligible health centers that receive grants under section 1001 (relating to voluntary family planning projects);

''(B) eligible health centers that receive grants under section 330 (relating to community health centers, migrant health centers, and centers regarding homeless individuals and residents of public housing); and

''(C) eligible health centers that receive grants under this Act for the provision of services in schools.

''(6) PARTICIPATION OF CERTAIN ELIGIBLE HEALTH CLINICS.—In the case of eligible health centers that receive grants under section 330 or 1001:

''(A) Within a reasonable period after the Secretary begins making grants under paragraph (1), the Secretary shall provide eligible

health centers with complete information about the training available from organizations receiving grants under such paragraph. The Secretary shall make reasonable efforts to encourage eligible health centers to arrange for designated staff to participate in such training.

''(B) All costs of such centers in obtaining the training shall be reimbursed by the organization that provides the training, using grants under paragraph (1).

''(C) Not later than one year after the date of the enactment the Children's Health Act of 2000, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers. Within a reasonable time after training under this section is initiated, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers in order to determine the effectiveness of such training. In preparing the reports required by this subparagraph, the Secretary shall in no respect interpret the provisions of this section to allow any interference in the provider-patient relationship, any breach of patient confidentiality, or any monitoring or auditing of the counseling process or patient records which breaches patient confidentiality or reveals patient identity.

''(b) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

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

Subtitle B—Special Needs Adoption Awareness

SEC. 1211. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 1202 of this Act, is amended by adding at the end the following section:

''SEC. 330G. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

''(a) SPECIAL NEEDS ADOPTION AWARENESS CAMPAIGN.—

''(1) IN GENERAL.—The Secretary shall, through making grants to nonprofit private entities, provide for the planning, development, and carrying out of a national campaign to provide information to the public regarding the adoption of children with special needs.

''(2) INPUT ON PLANNING AND DEVELOPMENT.—In providing for the planning and development of the national campaign under paragraph (1), the Secretary shall provide for input from a number and variety of adoption organizations throughout the States in order that the full national diversity of interests among adoption organizations is represented in the planning and development of the campaign.

''(3) CERTAIN FEATURES.—With respect to the national campaign under paragraph (1):

''(A) The campaign shall be directed at various populations, taking into account as appropriate differences among geographic regions, and shall be carried out in the language and cultural context that is most appropriate to the population involved.

''(B) The means through which the campaign may be carried out include—

''(i) placing public service announcements on television, radio, and billboards; and

''(ii) providing information through means that the Secretary determines will reach individuals who are most likely to adopt children with special needs.

''(C) The campaign shall provide information on the subsidies and supports that are available to individuals regarding the adoption of children with special needs.

''(D) The Secretary may provide that the placement of public service announcements, and the dissemination of brochures and other materials, is subject to review by the Secretary.

''(4) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—With respect to the costs of the activities to be carried out by an entity pursuant to paragraph (1), a condition for the receipt of a grant under such paragraph is that the entity agree to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

''(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(b) NATIONAL RESOURCES PROGRAM.—The Secretary shall (directly or through grant or contract) carry out a program that, through toll-free telecommunications, makes available to the public information regarding the adoption of children with special needs. Such information shall include the following:

''(1) A list of national, State, and regional organizations that provide services regarding such adoptions, including exchanges and other information on communicating with the organizations. The list shall represent the full national diversity of adoption organizations.

''(2) Information beneficial to individuals who adopt such children, including lists of support groups for adoptive parents and other postadoptive services.

''(c) OTHER PROGRAMS.—With respect to the adoption of children with special needs, the Secretary shall make grants—

''(1) to provide assistance to support groups for adoptive parents, adopted children, and siblings of adopted children; and

''(2) to carry out studies to identify the reasons for adoption disruptions.

''(d) APPLICATION FOR GRANT.—The Secretary may make an award of a grant or contract under this section only if an application for the award is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(e) FUNDING.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XIII—TRAUMATIC BRAIN INJURY

SEC. 1301. SHORT TITLE.

This title may be cited as the ''Traumatic Brain Injury Act Amendments of 2000''.

SEC. 1302. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) IN GENERAL.—Section 393A of the Public Health Service Act (42 U.S.C. 280b–1b) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking ''and'' at the end;

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

(C) by adding at the end the following:

''(3) the implementation of a national education and awareness campaign regarding such injury (in conjunction with the program of the Secretary regarding health-status goals for 2010, commonly referred to as Healthy People 2010), including the national dissemination of information on—

''(A) incidence and prevalence;

''(B) secondary conditions arising from traumatic brain injury upon discharge from hospitals and trauma centers.'';

(2) in subsection (d)—

(A) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia.''; and

(B) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''.

(b) NATIONAL REGISTRY.—Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended by inserting after section 393A the following section:

''NATIONAL PROGRAM FOR TRAUMATIC BRAIN INJURY REGISTRIES

''SEC. 393B. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States or their designees to operate the State's traumatic brain injury registry, and to academic institutions to conduct applied research that will support the development of such registries, to collect data concerning—

''(1) demographic information about each traumatic brain injury;

''(2) information about the circumstances surrounding the injury event associated with each traumatic brain injury;

''(3) administrative information about the source of the collected information, dates of hospitalization and treatment, and the date of injury; and

''(4) information characterizing the clinical aspects of the traumatic brain injury, including the severity of the injury, the types of treatments received, and the types of services utilized.''.

SEC. 1303. PROGRAMS OF NATIONAL INSTITUTES OF HEALTH.

(a) INTERAGENCY PROGRAM.—Section 1261(d)(4) of the Public Health Service Act (42 U.S.C. 300d–61(d)(4)) is amended—

(1) in subparagraph (A), by striking ''degree of injury'' and inserting ''degree of brain injury'';

(2) in subparagraph (B), by striking ''acute injury'' and inserting ''acute brain injury''; and

(3) in subparagraph (D), by striking ''injury treatment'' and inserting ''brain injury treatment''.

(b) DEFINITION.—Section 1261(h)(4) of the Public Health Service Act (42 U.S.C. 300d–61(h)(4)) is amended—

(1) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia.''; and

(2) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''.

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1261 of the Public Health Service Act (42 U.S.C. 300d–61) is amended by adding at the end the following:

''(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2004.''.

SEC. 1304. PROGRAMS OF HEALTH RESOURCES AND SERVICES ADMINISTRATION.

Section 1252 of the Public Health Service Act (42 U.S.C. 300d–51) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (A)(iv), by striking ''representing traumatic brain injury survivors'' and inserting ''representing individuals with traumatic brain injury''; and

(B) in subparagraph (B), by striking ''who are survivors of'' and inserting ''with'';

(2) in subsection (c)—

(A) in paragraph (1), by striking '', in cash,''; and

(B) in paragraph (2), by amending the paragraph to read as follows:

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.'';

(3) by designating subsections (e) through (h) as subsections (g) through (j), respectively; and

(4) by inserting after subsection (d) the following subsections:

''(e) CONTINUATION OF PREVIOUSLY AWARDED DEMONSTRATION PROJECTS.—A State that received a grant under this section prior to the date of enactment of the Children's Health Act of 2000 may compete for new project grants under this section after such date of enactment.

''(f) USE OF STATE GRANTS.—

''(1) COMMUNITY SERVICES AND SUPPORTS.—A State shall (directly or through awards of contracts to nonprofit private entities) use amounts received under a grant under this section for the following:

''(A) To develop, change, or enhance community-based service delivery systems that include timely access to comprehensive appropriate services and supports. Such service and supports—

''(i) shall promote full participation by individuals with brain injury and their families in decision making regarding the services and supports; and

''(ii) shall be designed for children and other individuals with traumatic brain injury.

''(B) To focus on outreach to underserved and inappropriately served individuals, such as individuals in institutional settings, individuals with low socioeconomic resources, individuals in rural communities, and individuals in culturally and linguistically diverse communities.

''(C) To award contracts to nonprofit entities for consumer or family service access training, consumer support, peer mentoring, and parent to parent programs.

''(D) To provide individual and family service coordination or case management systems.

''(E) To support other needs identified by the advisory board under subsection (b) for the State involved.

''(2) BEST PRACTICES.—

''(A) IN GENERAL.—State services and supports provided under a grant under this section shall reflect the best practices in the field of traumatic brain injury, shall be in compliance with title II of the Americans with Disabilities Act of 1990, and shall be supported by quality assurance measures as well as state-of-the-art health care and integrated community supports, regardless of the severity of injury.

''(B) DEMONSTRATION BY STATE AGENCY.—The State agency responsible for administering amounts received under a grant under this section shall demonstrate or express a willingness to obtain expertise and knowledge of traumatic brain injury and the unique needs associated with traumatic brain injury.

''(3) STATE CAPACITY BUILDING.—A State may use amounts received under a grant under this section to—

''(A) educate consumers and families;

''(B) train professionals in public and private sector financing (such as third party payers, State agencies, community-based providers, schools, and educators);

''(C) develop or improve case management or service coordination systems;

''(D) develop best practices in areas such as family or consumer support, return to work, housing or supportive living personal assistance services, assistive technology and devices, behavioral health services, substance abuse services, and traumatic brain injury treatment and rehabilitation;

''(E) tailor existing State systems to provide accommodations to the needs of individuals with brain injury (including systems administered by the State departments responsible for health, mental health, labor, education, mental retardation/developmental disorders, transportation, and correctional systems);

''(F) improve data sets coordinated across systems and other needs identified by a State plan supported by its advisory council; and

''(G) develop capacity within targeted communities.'';

(5) in subsection (g) (as so redesignated), by striking ''agencies of the Public Health Service'' and inserting ''Federal agencies'';

(6) in subsection (i) (as redesignated by paragraph (3))—

(A) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia.''; and

(B) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''; and

(7) in subsection (j) (as so redesignated), by amending the subsection to read as follows:

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

TITLE XIV—PREVENTION AND CONTROL OF INJURIES

SEC. 1401. AUTHORIZATION OF APPROPRIATIONS FOR PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 394A of the Public Health Service Act (42 U.S.C. 280b–3) is amended by striking ''and'' after ''1994'' and by inserting before the period the following: '', and such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XV—HEALTHY START INITIATIVE

SEC. 1501. SHORT TITLE.

This title may be cited as the ''Healthy Start Initiative Continuation Act''.

SEC. 1502. CONTINUATION OF HEALTHY START PROGRAM.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 1203 of this Act, is amended by adding at the end the following section:

''SEC. 330H. HEALTHY START FOR INFANTS.

''(a) IN GENERAL.—

''(1) CONTINUATION AND EXPANSION OF PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, Maternal and Child Health Bureau, shall under authority of this section continue in effect the Healthy Start Initiative and may, during fiscal year 2001 and subsequent years, carry out such program on a national basis.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'Healthy Start Initiative' is a reference to the program that, as an initiative to reduce the rate of infant mortality and improve perinatal outcomes, makes grants for project areas with high annual rates of infant mortality and that, prior to the effective date of this section, was a demonstration program carried out under section 301.

''(3) ADDITIONAL GRANTS.— Effective upon increased funding beyond fiscal year 1999 for such Initiative, additional grants may be made to States to assist communities with technical assistance, replication of successful projects, and State policy formation to reduce infant and maternal mortality and morbidity.

''(b) REQUIREMENTS FOR MAKING GRANTS.—In making grants under subsection (a), the Secretary shall require that applicants (in addition to meeting all eligibility criteria established by the Secretary) establish, for project areas under such subsection, community-based consortia of individuals and organizations (including agencies responsible for administering block grant programs under title V of the Social Security Act, consumers of project services, public health departments, hospitals, health centers under section 330, and other significant sources of health care services) that are appropriate for participation in projects under subsection (a).

''(c) COORDINATION.—Recipients of grants under subsection (a) shall coordinate their services and activities with the State agency or agencies that administer block grant programs under title V of the Social Security Act in order to promote cooperation, integrity, and dissemination of information with Statewide systems and with other community services funded under the Maternal and Child Health Block Grant.

''(d) RULE OF CONSTRUCTION.—Except to the extent inconsistent with this section, this section may not be construed as affecting the authority of the Secretary to make modifications in the program carried out under subsection (a).

''(e) MEDICALLY APPROPRIATE ULTRASOUND SERVICES; MEDICALLY APPROPRIATE SERVICES FOR AT-RISK MOTHERS AND INFANTS.—

''(1) IN GENERAL.—The Secretary may make grants to health care entities to provide—

''(A) for pregnant women, ultrasound services provided by qualified health care professionals upon medical indication and referral from health care professionals who provide comprehensive prenatal services; and

''(B) for pregnant women or infants, other health services (including prenatal care, genetic counseling, and fetal and other surgery) that—

''(i) are determined by a qualified treating health care professional to be medically appropriate in order to prevent or mitigate congenital defects (including but not limited to spina bifida and hydrocephaly) or other serious obstetric complications (including but not limited to placenta previa, premature rupture of membranes, or preeclampsia); and

''(ii) are provided during pregnancy or during the first year after birth.

''(2) ELIGIBLE PROJECT AREA.—The Secretary may make a grant under paragraph (1) only if the geographic area in which services under the grant will be provided is a geographic area in which a project under subsection (a) is being carried out, and if the Secretary determines that the grant will add to or expand the level of health services available in such area to pregnant women and infants.

''(3) TRANSPORTATION AND SUBSISTENCE EXPENSES FOR CERTAIN PATIENTS.—The purposes for which a grant under paragraph (1)(B) may be expended include paying, on behalf of a pregnant woman who is in need of the health services described in such paragraph, transportation and subsistence expenses to assist

the pregnant woman in obtaining such health services from the grantee involved. The Secretary may establish such restrictions regarding payments under the preceding sentence as the Secretary determines to be appropriate.

''(4) CERTAIN CONDITIONS.—A condition for the receipt of a grant under paragraph (1) is that the applicant for the grant agree as follows:

''(A) In the case of a grant under paragraph (1)(A), if ultrasound services indicate that there is a fetal anomaly or other serious obstetric complication, the applicant will refer the pregnant woman involved for appropriate medical services, including, as appropriate, for health services described in paragraph (1)(B) provided by grantees under such paragraph.

''(B) If the applicant provides nondirective pregnancy counseling to patients and is not subject to the condition under section 330F(b), such counseling provided by the applicant to patients will include (but is not limited to) the provision of adoption information and referrals.

''(5) RELATIONSHIP TO PAYMENTS UNDER OTHER PROGRAMS.—A grant may be made under paragraph (1) only if the applicant involved agrees that the grant will not be expended to pay the expenses of providing any service under such paragraph to a pregnant woman to the extent that payment has been made, or can reasonably be expected to be made, with respect to such expenses—

''(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

''(B) by an entity that provides health services on a prepaid basis.

''(6) EVALUATION BY GENERAL ACCOUNTING OFFICE.—

''(A) IN GENERAL.—During fiscal year 2004, the Comptroller General of the United States shall conduct an evaluation of activities under grants under paragraph (1) in order to determine whether the activities have been effective in serving the needs of pregnant women with respect to ultrasound services and the other health services described in paragraph (1)(B). The evaluation shall include an analysis of whether such activities have been effective in reducing the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups. Not later than January 10, 2005, the Comptroller General shall submit to the Committee on Commerce in the House of Representatives, and to the Committee on Health, Education, Labor, and Pensions in the Senate, a report describing the findings of the evaluation.

''(B) RELATION TO GRANTS REGARDING MEDICALLY APPROPRIATE SERVICES FOR AT-RISK MOTHERS AND INFANTS.—Before the date on which the evaluation under subparagraph (A) is submitted in accordance with such subparagraph—

''(i) the Secretary shall ensure that there are not more than three grantees under paragraph (1)(B); and

''(ii) an entity is not eligible to receive grants under such paragraph unless the entity has substantial experience in providing the health services described in such paragraph.

''(e) FUNDING.—

''(1) GENERAL PROGRAM.—

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

''(B) ALLOCATIONS.—

''(i) PROGRAM ADMINISTRATION.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary may reserve up to 5 percent for coordination, dissemination, technical assistance, and data activities that are determined by the Secretary to be appropriate for carrying out the program under this section.

''(ii) EVALUATION.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary may reserve up to 1 percent for evaluations of projects carried out under subsection (a). Each such evaluation shall include a determination of whether such projects have been effective in reducing the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups.

''(2) MEDICALLY APPROPRIATE ULTRASOUND SERVICES; MEDICALLY APPROPRIATE SERVICES FOR AT-RISK MOTHERS AND INFANTS.—

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

''(B) ALLOCATION.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary shall make available not less than 10 percent for providing ultrasound services under subsection (d)(1)(A) (provided by qualified health care professionals upon medical indication and referral from health care professionals who provide comprehensive prenatal services) through visits by mobile units to communities that are eligible for services under subsection (a).''.

TITLE XVI—ORAL HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 1601. ORAL HEALTH PROMOTION AND DISEASE PREVENTION.

Part B of title III of the Public Health Service Act, as amended by section 912 of this Act, is amended by inserting after section 317M the following section:

''ORAL HEALTH PROMOTION AND DISEASE PREVENTION

''SEC. 317N. (a) GRANTS TO INCREASE RESOURCES FOR COMMUNITY WATER FLUORIDATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States and Indian tribes for the purpose of increasing the resources available for community water fluoridation.

''(2) USE OF FUNDS.—A State shall use amounts provided under a grant under paragraph (1)—

''(A) to purchase fluoridation equipment;

''(B) to train fluoridation engineers;

''(C) to develop educational materials on the benefits of fluoridation; or

''(D) to support the infrastructure necessary to monitor and maintain the quality of water fluoridation.

''(b) COMMUNITY WATER FLUORIDATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with the Director of the Indian Health Service, shall establish a demonstration project that is designed to assist rural water systems in successfully implementing the water fluoridation guidelines of the Centers for Disease Control and Prevention that are entitled ''Engineering and Administrative Recommendations for Water Fluoridation, 1995'' (referred to in this subsection as the 'EARWF').

''(2) REQUIREMENTS.—

''(A) COLLABORATION.—In collaborating under paragraph (1), the Directors referred to in such paragraph shall ensure that technical assistance and training are provided to tribal programs located in each of the 12 areas of the Indian Health Service. The Director of the Indian Health Service shall provide coordination and administrative support to tribes under this section.

''(B) GENERAL USE OF FUNDS.—Amounts made available under paragraph (1) shall be used to assist small water systems in improving the effectiveness of water fluoridation and to meet the recommendations of the EARWF.

''(C) FLUORIDATION SPECIALISTS.—

''(i) IN GENERAL.—In carrying out this subsection, the Secretary shall provide for the establishment of fluoridation specialist engineering positions in each of the Dental Clinical and Preventive Support Centers through which technical assistance and training will be provided to tribal water operators, tribal utility operators and other Indian Health Service personnel working directly with fluoridation projects.

''(ii) LIAISON.—A fluoridation specialist shall serve as the principal technical liaison between the Indian Health Service and the Centers for Disease Control and Prevention with respect to engineering and fluoridation issues.

''(iii) CDC.—The Director of the Centers for Disease Control and Prevention shall appoint individuals to serve as the fluoridation specialists.

''(D) IMPLEMENTATION.—The project established under this subsection shall be planned, implemented and evaluated over the 5-year period beginning on the date on which funds are appropriated under this section and shall be designed to serve as a model for improving the effectiveness of water fluoridation systems of small rural communities.

''(3) EVALUATION.—In conducting the ongoing evaluation as provided for in paragraph (2)(D), the Secretary shall ensure that such evaluation includes—

''(A) the measurement of changes in water fluoridation compliance levels resulting from assistance provided under this section;

''(B) the identification of the administrative, technical and operational challenges that are unique to the fluoridation of small water systems;

''(C) the development of a practical model that may be easily utilized by other tribal, state, county or local governments in improving the quality of water fluoridation with emphasis on small water systems; and

''(D) the measurement of any increased percentage of Native Americans or Alaskan Natives who receive the benefits of optimally fluoridated water.

''(c) SCHOOL-BASED DENTAL SEALANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with the Administrator of the Health Resources and Services Administration, may award grants to States and Indian tribes to provide for the development of school-based dental sealant programs to improve the access of children to sealants.

''(2) USE OF FUNDS.—A State shall use amounts received under a grant under paragraph (1) to provide funds to eligible school-based entities or to public elementary or secondary schools to enable such entities or schools to provide children in second and sixth grades with access to dental care and dental sealant services. Such services shall be provided by licensed dental health professionals in accordance with State practice licensing laws.

''(3) ELIGIBILITY.—To be eligible to receive funds under paragraph (1), an entity shall—

''(A) prepare and submit to the State an application at such time, in such manner and containing such information as the state may require; and

''(B) be a public elementary or secondary school—

''(i) that is located in an urban area in which and more than 50 percent of the student population is participating in federal or state free or reduced meal programs; or

''(ii) that is located in a rural area and, with respect to the school district in which the school is located, the district involved has a median income that is at or below 235 percent of the poverty line, as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

''(d) DEFINITIONS.—For purposes of this section, the term 'Indian tribe' means an Indian tribe or tribal organization as defined in section 4(b) and section 4(c) of the Indian Self-Determination and Education Assistance Act.

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

TITLE XVII—VACCINE COMPENSATION PROGRAM

SEC. 1701. SHORT TITLE.

This title may be cited as the ''Vaccine Injury Compensation Program Amendments of 2000.''.

SEC. 1702. CONTENT OF PETITIONS.

(a) IN GENERAL.—Section 2111(c)(1)(D) of the Public Health Service Act (42 U.S.C. 300aa–11(c)(1)(D)) is amended by striking ''and'' at the end and inserting ''or (iii) suffered such illness, disability, injury, or condition from the vaccine which resulted in inpatient hospitalization and surgical intervention, and''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect upon the date of the enactment of this Act, including with respect to petitions under section 2111 of the Public Health Service Act that are pending on such date.

TITLE XVIII—HEPATITIS C

SEC. 1801. SHORT TITLE.

This title may be cited as the ''Hepatitis C and Children Act of 2000''.

SEC. 1802. SURVEILLANCE AND EDUCATION REGARDING HEPATITIS C.

Part B of title III of the Public Health Service Act, as amended by section 1601 of this Act, is amended by inserting after section 317N the following section:

''SURVEILLANCE AND EDUCATION REGARDING HEPATITIS C VIRUS

''SEC. 317*O*. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may (directly and through grants to public and nonprofit private entities) provide for programs to carry out the following:

''(1) To cooperate with the States in implementing a national system to determine the incidence and prevalence of cases of infection with hepatitis C virus, including the reporting of chronic hepatitis C cases.

''(2) To identify and contact individuals who became infected with such virus as a result of receiving blood transfusions prior to July 1992 when the individuals were infants, small children, or adolescents.

''(3) To provide appropriate referrals for counseling, testing, and medical treatment of individuals identified under paragraph (2) and to ensure, to the extent practicable, the provision of appropriate follow-up services.

''(4) To develop and disseminate public information and education programs for the detection and control of hepatitis C, with priority given to recipients of blood transfusions; women who gave birth by caesarean section; children who were high-risk neonates; veterans of the Armed Forces; and health professionals.

''(5) To improve the education, training, and skills of health professionals in the detection and control of cases of infection with hepatitis C, with priority given to pediatricians and other primary care physicians.

''(b) LABORATORY PROCEDURES.—The Secretary may (directly and through grants to public and nonprofit private entities) carry out programs to provide for improvements in the quality of clinical-laboratory procedures regarding hepatitis C, including reducing variability in laboratory results on hepatitis C antibody and PCR testing.

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

TITLE XIX—NIH INITIATIVE ON AUTOIMMUNE DISEASES

SEC. 1901. SHORT TITLE.

This title may be cited as the ''NIH Autoimmune Diseases Initiative Act of 2000''.

SEC. 1902. JUVENILE DIABETES, JUVENILE ARTHRITIS, LUPUS, MULTIPLE SCLEROSIS, AND OTHER AUTOIMMUNE-DISEASES; INITIATIVE THROUGH DIRECTOR OF NATIONAL INSTITUTES OF HEALTH.

Part B of title IV of the Public Health Service Act, as amended by section 1002 of this Act, is amended by adding at the end the following:

''AUTOIMMUNE DISEASES

''SEC. 409E. (a) EXPANSION, INTENSIFICATION, AND COORDINATION OF ACTIVITIES.—

''(1) IN GENERAL.—The Director of NIH shall expand, intensify, and coordinate research and other activities of the National Institutes of Health with respect to juvenile-onset diabetes, rheumatoid arthritis, systemic lupus erthematosus, multiple sclerosis, Sjogren's syndrome, scleroderma, chronic fatigue syndrome, Crohn's disease and colitis (in this section referred to as 'autoimmune diseases').

''(2) ALLOCATIONS BY DIRECTOR OF NIH.—With respect to amounts appropriated to carry out this section for a fiscal year, the Director of NIH shall allocate the amounts among the national research institutes that are carrying out paragraph (1).

''(3) ADDITIONAL DISEASES OR DISORDERS.—In addition to the diseases or disorders specified in paragraph (1), the term 'autoimmune disease' includes for purposes of this section such other diseases or disorders as the Secretary determines to be appropriate.

''(b) COORDINATING COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall establish a committee to be known as Autoimmune Diseases Coordinating Committee (referred to in this subsection as the 'Coordinating Committee').

''(2) DUTIES.—The Coordinating Committee shall, with respect to autoimmune diseases—

''(A) provide for the coordination of the activities of the national research institutes; and

''(B) coordinate the aspects of all Federal health programs and activities relating to such diseases in order to assure the adequacy and technical soundness of such programs and activities and in order to provide for the full communication and exchange of information necessary to maintain adequate coordination of such programs and activities.

''(3) COMPOSITION.—The Coordinating Committee shall be composed of the directors of each of the national research institutes involved in research with respect to autoimmune diseases and representatives of all other Federal departments and agencies whose programs involve health functions or responsibilities relevant to such diseases, including the Centers for Disease Control and Prevention and the Food and Drug Administration.

''(4) CHAIR.—From among the members of the Coordinating Committee, the Committee shall designate an individual to serve as the chair of the Committee. With respect to autoimmune diseases, the Chair shall serve as the principal advisor to the Secretary, the Assistant Secretary for Health, and the Director of NIH, and shall provide advice to the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, and other relevant agencies.

''(5) FULL-TIME STAFF.—The Secretary shall ensure that the Coordinating Committee is staffed and supported by not fewer than three scientists or health professionals for whom such service is a full-time Federal position. The Secretary shall in addition ensure that the Committee is provided with such administrative staff and support as may be necessary to carry out the duties of the Committee.

''(c) ADVISORY COUNCIL.—

''(1) IN GENERAL.—The Secretary shall establish an advisory council to be known as the Autoimmune Diseases Public Advisory Council (referred to in this subsection as the 'Advisory Council').

''(2) DUTIES.—The Advisory Council shall provide to the Director of NIH and the Coordinating Committee under subsection (b) recommendations on carrying out this section, including the plan under subsection (d).

''(3) COMPOSITION.—The Advisory Council shall be composed exclusively of not more than 18 members appointed to the Council by the Secretary from among individuals who are not officers or employees of the United States. The Secretary shall ensure that the membership of the Advisory Council includes—

''(A) scientists or health professionals who are knowledgeable with respect to autoimmune diseases;

''(B) representatives of autoimmune disease patient advocacy organizations, including organizations advocating on behalf of diseases affecting small patient populations; and

''(C) patients and parents of children with such diseases, including autoimmune diseases affecting small patient populations.

''(d) PLAN FOR NIH ACTIVITIES.—

''(1) IN GENERAL.—The Coordinating Committee shall develop a plan for conducting and supporting research and education on autoimmune diseases through the national research institutes, shall review the plan not less frequently than once each fiscal year, and shall revise the plan as appropriate. The plan shall—

''(A) provide for a broad range of research and education activities relating to biomedical, psychosocial, and rehabilitative issues, including studies of the disproportionate impact of such diseases on women; and

''(B) establish priorities among the programs and activities of the National Institutes of Health regarding such diseases.

''(2) CERTAIN ELEMENTS OF PLAN.—The plan under paragraph (1) shall, with respect to autoimmune diseases, provide for the following:

''(A) Research to determine the reasons underlying the incidence and prevalence of the diseases.

''(B) Basic research concerning the etiology and causes of the diseases.

''(C) Epidemiological studies to address the frequency and natural history of the diseases, including any differences among the sexes and among racial and ethnic groups.

''(D) The development of improved screening techniques.

''(E) Clinical research for the development and evaluation of new treatments, including new biological agents.

''(F) Information and education programs for health care professionals and the public.

''(3) RECOMMENDATIONS OF ADVISORY COUNCIL.—In developing the plan under paragraph (1), and reviewing and revising the plan, the Coordinating Committee shall consider the recommendations of the Advisory Council regarding the plan.

''(4) IMPLEMENTATION OF PLAN.—The Director of NIH shall ensure that programs and activities of the National Institutes of Health regarding autoimmune diseases are implemented in accordance with the plan under paragraph (1).

''(e) REPORTS TO CONGRESS.—The Coordinating Committee under subsection (b)(1) shall annually submit to the Committee on Commerce of the House of Representatives, and the Committee on Health, Education, Labor and Pensions of the Senate, a report that describes the research, education, and other activities on autoimmune diseases being conducted or supported through the national research institutes, and that in addition includes the following:

''(1) The plan under subsection (d)(1) (or revisions to the plan, as the case may be).

''(2) The recommendations of the advisory council under subsection (c) regarding the plan (or revisions, as the case may be).

''(3) Provisions specifying the amounts expended by the National Institutes of Health with respect to each of the autoimmune diseases included in the plan.

''(4) Provisions identifying particular projects or types of projects that should in the future be conducted or supported by the national research institutes or other entities in the field of research on autoimmune diseases.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005. The authorization of appropriations established in the preceding sentence is in addition to any other authorization of appropriations that is available for conducting or supporting through the National Institutes of Health research and other activities with respect to autoimmune diseases.''.

TITLE XX—GRADUATE MEDICAL EDUCATION PROGRAMS IN CHILDREN'S HOSPITALS

SEC. 2001. EXTENSION OF AUTHORIZATION OF APPROPRIATIONS.

Section 340E(f) of the Public Health Service Act (42 U.S.C. 256e(f)) is amended—

(1) in paragraph (1)(A)—

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

(B) in clause (ii), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(iii) for each of the fiscal years 2002 through 2005, such sums as may be necessary.''; and

(2) in paragraph (2)—

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

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

(C) by adding at the end the following:

''(C) for each of the fiscal years 2002 through 2005, such sums as may be necessary.''.

TITLE XXI—SPECIAL NEEDS OF CHILDREN REGARDING ORGAN TRANSPLANTATION

SEC. 2101. SHORT TITLE.

This title may be cited as the ''Pediatric Organ Transplantation Improvement Act of 2000''.

SEC. 2102. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK; AMENDMENTS REGARDING NEEDS OF CHILDREN.

(a) IN GENERAL.—Section 372(b)(2) of the Public Health Service Act (42 U.S.C. 274(b)(2)) is amended—

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

(2) in each of subparagraphs (K) and (L), by striking the period and inserting a comma; and

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

''(M) recognize the differences in health and in organ transplantation issues between children and adults throughout the system and adopt criteria, polices, and procedures that address the unique health care needs of children,

''(N) carry out studies and demonstration projects for the purpose of improving procedures for organ donation procurement and allocation, including but not limited to projects to examine and attempt to increase transplantation among populations with special needs, including children and individuals who are members of racial or ethnic minority groups, and among populations with limited access to transportation, and

''(O) provide that for purposes of this paragraph, the term 'children' refers to individuals who are under the age of 18.''.

(b) STUDY REGARDING IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall provide for a study to determine the costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans and health insurance cover such costs. The Secretary may carry out the study directly or through a grant to the Institute of Medicine (or other public or nonprofit private entity).

(2) RECOMMENDATIONS REGARDING CERTAIN ISSUES.—The Secretary shall ensure that, in addition to making determinations under paragraph (1), the study under such paragraph makes recommendations regarding the following issues:

(A) The costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans, health insurance and government programs cover such costs.

(B) The extent of denial of organs to be released for transplant by coroners and medical examiners.

(C) The special growth and developmental issues that children have pre- and post-organ transplantation.

(D) Other issues that are particular to the special health and transplantation needs of children.

(3) REPORT.—The Secretary shall ensure that, not later than December 31, 2000, the study under paragraph (1) is completed and a report describing the findings of the study is submitted to the Congress.

TITLE XXII—MISCELLANEOUS PROVISIONS

SEC. 2201. REPORT REGARDING RESEARCH ON RARE DISEASES IN CHILDREN.

Not later than 180 days after the date of the enactment of this Act, the Director of the National Institutes of Health shall submit to the Congress a report on—

(1) the activities that, during fiscal year 2000, were conducted and supported by such Institutes with respect to rare diseases in children, including Friedreich's ataxia; and

(2) the activities that are planned to be conducted and supported by such Institutes with respect to such diseases during the fiscal years 2001 through 2005.

TITLE XXIII—EFFECTIVE DATE

SEC. 2301. EFFECTIVE DATE.

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

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Florida (Mr. BILIRAKIS).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 4365.

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

There was no objection.

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

Mr. Speaker, I am very pleased to bring H.R. 4365, the Children's Health Act of 2000, to the floor of the House today. Every mother knows that America's children are its future.

On Sunday, we will celebrate Mother's Day to honor millions of women for the loving care they provide. I can think of no better gift to them than passage of this legislation to protect children from the threat of disease.

My subcommittee has examined some of the difficult barriers we face in working to improve children's health. Witnesses have testified about a number of serious childhood afflictions, including autism, childhood asthma and juvenile diabetes. We also discussed measures to promote adoption of children with special health needs.

Mr. Speaker, H.R. 4365 is an extended version of the original children's health bill, H.R. 3301. I was pleased to introduce both bills with the ranking member of the Subcommittee on Health and Environment, the gentleman from Ohio (Mr. BROWN). Together we have worked on a bipartisan basis and overcome significant, significant obstacles to bring this bill to the floor, and towards that end, I would like to personally thank the two members of our staffs, Anne Esposito of my staff, and Eleanor Dehoney from the staff of the gentleman from Ohio (Mr. BROWN), and Mr. Jason Lee and Marc Wheat of the majority staff for all of their efforts in this regard.

The bill before us, like its predecessor, authorizes and reauthorizes children's disease research and prevention activities conducted under the Public Health Service Act. Among its key provisions, the bill establishes a new pediatric research initiative within the National Institutes of Health to enhance opportunities for research and improve coordination of efforts to prevent or cure diseases affecting children.

The bill also addresses a number of specific concerns, including autism, fragile X, birth defects, early hearing loss, epilepsy, asthma, juvenile arthritis, skeletal malignancies, juvenile diabetes, adoption awareness, traumatic brain injury, injury prevention,

Healthy Start, oral health, vaccine injury compensation, hepatitis C, autoimmune diseases, graduate medical education in children's hospitals, organ transplantation needs of children and rare diseases in children. Equally important, it does not include specific funding earmarks or other controversial provisions.

This legislation incorporates a number of separate legislative proposals. I would like to acknowledge the efforts of those Members who worked to develop provisions that were included in the bill. I also want to acknowledge all of the patient advocates and cosponsors of the original children's health bill who lent their strong support to this initiative. Their dedication helped keep this legislation alive.

We can never estimate the human toll of childhood diseases. However, they also have an enormous financial impact through billions of dollars in increased health care costs. Every dollar spent by the Federal Government on disease research and prevention is an extremely wise investment.

Any parent can tell you that nothing is more heart wrenching than watching your own child suffer with an illness. As a father and grandfather myself, I know how terrible that can be. Today, however, we have a rare opportunity to do something that will give hope to families devastated by childhood disease.

It is my hope that Members will put aside their personal agendas and political disagreements to support passage of this consensus-based measure. Childhood diseases inflict pain and disruption on countless American children and their families. For the patients, families, caregivers and friends whose lives have been touched by childhood diseases, we should demonstrate our shared commitment to ending these terrible afflictions by approving H.R. 4365.

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

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

There are times, Mr. Speaker, when I feel especially privileged to be here and this is one of those times. This bill can help children I have met. It gives hope to parents I have met. I have two amazing daughters. I know how it feels when the only thing that matters is to end whatever it is that is causing your child pain. When the only thing that matters is to smooth the path for them to make sure the odds are and stay solidly in their favor. I can only imagine how the parents of a child with autism or arthritis or epilepsy must feel as they seek help for their children only to encounter dead end after dead end; to look for answers and to be told that the knowledge simply is not there, to be told that research is lacking.

H.R. 4365 is not a glamorous bill. Its passage is not going to make or break any campaigns. You are not going to hear about it on Meet the Press. But H.R. 4365 responds to very real needs. It does several good things.

The initiatives authorized in H.R. 4365 intensify efforts to find a cure for autism. The initiatives authorized could contribute to the cure and the prevention of juvenile diabetes, juvenile arthritis, epilepsy and asthma. The initiatives could contribute to the prevention of birth defects. It could help children with traumatic brain injury and protect more children from the environmental injuries like lead poisoning.

H.R. 4365 promotes children's health in other important ways. It extends the authorization for resources to support graduate medical education in our Nation's freestanding children's hospitals. It establishes a pediatric research initiative within NIH to create a more level playing field for research targeting children. The bill offers hope to children and hope to their families and if we put the resources behind it as we should, this bill will deliver children in the future from illnesses and disabilities that compromise their health and their well-being.

I feel privileged to have worked with families and community leaders and Members on both sides of the aisle who are committed to the goals of this bill and who have worked tirelessly to see that something actually gets done to achieve these goals.

I thank the gentleman from Florida (Mr. BILIRAKIS) for his good work, Jason Lee and Anne Esposito in his office and Donna Pignatelli, Ellie Dehoney and Katie Porter in mine. I hope the House will join in supporting this legislation.

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

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman for yielding me this time. As the previous speaker, I do not think there is a moment that I have been more proud to be a Member of this body than I am today. The Children's Health Act is Congress's Mother's Day present to the Nation as well as an early Father's Day present. What makes us good mothers and fathers is our devotion to our children. Nothing so sharpens, focuses and deepens a parent's devotion as when their children are ill. When the child's illness is chronic, the parent's devotion becomes life long. Parents will do whatever they can for their children, but sometimes they need our help. They need Congress to fund research about the treatment and the cure for these diseases. They need us to help educate physicians and to monitor the incidence of these diseases. This bill will provide new hope to parents of children with the long list of diseases that the gentleman from Florida (Mr. BILIRAKIS) laid out in the beginning. In addition, it creates a brand new pediatric research initiative at the National Institutes of Health.

I would like to focus my remarks on the story of autism in this bill. Autism is the third most common childhood disorder in America. It affects 400,000 people in the United States. One out of every 500 babies born in this country has autism. Parents with children with autism see their children grow and develop normally and suddenly they seem to vanish. They lose their communication skills, their language skills. It is an agony for the parents.

This disease was misdiagnosed for a generation. Parents were told that their children were autistic because they had been poorly parented or traumatized. It was a cruel misdiagnosis on the part of these physicians. But the parents of these children formed an organization called Cure Autism Now and they did what the civics books told them to. They came to Washington, they told their elected representatives of their experience and they asked for our help. We put together an autism bill and we began the long process.

These parents came to press conferences, sometimes press conferences without press. They came and they did everything humanly possible to make the country and to make the Members of the United States Congress aware of their children's special needs. They came to the hearings and they testified. It is a scary thing to come to a hearing before the United States Congress and talk about your child, but they did that.

Then they suffered the agonies of the congressional clock, and they waited month after month, year after year for Congress to slowly get around to this bill. Today that day has finally come. Then finally in the last few days, they suffered the agonies of watching the possibility that this bill would get hijacked by other agendas, perfectly good agendas but agendas that would make the bill controversial.

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Finally, today, just about when they had been ready to give up hope, the system worked and today we take up their bill, and we should be proud to do so.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentlewoman from Colorado (Ms. DEGETTE), my friend who has done as much or more on this legislation than any Member of the House.

Ms. DEGETTE. Mr. Speaker, I would like to thank the gentleman from Florida (Mr. BILIRAKIS), the chairman of our subcommittee and the gentleman from Ohio (Mr. BROWN) for their tireless efforts on what was not an easy process here. This is a good bill, and I am proud to support it.

Mr. Speaker, nothing can be more important to our Nation's future than our children. Numerous indicators of the well-being of our children paint a mixed picture of both success and shortcomings. I think this will give us a mixed view of what our Nation's future holds.

Reports of both gains and continued unmet needs are also apparent with regard to a variety of other pediatric

health care needs. Infant mortality, immunization rates, pediatric asthma care, youth violence, and the critically important fact that we still have 11 million children in this country who do not have health insurance.

Mr. Speaker, H.R. 4365 will increase research and prevention efforts targeted to improve the lives of the children. I do not think that we can question such a focus, but some have. If we have any doubt, according to a report issued by the President's National Science and Technology Council, the combined research spending for children in adolescence throughout the Federal Government represents less than 3 percent of the total Federal research enterprise. Thus, the Federal Government commits less than 3 percent of its research focused on the lives of children, despite the fact that they are 30 percent of our population and they are our future.

I would like to take the opportunity to highlight 2 important provisions of this bill. First of all, diabetes affects 16 million Americans and their families, often striking in childhood and becoming a lifelong disease. Type 1 diabetes is one of the most costly, chronic diseases of childhood. Now we are seeing Type 2 diabetes increasing among children.

I am pleased that this bill includes a provision authorizing the Centers for Disease Control and Prevention to implement a national public health effort to address Type 2 in youth. It also expands clinical trials for children with diabetes to move some of the remarkable research on diabetes from the laboratory bench to the patient's bedside.

Today's bill also incorporates the provisions from my legislation, H.R. 4008, that will require the Organ Transplantation Network to adopt criteria policies and procedures that will address the unique health care needs of children and organ transplantation. Virtually identical language was passed by this House just last month by a vote of 420 to zero. It improves the lives of children by requiring the Organ Transplantation Network to adopt criteria policies and procedures that address the unique needs of children.

Through the passage of this bill, we have the opportunity to help millions of children in this country. We owe to our children, our families, and our Nation nothing less than this sound investment in our future.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. SMITH).

Mr. SMITH of New Jersey. Mr. Speaker, I thank my friend for yielding me this time.

Mr. Speaker, H.R. 4365, the Child Health Act of 2000, must be passed today and sent swiftly to the President for his signature.

Mr. Speaker, I would like to focus a few moments on the silent epidemic of autism, we are in the midst of a silent epidemic of autism. No State, no county, no Federal agency systematically tracks cases of autism, but even faint glimpses of the truth are terrifying to behold.

According to the Federal Department of Education, autistic special education students have increased by 153 percent from 1994 to 1999. In my home State of New Jersey, the Department of Education has said the number of kids classified as autistic in our school system has increased from 241 in 1991 to an incredible, astonishing 2,354 in 1999, an 876 percent increase.

Mr. Speaker, at my request, the CDC conducted a ground-breaking autism prevalence investigation in Brick Township in New Jersey. The findings of the 2-year investigation were released just last month. We are informed that Brick's rate of classic autism was a whopping 4 per 1,000 children between ages 3 and 10, and the rate of autism spectrum disorders was 6.7 cases per 1,000. That is higher than most people had thought. Normally it is about 2 per 1,000. We had an incidence of 4 per 1,000.

Mr. Speaker, I want to thank the gentleman from Florida (Mr. BILIRAKIS) for including the essence of my ASSURE bill which will create 3 to 5 ''Centers of Excellence in Autism'' under the auspices of the CDC so that the Federal Government will now be able to monitor the prevalence of autism at the national level and develop, hopefully, better teaching methods and health professionals to improve the treatment. It also authorizes CDC to create a National Autism and Pervasive Developmental Disability Surveillance Program. This program would use a combination of grants, cooperative agreements, and technical assistance to improve the collection, analysis and reporting on this very serious anomaly that is afflicting so many of our children.

Mr. Speaker, once again, I want to congratulate the gentleman from Florida (Mr. BILIRAKIS) on a great bill and I hope all of my colleagues will support it.

Most experts in autism research believe that while genetics are a major determinant in developing autism, something else is at work. The epidemiological research provided under H.R. 4365 will help researchers sort out how much of the problem is genetic and how much is environmental or developmental. If autism has a link to certain environmental pollutants, the surveillance programs established under ASSURE will be able to tell us more about these links. If autism is related to an immunological response to certain vaccines, the data provided by ASSURE can be used to support or dismiss this hypothesis.

Regardless of one's opinion on what causes autism, the bottom line is that we will never be able to get the answers parents need without the data generated by this bill. Once the CDC has established the centers of excellence, they will serve as a model for states to copy and form their own registries and surveillance programs. The centers will also improve the standard of care for autistic persons by providing education and training for health professionals, so that the latest proven treatments and interventions can be utilized to the maximum possible extent.

Also included in the Children's Health Act are provisions of H.R. 997, introduced by Congressman JIM GREENWOOD and myself, to improve autism research programs at the National Institutes of Health (NIH). This proposal, Section (B) of Title I, boosts the biomedical research needed to help solve the puzzle of autism.

And that's just Title I. In addition, there are a host of vital initiatives to improve surveillance efforts of children with diabetes, promote adoption, and reduce asthma and enhance services to asthmatics. All of these other provisions deserve out full support.

Today, Congress has an enormous opportunity to speak out on behalf of those whose voices have been silenced by autism. Kids like Alanna and Austin Gallagher in Brick Township, New Jersey.

Today, we can help restore breath to kids afflicted with asthma. People like Tommy Farese of Spring Lake, and my own two daughters Melissa and Elyse.

Today, we may save and extend the lives of children stricken by juvenile diabetes, such as young Charlie Coats of East Windsor.

It is for these children, their mothers and fathers, and the countless others like them across out nation, that we enact H.R. 4365. Join with me in supporting this legislation.

Ms. DEGETTE. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. ROTHMAN).

Mr. ROTHMAN. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I rise today in strong support of H.R. 4365, the Children's Health Act of 2000. In particular, I want to commend the authors of this legislation for the great strides it makes in autism research.

Mr. Speaker, autism is not rare. Four hundred thousand people in the United States, mostly children, are affected by this terrible disease. While 5 percent of those with autism may gain some progress with early intervention, 95 percent of them, or more than 350,000 people, will still suffer. They will never marry, they will never live on their own, and more than half of them will never even learn to speak.

Families affected by autism are forced to bear an extraordinary burden. Parents and siblings and friends have to learn to try to communicate with a child, many of whom are incapable of either verbal or nonverbal communication, and children who have often erratic behavior. It is a disease little understood. I have been trying since I came to Congress for find funding for autism research for the various autism clusters that we believe are occurring throughout New Jersey. I am proud that this bill lays the foundation for a comprehensive research effort on autism.

Mr. Speaker, this day has been a long time in coming, and I know those families who have been affected are grateful that it is now here. I urge all of my colleagues on behalf of my nephew, Jack, who suffers with autism and on behalf of a girl by the name of Heather Simms, who has been in confinement

for 5 years, having been brought into an institution at the age of 12, who today celebrates her 17th birthday, that this is a special day for all of the autistic children in the United States, their parents and loved ones. I urge my colleagues to support H.R. 4365 for its dramatic increase in national funding and attention for autism research.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Ohio (Ms. PRYCE).

Ms. PRYCE of Ohio. Mr. Speaker, let me first congratulate the gentleman from Florida (Mr. BILIRAKIS) and my colleague, the gentleman from Ohio (Mr. BROWN) for their very, very important work.

We all hope that the wealth of our Nation and the amazing technological advances that have been made in medicine will give us the necessary resources to protect our children from harm. We have made tremendous progress, but the sad fact is that there are still so many diseases that affect our children for which there is no cure, or even effective treatment.

The legislation before us will give child victims and their families hope by devoting more Federal resources to diseases such as autism, Fragile X, asthma, skeletal malignancies, juvenile diabetes, the list goes on and on. Sadly, it is quite long.

This legislation will also focus on prevention by encouraging healthy pregnancies, analyzing data about birth defects, and investigating the deaths and severe complications through pregnancy. In addition, a new pediatric research initiative at NIH, along with reauthorization for money to train physicians at children's hospitals, will help us better understand the way in which diseases attack children and how to give them the most effective and appropriate care. There are critical differences between medical care for adults and medical care for children, which must be reflected in training of physicians and treatments designed for a child's system, which is still developing. This legislation recognizes and focuses on these important differences.

Mr. Speaker, while we may never be able to make a child understand why they are sick or are made to suffer, we can invest in the research that will allow our best and brightest scientists to solve the mysteries of childhood disease so that more children can live the carefree youths to which they are entitled. What better way to invest our Nation's resources.

Mr. Speaker, I urge my colleagues to support this important child health initiative that will give hope to children and families across America who are searching for answers and praying for a return to the normalcy that will come with good health. As America's leaders, this investment in our children's health is really the least we can do to secure a better future for our Nation.

Ms. DEGETTE. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN), a distinguished member of the committee.

(Mr. GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GREEN of Texas. Mr. Speaker, I want to thank the gentleman from Florida (Mr. BILIRAKIS), the chairman of our Subcommittee on Health of the Committee on Commerce, and the gentleman from Ohio (Mr. BROWN), the ranking member, for this legislation.

Just two weeks ago during our Easter Passover break at Texas Children's Hospital in Houston, the gentleman from Texas (Mr. BENTSEN) and I held a juvenile diabetes forum to hear from parents and experts on that terrible disease. Every member of the audience cried, literally, as we heard from the parents of 3-year-old Larry Baltazar who has recently been diagnosed with this disease. This legislation will help Larry, along with helping millions of other children who are diagnosed with juvenile diabetes, asthma, Fragile X and autism. It will help children who are diagnosed with birth defects and those who suffer a traumatic brain injury.

One thing that this legislation does not do, and I hope we can get this remedied in the conference committee, is increase funds to States for immunizations. Despite gains in recent years, we still are not doing enough to make sure that children get the right immunizations when they need it. In States like Texas, Michigan and Nevada, one in four children are not receiving the proper immunizations. In Houston, over 44 percent of the children do not receive at least one of their immunizations. In California, 27 percent do not receive at least one of their immunizations.

Over the past 5 years, Federal infrastructure funding to States, used by States and cities to identify needs, conduct community outreach, establish registries, deal with disease outbreaks and undertake educational and tracking efforts, among other things, has been cut from $271 million in 1995 to $139 million for the past 3 years. The gentleman from Pennsylvania (Mr. GREENWOOD) and I have introduced H. Con. Res. 315, which calls for an increase in funds to section 317, and we hope this increase will be included in the final version of the children's health legislation as it comes out of conference.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. WATKINS).

Mr. WATKINS. Mr. Speaker, I rise today in strong support of H.R. 4365, the Children'S Health Act of 2000. More specifically, I would like to call to the attention of my colleagues one very important aspect of this legislation that authorizes further research into a disease known as Fragile X, the most commonly inherited cause of mental retardation.

Fragile X affects one in every 2,000 newborn boys, and one in every 4,000 newborn girls. One in every 260 women is a carrier and has a 50 percent chance with each pregnancy of having a child with Fragile X. Most of these afflicted children will require a lifetime of special loving care at a cost of over $2 million each.

However, there is good news. One of the first discoveries of the human genome project, the cause of Fragile X has been linked to the absence of a single protein.

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Since that time, great strides have been made in understanding how this disease causes mental retardation, seizures, aggressive outbursts, and severe anxiety.

This research has led Dr. James Watson, who shared the Nobel Peace Prize with Dr. Francis Crick on their discovery of DNA, to believe that a cure for this heartbreaking disease is within sight.

H.R. 4365 authorizes the establishment of at least three fragile X research centers through grants or contracts with public or private institutions. It also provides a program encouraging health professionals to conduct fragile X research by repaying a portion of the educational costs.

Mr. Speaker, I dedicate this day and legislation to my friends, David and Mary Beth Busby, who have two mentally retarded sons who suffer because of fragile X and, along with many good people of the FRAXA Research Foundation and many fine scientists within the National Institutes of Health, have completely devoted themselves to finding a cure for this disease.

I also dedicate this legislation to the mentally retarded children of McCall's Chapel in Ada, Oklahoma, and to Harman Samples, a childhood friend, mentally retarded from fragile X, with whom I shared many noon hours in school and shared two-stick nickel popsicle with as a boy in elementary and high school. Harmon's mother, Christine Sample, told me Harmon provided the physical strength to move and lift his invalid father before his death.

Much more remains to be done, however, and having co-sponsored legislation authorizing more research into Fragile X in the past, I whole heartedly offer my support for H.R. 4365 and encourage my colleagues to do likewise.

Ms. DEGETTE. Mr. Speaker, I am very pleased to yield 2 minutes to the gentleman from California (Mr. WAXMAN), someone who has worked on these issues for many, many years.

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

Mr. Speaker, I rise in support of this bill. I want to commend the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN), our chairman and ranking member, for their work on this legislation.

Mr. Speaker, this bill includes many important provisions which will advance the treatment, the cure, and prevention of childhood diseases and disorders. I am also pleased to point out that this bill includes two titles which I have authored. Both titles promise to make significant advances in the treatment and prevention of childhood asthma and of autoimmune diseases like multiple sclerosis, juvenile diabetes, and lupus.

Title V of the bill, the Children Asthma Relief Act of 1999, was introduced by the gentleman from Michigan (Mr. UPTON) and myself, and title XIX is based on H.R. 2573, the NIH Autoimmune Disease Initiative Act of 1999, which was authored by the gentlewoman from Maryland (Mrs. MORELLA) and myself.

Today more than 5 million children suffer from asthma. It is one of the most significant and prevalent chronic diseases in America. That is why this bill provides new funding for pediatric asthma prevention and treatment programs, allowing States and local communities to target and improve the health of low-income children suffering from asthma.

As regards the autoimmune diseases, this would expand, intensify, and coordinate the efforts of NIH in research and education on autoimmune diseases. There are more than 80 autoimmune diseases, including multiple sclerosis, lupus, and rheumatoid arthritis, in which the body's immune system mistakenly attacks healthy tissues.

These diseases affect more than 13.5 million Americans and are major causes of disability. Most striking of all, three-quarters of those infected with an autoimmune disease are women.

The research efforts at NIH will be coordinated as a result of an office that would look at the activities throughout the NIH.

I do want to point out some serious concerns over one section of the bill, title XII's adoption awareness provisions. This title was the subject of great controversy and debate. The original language raised many serious objections regarding adoption and abortion policy.

I hope we will continue to look at this part of the bill, because it does offer some troublesome issues to be resolved.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from New Jersey (Mrs. ROUKEMA).

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I certainly thank the chairman for yielding time to me, and thank him most deeply and sincerely for all his leadership on this.

Mr. Speaker, all of us recognize the trauma and heartbreak that parents and all family members endure when serious illness strikes a child in the family. We must take this step today to set us on the way to making a happier, healthy life for all our children and for future generations.

I specifically want to thank Mary Higgins Clark, the notable author, and her son, David Clark, for reaching out to me on behalf of not only of her son and grandson, but for the millions of the dear children who suffer from fragile X.

As has been noted, fragile X is the most common inherited cause of mental retardation. With this legislation, we are clearly on the brink of a breakthrough against this tragic mental defect. The research models that have been identified here in this legislation would put us well on the road to researching recovery and a cure.

Again, I want to thank those who have brought this to my attention. I want to thank all those who did the work on this legislation, but specifically, let me dedicate this research in the name of David Frederick Clark of Hillsdale, New Jersey.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 1½ minutes to the gentlewoman from California (Mrs. CAPPS), our distinguished colleague on the committee.

Mrs. CAPPS. Mr. Speaker, I rise in strong support of H.R. 4365, the Children's Health Act of 2000.

As a school nurse, a mother, a grandmother, children's health is an issue that has been of great concern to me throughout my life. This bill would dedicate more Federal spending to childhood diseases, including autism, early hearing loss, juvenile diabetes, and many others.

I want to highlight the new focus on infant hearing loss. I recently served as a panelist at a briefing on infant hearing held by the National Campaign for Hearing Health. Every day, 33 newborns leave hospitals in this country with undiagnosed hearing loss. Yet, only one-third of all infants are tested for this most common birth defect. More than half of the infants born today with hearing impairments go undetected until age two or three, which can have a long-term impact on language, social, and cognitive skills.

We can do better than that for our children, especially since new and effective treatments are now available. This legislation will provide needed grants to develop statewide newborn and infant hearing screening evaluations and intervention programs and systems.

Mr. Speaker, I urge my colleagues to join parents and grandparents with children and grandchildren who suffer from these childhood diseases in supporting this very important bill.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from South Carolina (Mr. DEMINT).

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

As the original sponsor of H.R. 2511, the Adoption Awareness Act, along with the gentleman from Virginia (Chairman BLILEY), a champion of adoption issues, I am pleased to endorse the Infant Adoption Awareness Act included in the child health bill.

While this language is not as broad as the original legislation, it does reflect significant efforts to advance the purpose of the Adoption Awareness Act. This language was drafted with input from a wide variety of organizations, including those in the adoption and public health communities.

Women facing unplanned pregnancies deserve to hear about their options from a well-trained counselor who can provide accurate, up-to-date information on adoption. This Act provides professional development for pregnancy counselors in adoption counseling. The training will enable pregnancy counselors to feel confident in their knowledge of the adoption process, relevant State and local laws, and the legal, medical, and financial resources which can be provided to women with unplanned pregnancies.

Furthermore, there are true experts in the field of adoption counseling who are extremely familiar with the adoption process from the viewpoint of the birth mother placing a child for adoption. These individuals should be the trainers for the pregnancy counselors receiving the training.

I am pleased to support the Infant Adoption Awareness Act as a step in the right direction to bring complete and accurate adoption information to women facing unplanned pregnancies. I hope that this step significantly advances our Nation in the direction of eliminating a perceived anti-adoption bias in pregnancy counseling in providing lasting answers to difficult circumstances.

I truly believe that in our great Nation, while there may be unwanted pregnancies, there are no unwanted children.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 1 minute to our colleague, the gentleman from Iowa (Mr. GANSKE), a member of the committee.

Mr. GANSKE. Mr. Speaker, I thank the gentlewoman for yielding time to me.

Mr. Speaker, I will vote for this bill. It does many good things. But Mr. Speaker, I have to ask, if we are going to legislate on this floor on fragile X, autism, juvenile diabetes, then why do we not address on this floor the number one public health issue before the country, and that is the use of tobacco?

It has been well recognized that tobacco companies for a long time have been targeting kids to get them to smoke. Why? Because nicotine is one of the most addicting substances known. It is as addicting as morphine. Those tobacco companies know if they get kids hooked early it is very, very difficult to get them to quit.

Three thousand kids today will start smoking. One thousand of those kids will eventually die of a tobacco-related disease. I think it is a travesty that we

are not bringing that issue to this floor. I and the gentleman from Michigan (Mr. DINGELL) have a bipartisan bill, the tobacco authorities bill, that gives the FDA authority to regulate tobacco. It is not a tax bill, it is not a liability bill. It simply says that those tobacco companies that have been targeting kids have to stop.

Mr. BILIRAKIS. Mr. Speaker, I yield 1½ minutes to the gentleman from Florida (Mr. STEARNS).

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

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

Mr. Speaker, I rise in support of H.R. 4365 and applaud the chairman for the work he is doing here. He has lots of Members who want priorities. I think this is a very important bill.

Part of the bill is this adoption awareness, and specifically infant adoption awareness ensures that family planning counselors have access to training on presenting complete and accurate adoption information and referrals to women facing unplanned pregnancies.

Two, the special needs adoption awareness directs the Secretary of Health and Human Services to make grants to carry out a national campaign to provide information to the public on adoption of special needs children, establishes a toll-free telephone line for providing information, makes grants to support groups for adoptive parents, and for research on reasons for adoption disruptions.

I think this is extremely important here in Congress to realize that adoption awareness is a solution for many women. I applaud the chairman for all the work he is doing. I am pleased to be a cosponsor and to provide support.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to my friend, the gentlewoman from California (Ms. ROYBAL-ALLARD).

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in support of H.R. 4365, and would like to focus on one element of this bill, the Folic Acid Promotion and Birth Defects Prevention Act, which I introduced last year with the gentlewoman from Missouri (Mrs. EMERSON).

This provision will help prevent an estimated 2,500 U.S. babies a year from being born with serious birth defects of the brain and spine, such as spina bifida. Added to this tragedy is the fact that up to 70 percent of these birth defects can be prevented if women of childbearing age consume 400 micrograms of folic acid daily.

Unfortunately, thousands of U.S. women are unaware of this fact. The Folic Acid Promotion and Birth Defects Prevention Act in this bill addresses this problem by authorizing the Centers for Disease Control to launch a national education and public awareness campaign to inform women of the benefits of folic acid.

Like so many public health needs, common sense tells us that devoting a few extra dollars to this problem today will save thousands of dollars in future health care costs, but more importantly, will prevent the occurrence of these tragic birth defects.

On behalf of our Nation's families, I urge my colleagues to support H.R. 4365.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BENTSEN).

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

Mr. BENTSEN. Mr. Speaker, I rise in strong support of H.R. 4365, the Children's Health Act of 2000.

I want to focus on one point of this bill. While I support every part of it, particularly the pediatric research, I want to talk a little bit about the graduate medical education part of this bill, because I have the honor of representing the Texas Medical Center, which is the largest Medical Center in the world and includes the largest children hospital, Texas Children's Hospital, as well as Hermann Children's Hospital in the Harris County Hospital District.

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That being said, there is a great deal of clinical research that is done through graduate medical education at Children's Hospital which is not reimbursed because our medical education system is funded through the Medicare program and really does need to be restructured.

This bill is the first step following up on what we did last year in funding, at least in part, some of that medical education that is conducted at children's hospitals. Congress should go a lot further, frankly, but I am pleased that this bill includes that.

Mr. Speaker, let me say what I regret about this bill. What I regret is where it is lacking, and that is in the Medicaid program itself. There are 3 million children, including 800,000 children in my home State of Texas, who are eligible for Medicaid but not enrolled in the program. Texas leads the Nation in the number of children, nearly a million children, not enrolled in the program.

The gentlewoman from Colorado (Ms. DEGETTE) and myself have both offered bills that would begin to address this problem and bring these children into the system. This creates an even greater burden in our children's hospitals because when these kids get sick, they end up at the children's hospitals and we pay for it through the disproportionate share program. The fact is they ought to be enrolled in the Medicaid program and getting the preventive health care they need, instead of showing up at the emergency room at the last minute at a much higher cost structure.

So I regret the fact that the committee chose not to include these bills in this bill. I think overall, this is a good bill. But I would hope that the Committee on Commerce will move swiftly to bring these children into the Medicaid program and start to address this problem. And I think by doing that, we will not only be doing a lot for these kids, but we will be doing a lot for our children's hospitals throughout the country.

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

Mrs. MORELLA. Mr. Speaker, I thank the gentleman from Florida (Mr. BILIRAKIS) for yielding the time to me, and I certainly commend the gentleman for his leadership, along with the leadership of the gentleman from Ohio (Mr. BROWN), ranking member, for this legislation, the Children's Health Act of 2000. I strongly support it.

Mr. Speaker, the bill attempts to foster Federal and State cooperation in creating public awareness about some of the devastating effects of disorders such as autism, epilepsy, fragile X, asthma and skeletal cancer in children.

I am pleased that it authorizes the Director of NIH to expand programs and activities dealing with autoimmune diseases, including the formation of coordinating committee and advisory councils to develop NIH activities in this area and report to Congress on how funds are being spend on autoimmune diseases.

Mr. Speaker, let me put a face on these dreaded diseases. They include juvenile diabetes, juvenile arthritis, rheumatic fever, Crohn's disease, pediatric lupus, Grave's disease, Evans syndrome, autoimmune hepatitis, primary biliary cirrhosis, and the list goes on and on.

There have been so few epidemiology studies on the prevalence of these diseases in children that we can only give a best effort estimate that upwards of 9 million pediatric and adolescent children are afflicted with one or more autoimmune diseases. The lack of epidemiology studies clearly shows that there is a need for comprehensive approach to research in these areas.

This is a comprehensive approach; this is a comprehensive bill. It is a bill that I urge my colleagues to support unanimously, H.R. 4365.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. LOWEY).

Mrs. LOWEY. Mr. Speaker, I rise in strong support of H.R. 4365. By expanding pediatric research efforts and providing additional resources for a number of diseases which afflict children, this bill will go a long way toward improving health care for our children and enhancing their health and safety.

As the main Democratic sponsor of the Safe Motherhood Monitoring and Prevention Research Act, I am particularly pleased that H.R. 4365 includes provisions to ensure that maternal health and safe motherhood research and programs are top public health priorities.

As we all know, the CDC is the premier source of health surveillance in

this country, and for the past 13 years they have been monitoring the maternal deaths, risks, and complications through the Pregnancy Mortality Surveillance System. The CDC also assists States in determining which women may be at increased risk for pregnancy-related complications and what types of interventions can decrease these risks through the Pregnancy Risk Assessment Monitoring System or PRAMS.

While most of us think that childbirth and pregnancy are completely safe, CDC's research tells us otherwise. According to the CDC, two to three women die each day from pregnancy-related conditions and nearly 5,000 women experience major complications either before or after labor begins. Even more disturbing is the news that black women are four times more likely and Hispanic women 1.7 times per likely to die during pregnancy than their white counterparts and that access to prenatal care does not close this gap.

That is why it is critical that we give the CDC the tools they need to collect data, investigate maternal deaths, research risks, and examine problems like domestic violence during pregnancy. Armed with that information and research, the CDC will also get the word out to women who need it most and the doctors who serve them.

Mr. Speaker, no woman should die due to pregnancy in 2000. So as we approach Mother's Day, I am delighted that this bill will enable CDC to do its good work.

The SPEAKER pro tempore (Mr. BARRETT of Nebraska). The gentleman from Ohio (Mr. BROWN) is advised that he has 30 seconds remaining, as does the gentleman from Florida (Mr. BILIRAKIS).

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

Mr. Speaker, I ask House support of H.R. 4365. This legislation has been a good faith effort with the gentleman from Florida (Mr. BILIRAKIS), my office, and this committee working together. It will mean an absolute difference in children's lives; children who have often been ignored by the system in juvenile arthritis or juvenile diabetes and tests conducted not always for children and the unique diseases they have.

Mr. Speaker, I ask House support of this legislation.

Mr. Speaker, I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, an awful lot of blood, sweat and tears has gone into trying to secure a better future for our children by helping to reduce the incidence of disease and illness. I thank my Committee on Commerce colleagues, particularly the gentleman from Ohio (Mr. BROWN) and I applaud all the Members for having the good sense to set aside some of our partisan agendas in order to improve the lives of our children and all of their families throughout this country. I ask all of the Members to support this legislation.

Mr. WEYGAND. Mr. Speaker, while I am in support of H.R. 4365, the Child Health Research and Prevention Amendments, this bill should not be on the floor today under the suspension of the rules—where no member can offer an amendment to strengthen and improve this bill.

I commend those of my colleagues who drafted this bill in the back rooms of Congress. They have drafted a good piece of legislation. But Congress works best when more than a minority of the members are involved in developing legislation. As a cosponsor of H.R. 3301, the base bill for this new draft legislation, I will vote in favor of the bill on the floor today. Make no mistake, however, that thousands of extremely ill children are being ignored by the House of Representatives today.

Well over a month ago, my staff contacted the Commerce Committee—both the majority and the minority—asking if this bill could also direct the NIH to review their work on children with the rare illness ''Hutchinson-Gilford Progeria Syndrome,'' similar to the study being asked for in the bill regarding Friedreich's ataxia. Other members of the House worked with me on this effort. I also joined with a member of the Majority to inquire if we could similarly add Spinal Muscular Atrophy to the same section of the bill. These measures are not in the bill today, and this process—which bars amendments—has kept these children and thousands of others from being heard, and helped by this bill.

In fact, this bill has not been open to amendments at any point since its introduction. Two committee mark-up sessions for this bill were canceled, and yet we are here voting for final passage! I ask you, Mr. Speaker, why has the leadership forgone the democratic process in order to pass a children's health bill? I would say it is because of tobacco and guns, the soft spot on the heart of the Republican leadership.

The failure of the leadership with regard to this bill represents a terrible missed opportunity for thousands of sick children. Because the Republican leadership couldn't stomach a vote on tobacco or gun safety—both huge problems for children's health—we bypassed regular order. That act has forced the House to forgo working together to develop a bill that could have helped even more children. My efforts to improve the bill are only one of 435 stories of members in this body. We have not only ignored the democratic process, we have ignored the needs of thousands of children in order to avoid some tough votes.

Shame on the leadership for failing our nation's children—not through the good of this bill, but through the leadership's failure to do even more for children.

Mrs. EMERSON. Mr. Speaker, it is with pleasure that I speak in support of this essential Children's Health Act of 2000. There are many of us who have worked very hard to get to this day, and I applaud the Commerce Committee and Mr. BILIRAKIS and Mr. BROWN for getting a consensus on this bill so it could come to the floor.

I represent 26 rural counties in Southern Missouri. These counties are home to some of the most poverty stricken communities in the State. Most of them lack even basic health care services. And many lack decent roads and reliable phone service. Many people in these communities find themselves isolated from their extended family, their friends and their neighbors.

Many young mothers-to-be in my rural district are isolated from family and friends—and they live miles away from nurses and doctors. This isolation often prevents them from getting prenatal care and adds to the fears and uncertainties that come along with being a new or expectant mother. Many American women fall through the cracks of our health system. Women throughout our nation face great challenges in securing healthy pregnancies and healthy children.

Consider the following: At the turn of this century more American women died in childbirth than from any other cause except for tuberculosis. At the close of this century, after all of the medical advances made in this country, it's easy to assume that today pregnancy and childbirth are safer for American women and their babies.

But this is a false assumption.

Last June, the CDC released a report that makes it painfully clear that the promise of safe motherhood is eluding too many women. In fact, during the past 15 years alone, total maternal deaths have not declined one bit in our nation. Just think of it. Today, tuberculosis claims about one American life out of 1,000 a year. But 2–3 women out of 10,000 lose their lives each day due to pregnancy-related conditions. And out of 1,000 live births in our country each year, 8 babies die. More infants die each year in the United States than in 24 other developed nations.

As a Member of Congress and as a mother of four daughters, this maternal and infant mortality rate is simply unacceptable. We've got to find out why safe motherhood is still out of reach for so many American women. I am very proud to join many of my esteemed colleagues in supporting this legislation that will have significant progress of maternal and infant health in this country.

The legislation includes several provisions that my colleague NITA LOWEY and I introduced as a stand alone bill, Safe Motherhood Monitoring and Prevention Research Act of 1999, which are especially beneficial to pregnant women, infants, and children.

The Safe Motherhood Portion of the bill achieves 3 key goals, all necessary components to true progress in the enhancement of material and infant care.

First, it expands CDC's Pregnancy Risk Assessment Monitoring System (PRAMA) so that all 50 states will benefit from a public health monitoring system of pregnancy-risk related factors.

Second, this bill authorizes an increase in federal funding for preventive research, so we can identify basic health prevention activities to improve maternal health.

The third and final component of this section of the bill directs the Secretary to help states and localities create public education and prevention programs to prevent poor maternal outcomes for American women.

In addition, this bill emphasizes the need to expand existing prevention programs and pregnancy risk assessment systems to include those areas of the country where underserved and at-risk populations reside.

Finally, I am also pleased that this bill includes many of the provisions in a bill I introduced last year called the Healthy Kids 2000

Act. This bill expands the opportunities for Pediatric Research by creating a pediatric research initiative within NIH, promotes the use of folic acid as a way to prevent birth defects, and creates a national Center on Birth Defects and Developmental Disabilities.

There are so many wonderful parts of this bill. On behalf of our youngest and most vulnerable citizens, I urge my colleagues to Vote for the Children's Health Act of 2000, and I urge the Senate to take action on this bill to move the process forward.

Mr. TIERNEY, Mr. Speaker, I commend the bipartisan effort that has produced this important bill, H.R. 4365, the Children's Health Act of 2000. I understand that in the spirit of cooperation, many amendments to this bill were laid aside in order to bring this legislation to the floor and ensure that the urgently needed programs included in H.R. 4365 were not jeopardized by disagreements on other matters.

I would like to mention one change to the bill that I believe is quite worthy and would not raise controversy. Had this bill come up under a rule rather than as a suspension, Mr. WEYGAND and I would have sought an amendment to include Hutchinson-Gilford Progeria Syndrome under Section 2201 of the bill as one of the rare childhood diseases on which NIH would have to report its activities.

This syndrome, commonly known as Progeria, is a genetic condition that manifests itself as accelerated aging in children. While it is quite rare, with an estimated incidence of roughly one in every 8 million newborns, Progeria is devastating. The average life span of an affected child is 13 years, and the disease is, without exception, fatal. Up until now, there has been little to no NIH research directly in this area. However, such research has the potential to benefit many individuals in addition to the victims of Progeria. According to Dr. Ted Brown, Professor and Chairman of the Department of Human Genetics at the New York State institute for Basic Research, ''Finding a cure for Progeria may provide keys for treating millions of people with heart disease associated with natural aging.''

Requiring the NIH report on activities relating to rare childhood diseases to include Progeria as one of those conditions is thoroughly consistent with the purpose of the bill before us today, and we thank the sponsors and managers of the bill who have been sympathetic to our suggested change. However, because of the process by which H.R. 4365 came to the floor, it was not possible to include this important and justified amendment. Mr. WEYGAND and I hope that the Senate's consideration of this legislation will proceed in a more deliberative manner, and we will work with our Senate counterparts to include Progeria language when this bill moves in the other Congressional chamber. It is our hope that the bill that emerges from conference will contain language bringing much-needed attention to this underrecognized and tragic condition.

Mr. BLILEY. Mr. Speaker, I commend the gentlemen from Florida and Ohio for introducing H.R. 4365, the Children's Health Act of 2000. This important legislation, introduced by Representatives BILIRAKIS and BROWN, contains a host of significant provisions that, when enacted into law, will improve the lives of untold numbers of children and families throughout this country.

Though too numerous to mention each provision individually, I want to comment on a few that I believe are parrticularly important. This Act makes important strides in the fight against autism—a heart-breaking condition. Autism is a serious disease, affecting 1 in every 500 children born today. More prevalent than Down's syndrome, childhood cancer or cystic fibrosis, it hits children during the first two years of life and causes severe impairment in language, cognition and communication.

As a proud adoptive father of two, I am pleased that this Act also advances adoption policy in this country by ensuring family planning counselors have access to training on presenting complete and accurate adoption information to women facing unplanned pregnancies. In the interest of time, I ask that I be permitted to extend my remarks for a more full discussion of this aspect of the legislation. Moreover, this bill contains several initiatives that will foster the adoption of special needs children. The Act also authorizes the Healthy Start program for the first time. For at-risk pregnant women served by this program, it authorizes ultra-sound screening and expands access to surgical services to the fetus, mother, and infant during the first year after birth.

The Act will enable the families of children who have had an adverse reaction to rotavirus vaccine to receive compensation under the vaccine injury compensation program. It extends the authorization of appropriations for graduate medical education in children's hospitals—an authorization that the Commerce Committee initiated in a bill signed into law last year.

The list goes on: the Act will bring help to children suffering from juvenile diabetes, pediatric asthma, juvenile arthritis, birth defects, hearing loss, epilepsy, skeletal malignancies, traumatic brain injury, dental disease, and a wide range of autoimmune diseases. It also ensures that our nation's organ transplantation system recognizes children's unique health care needs.

It is important that the Members of this House vote for passage of this critically important bill to secure a better future for America's children by helping to reduce the incidence of disease and illness. We know we can lessen the incidence of these diseases through heightened research activities, and through the use of successful interventions that still remain out of reach by many in our society.

Again, I thank my Commerce Committee colleagues and many other Members who have contributed to this bill. By voting to pass this bill, I applaud those Members for having the good sense to set aside some of our more partisan agendas in order to do a good work for our children and all of their families throughout this country.

Ten months ago, Congressman JIM DEMINT of South Carolina and I introduced H.R. 2511, the Adoption Awareness Act. During consideration by the Committee on Commerce, the language of H.R. 2511 changed but the central purpose remained the same: the Infant Adoption Awareness Act ensures that counselors in health clinics and other settings provide women who have unplanned pregnancies complete and accurate information on adoption.

As Chairman of the Commerce Committee, I have been responsible for the negotiations leading to the Infant Adoption Awareness Act for these many months, and I want to take this opportunity to explain the bill at length to my colleagues in case there is any confusion with the text of the original Adoption Awareness Act, H.R. 2511.

What struck Congressman DEMINT and me was that the studies and statistics available in this field show a lack of activity which may well reflect an anti-adoption bias in pregnancy counseling. According to a University of Illinois study by Professor Edmund Mech, Orientations of Pregnancy Counselors Toward Adoption, 40 percent of self-identified ''pregnancy counselors'' in settings such as health, family planning, and social service agencies do not even raise the issue of adoption with their pregnant clients. Of the 60 percent who raise the issue of adoption in some form, 40 percent provide inaccurate or incomplete information. Furthermore, while pregnancy counselors themselves may not have a negative bias towards adoption, they presuppose that their client is not interested and therefore do not present adoption as a true option for women facing unplanned pregnancies (Source: Mech, Pregnant Adolescents: Communicating the Adoption Option). The Infant Adoption Awareness Act would set up a training program by which clinic workers and others could receive professional inservice training in educational adoption counseling. By being properly trained, these counselors would be equipped to provide valuable information on adoption to their clients.

While many societal factors have changed in the last twenty years, including the acceptance of non-marital teen parenting, the availability of welfare, and increased availability of abortion services, there has been a dramatic drop in the number of adoptions among live births to unwed mothers. Prior to 1973, an adoption placement occurred for almost one of every ten premarital births. By the 1990s, the number had dropped to an adoption placement for one of less than every hundred premarital births. A long-term study of the Adolescent Family Life (AFL) pregnancy programs which included an adoption counseling component showed that—given necessary adjustments for client and community characteristics—more women chose to place their child for adoption when enrolled in an AFL Care project which provided adoption counseling as a part of pregnancy resolution decision-making (Source: McLaughlin and Johnson, Battelle Human Affairs Research Centers, The Relationship of Client and Project Characteristics to the Relinquishment Rates of the AFL Care Demonstration Projects). Thus, this Act intends to ensure that the public health and other professionals coming in contact with a high percentage of women facing unplanned pregnancies—often unwed adolescents—are properly prepared to have a complete and accurate discussion of adoption.

The Act allows for a six month period in which representatives of the adoption community come together to adopt or develop best-practices guidelines for counseling on adoption to women facing unplanned pregnancies. Specifically, the Secretary should include representatives of diverse viewpoints in the adoption community, including organizations representing agencies arranging infant adoptions, adoption attorneys, adoptive parents, social services, and appropriate groups representing the adoption triad (birth parents, infant, and adoptive parents). Organizations with significant expertise and history in this arena include

the National Council For Adoption, Loving and Caring, Bethany Christian Services, the American Academy of Adoption Attorneys, and the American Bar Association Family Law Section's Adoption Committee and these organizations should be represented on the panel. While recognizing the sensitivity of making an adoption decision, the organizations represented should be those which promote adoption in a realistic, positive manner as beneficial to the birth parents, child, and adoptive parents. The best-practices guidelines should focus on the essential components of adoption information and counseling to be presented during a pregnancy counseling session. Furthermore, the guidelines should include important variables to be presented, such as state laws on adoption, and available medical, legal, and financial resources. Previous curricula developed for these purposes should be the starting point and, as an interim set of guidelines, be determinative.

The role of the public health clinics on the panel developing the best practices guidelines (and organizations representing their interests, such as the Family Planning Councils of America) is to ensure the guidelines are relevant to the health clinic setting. The experts in adoption counseling, including those who have a history of developing and delivering training or tools to teach adoption counseling, should shape the best-practices guidelines to provide an excellent model for presenting adoption to women facing unplanned pregnancies. Since different attitudes towards adoption exist throughout the country which can be attributed to racial, ethnic, religious, social, and geographic differences, the best-practices guidelines should act as a blueprint or model while still allowing localities the flexibility to address their local situation. Therefore, the best-practices guidelines would be a model which could be tailored to address the individual needs of the pregnant woman.

After the best-practices guidelines are developed, the Secretary shall make grants to adoption organizations to carry out training, which will often be training trainers, to teach pregnancy counselors how to present complete and accurate information on adoption. The guidelines are meant to be the basis for the adoption, improvement, or development of a training curriculum by grantees. Furthermore, the grantees can carry out the training programs directly or through grants or contracts with other adoption organizations. For instance, a national office could subgrant or contract with local affiliates throughout the nation or a region thereof. The Secretary should use discretion in ensuring that all regions of the nation will have adequate access to the training without having duplicate services in an area with a small number of eligible health clinics. There are no geographic limitations on where the trainers should be trained. The intent is to provide for training of trainers, often on a statewide or regional basis, so truly expert trainers can teach others.

The trainers should be highly qualified individuals with an expertise in adoption counseling. ''Adoption counseling'' in the adoption community implies an in-depth discussion of adoption which includes knowledge of various types of adoption and familiarity with the viewpoint and challenges of birth mothers, putative fathers, adoptive parents, and the best interest of the child. Trainers should have experience in providing adoption information and referrals in the geographic area of the eligible health centers. With a knowledge of state laws and access to local support networks, a trainer will be able to provide a more extensive review of local information and resources to the pregnancy counselors. The most essential component of the training, however, is to teach pregnancy counselors how to accurately and completely present adoption as an option to their clients and to ensure counselors are able to answer the frequently asked questions clients have regarding adoption.

The Infant Adoption Awareness Act refers to pregnancy counselors providing adoption information and referrals as a part of pregnancy counseling. It is important to note that handing a client a piece of paper or booklet explaining the adoption process and providing phone numbers of agencies or attorneys for adoption referrals does not constitute adoption information and referrals. Adoption information means a counselor is able to fully explore the option of adoption with a client. This includes answering relevant questions such as the types of adoptions, financial and medical resources for birth mothers, and state laws regarding relinquishment procedures and putative father involvement. Referral upon request includes following the procedures of the health clinic to make an appointment for the client and follow-up as necessary. Referral may be made to an in-house adoption provider, such as a staff member of a licensed adoption agency. Since adoption is explored in the context of pregnancy counseling sessions in which counselors and clients have a limited amount of time, it is essential that the counselors provide complete and accurate summary information to their clients at that time.

The intent of this Act is to ensure that pregnancy counselors are well-trained, knowledgeable and comfortable presenting adoption to their clients. While adoption may not be the right choice for every woman facing an unplanned pregnancy, each woman should be presented adoption information to make a well-informed decision. Many women have not thought of the possibility of adoption, do not know how to explore the details of adoption, or have misconceptions of the adoption process which hinder their consideration of the alternative of adoption. Since pregnancy counselors act as an important resource for these women, they must be equipped to fully address the option of adoption with their clients.

The adoption organizations eligible to receive grants for training (or subgrants or contracts) are those national, regional, or local private, non-profit institutions among whose primary purposes is adoption, and are knowledgeable on the process of adopting a child and on providing adoption information and referrals to pregnant women. These adoption organizations must work in collaboration with existing Health Resources Services Administration (HRSA) funded ''training centers.'' Of particular importance is the organization's experience in explaining the process involved to the birth mother placing the child for adoption. It is essential that adoption is among the primary purposes of the entity, as it should be organizations with true experts in adoption counseling who are training pregnancy counselors.

Health centers which are eligible to have staff receive training are public and nonprofit private entities that provide health-related services to pregnant women. The designated staff of the health centers means the counselors who will interact and provide counseling to women with unplanned pregnancies. The designated staff members are those who provide pregnancy or adoption information and referrals (or will provide such information and referrals after receiving training). Furthermore, while the Act sets out those health centers which should receive priority in being trained, nothing should be construed to prohibit those who provide counseling in other settings, such as on military bases and corrections facilities, to be eligible to participate in the adoption counseling training sessions.

The grant is conditioned on the agreement of the adoption organization to make reasonable efforts to ensure that the eligible health centers which may receive training under this grant include, but are not limited to, those that receive federal family planning funding, community health centers, migrant health centers, centers for homeless individuals and residents of public housing and school-based clinics.

The Secretary has the duty to provide eligible health centers (which receive funding under Section 330 and 1001) with complete information about the training available from the adoption organizations receiving the training grants. Furthermore, the Secretary has the duty to encourage eligible health centers to have their designated staff participate in the training. The Secretary must make reasonable efforts to encourage staff to undergo training within a reasonable period after the Secretary begins making grants for such training. The grantees will cover the costs of training the designated staff and reimbursing the health center for costs associated with receiving the training. Adoption counseling training is a type of professional development for pregnancy counselors and should be reimbursed on a similar basis as other professional development activities which staff receive in the local area.

Within one year, the Secretary shall submit to the appropriate Committees of Congress a report prepared by an independent evaluator, paid for by funds set aside under this Act evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers. The study should be scientifically-based and sufficiently broad so as to gain an understanding of the current practices of providing adoption information in Federally funded health clinics throughout the country. This should include the attention given to adoption relative to other options discussed in pregnancy counseling. Further, the study should indicate how often and in what form (written, verbal) adoption information is offered, the completeness and accuracy of the adoption information provided, and non-identifying information about the options ultimately chosen by clients.

Within a reasonable period of time, the Secretary shall submit to the appropriate Committees of Congress a report evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers to determine the effectiveness of the training. The study should be scientifically-based, that is, more than a checklist asserting that adoption counseling, information, or referral has been provided, and focus on those health centers in which designated staff have been provided training through this Act. In conducting these studies, the Secretary shall ensure that the research does not allow any interference in the provider-patient relationship, any breach of patient confidentiality, or

any monitoring or auditing of the counseling process which breaches patient confidentiality or reveals patient identity.

Funding for research in adoption counseling practices has been sporadic at best. Despite the acknowledged need to ensure pregnancy counselors can present adoption in a positive, accurate manner, funding for such studies has not materialized in proportion to the need. The Adolescent Family Life Program in the Office of Population Affairs provided for limited studies in the 1980s and follow-up studies on the effectiveness of the AFL Demonstration Programs into the early 1990s. The Office of Adolescent Pregnancy Programs in the 1990s proposed an objective of increasing to 90 percent the number of pregnancy counselors who are able to counsel on adoption in a complete, accurate manner. With a change of Administration, this goal never materialized as one of the priorities of the Public Health Service. Furthermore, plans for follow-up study by the Department of Health and Human Services to determine if the orientations of pregnancy counselors toward adoption had changed were dropped in 1995. Thus, research in this area is of critical importance.

Additionally, there is an understanding that this Act would include ''charitable choice'' language allowing faith-based organizations to compete for grants on the same basis as any other non-governmental provider without impairing the religious character of such institution, upon agreement by the White House and House Leadership on ''charitable choice'' language for other legislation. Under charitable choice, the Federal Government cannot discriminate against an organization that applies to receive such a grant on the basis that the organization has a religious character and programs must be implemented consistent with the Establishment and Free Exercise Clauses of the United States Constitution. While following the agreed upon charitable choice model, the language must be crafted to conform it to the purpose and structure of this Act.

While we have come a long way, much work remains to be done. I look forward to working with my colleagues on the Appropriations Committee on this adoption priority and with members of the other body to enact this important provision into law this year, on which better and more humane Federal policies can be built in the future.

Mr. DINGELL. Mr. Speaker, I am in support of H.R. 4365, the Children's Health Act of 2000. This bill is an important first step toward improving the health and well-being of our nation's next generation.

H.R. 4365 enhances the national research infrastructure and reinforces surveillance and prevention initiatives for such conditions as fragile X, autism, asthma, juvenile arthritis, childhood malignancies, traumatic brain injury, hepatitis C, and immediate adverse reactions to vaccines. I am particularly pleased to see two provisions that reflect the tireless efforts of my colleague DIANA DEGETTE: one to advance the quest for a treatment and cure for juvenile-onset diabetes, and the second to improve pediatric organ transplant services. H.R. 4365 also strengthens existing activities to promote the use of folic acid in the prevention of certain birth defects, a measure that will reduce human suffering and save healthcare dollars.

Other highlights of the bill include the expansion of oral health and epilepsy treatment services to undeserved children, and the reauthorization of the Healthy Start initiative, a demonstration program established to reduce infant mortality and improve pregnancy outcomes.

Investments in America's researchers are also evidenced in H.R. 4365 through the extension of authorized appropriations to children's hospitals for the cost of graduate medical education. The bill enhances biomedical pediatric research by establishing a Pediatric Research Initiative within NIH, and centralizes the coordination of NIH research activities in the area of pediatric autoimmune disorders. Finally, to attract the most promising young research minds in the country to work on often overlooked childhood disorders, the bill contains loan repayment programs for biomedical researchers and physician-scientists.

Regrettably, however, this children's health bill is not the best we could do for America's children. A number of my colleagues had amendments that would have strengthened H.R. 4365, but the irregular procedures used by the majority for the bill blocked their consideration. These include, but are not limited to: (1) supplementing S–CHIP and Medicaid to provide seamless access to state-of-the-art prenatal services to all pregnant women; (2) assuring equal access to pediatric specialists, medically necessary drugs and clinical trials for children with rare and/or serious health problems; (3) attending to state-by-state disparities in new born screening for genetic diseases by authorizing HHS to carry out the recommendations of the Task Force on Newborn Screening, an issue of deep concern to my colleague Mr. PALLONE; and (4) an excellent proposal by my good friend Mr. TOWNS for establishing guidelines for the administration of psychotropic medications to children under five.

An even more glaring omission from this bill is the lack of a provision to restore FDA's jurisdiction over the regulation of youth tobacco use. This issue was thoughtfully raised in legislation introduced by my colleague, Dr. GREG GANSKE, which enjoys a broad base of bipartisan support. The process by which the legislation comes before us today is characterized by the majority's determination to block any discussion of this important issue.

I have additional concerns about the difficulties that will arise for this particular Children's Health bill, H.R. 4365, as companion legislation is crafted by the Senate. Title XII, the Infant Adoption Awareness Act of 2000, has drafting problems, and leaves the bill vulnerable to a host of family planning and adoption issues that are beyond the agreed upon scope of this Children's Health bill.

I will be one of the first to suggest that adoption is an important national issue. As of March 31, 1999, America had 117,000 children in the public foster care system who are awaiting adoptive parents and a permanent place to call ''home.'' This represents an increase of over 7,000 children since 1998, perhaps in part because Public Law 105–89, the Adoption and Safe Families Act has made more foster children, who are unable to return home safely, available for adoption. Something is wrong, however, when adoptive parents tell us that it is easier to pursue an international adoption than to adopt a special needs child from America.

If we wanted to address adoption issues, we should have considered legislation sponsored by Senator LEVIN that the Senate has passed three times. It would facilitate the creation of a national voluntary reunion registry. In the era of genetic medicine, with its emphasis on family medical history information, this not only makes sense as public policy, but addresses the life-long psychological issues that often shroud the adoption process. Again, irregular procedures blocked mere discussion of this issue.

Mr. Speaker, I will support this bill. I do so, however, with the fervent belief that we can, and should, do more for America's children than is reflected in H.R. 4365. The children of every district in this nation have waited too long for the many laudable provisions in the bill; but they also deserve more, and they deserve it soon.

Mr. BILIRAKIS. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and pass the bill, H.R. 4365, as amended.

The question was taken.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

LONG ISLAND SOUND RESTORATION ACT

Mr. SHUSTER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3313) to amend section 119 of the Federal Water Pollution Control Act to reauthorize the program for Long Island Sound, and for other purposes, as amended.

The Clerk read as follows:

H.R. 3313

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 ''Long Island Sound Restoration Act''.

SEC. 2. NITROGEN CREDIT TRADING SYSTEM AND OTHER MEASURES.

Section 119(c)(1) of the Federal Water Pollution Control Act (33 U.S.C. 1269(c)(1)) is amended by inserting '', including efforts to establish, within the process for granting watershed general permits, a system for trading nitrogen credits and any other measures that are cost-effective and consistent with the goals of the Plan'' before the semicolon at the end.

SEC. 3. ASSISTANCE FOR DISTRESSED COMMUNITIES.

Section 119 of the Federal Water Pollution Control Act (33 U.S.C. 1269) is amended—

(1) by redesignating subsection (e) as subsection (f); and

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

''(e) ASSISTANCE TO DISTRESSED COMMUNITIES.—

''(1) ELIGIBLE COMMUNITIES.—

''(A) STATES TO DETERMINE CRITERIA.—For the purposes of this subsection, a distressed community is any community that meets affordability criteria established by the State in which the community is located, if such criteria are developed after public review and comment.

''(B) CONSIDERATION OF IMPACT ON WATER AND SEWER RATES.—In determining if a community is a distressed community for the purposes