consumer. And, of course, the slower the Internet connection, the greater the tab.

The consumer also pays for spam through higher costs incurred by Internet Service Providers, or ''ISPs.'' The exponential growth in spam leaves ISPs with no choice but to expand their server capacity to accommodate the heavier traffic. These investments pose a significant, but unavoidable, burden on ISPs that many must pass along to consumers.

H.R. 3113 is a common-sense approach that will go far to putting an end to this practice. First, it permits an ISP to legally enforce its own policy with regard to whether it will accept spam or not. This protects ISPs and consumers alike. Second, it allows consumers to opt-out of receiving spam from individual senders. And finally, it empowers consumers to ''just say no'' to receiving future messages from a particular company when he or she has had enough.

Mr. Speaker, again I want to commend my colleagues for their diligent efforts.

Ms. ESHOO. Mr. Speaker, I rise in support of H.R. 3113, The Unsolicited E-Mail Act.

The problem of junk e-mail is reaching epidemic proportions. I've received hundreds of calls and letters from constituents in my congressional district pleading with me to do something about the spam that plagues their computers.

In Silicon Valley, where e-mail is often the communication medium of choice, deleting unwanted messages has posed a significant time and financial burden.

More importantly, the proliferation of unwanted e-mail messages has raised real privacy concerns.

In 1991, Congress passed the Telephone Consumer Protection Act to restrict the use of automated, prerecorded telephone calls and unsolicited commercial faxes on the grounds that they were a nuisance and an invasion of privacy. Shouldn't we provide the same level of protection for e-mail?

Unwanted e-mail also poses a significant burden on the Internet infrastructure and on companies providing Internet access services. Unwanted and unwelcome data have flooded ISPs, considerably increasing their costs for network bandwidth, processing e-mail, and staff time.

H.R. 3113 offers a balanced and effective approach to the junk e-mail problem by ensuring that providers and consumers control their own mailboxes, and still allowing businesses to market by e-mail to the millions of consumers who desire it.

I urge my colleagues to support this thoughtful bill.

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

The SPEAKER pro tempore (Mr. ISAKSON). The question is on the motion offered by the gentlewoman from New Mexico (Mrs. WILSON) that the House suspend the rules and pass the bill, H.R. 3313, as amended.

The question was taken.

Mrs. WILSON. 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.

DRUG ADDICTION TREATMENT ACT OF 2000

Mr. BLILEY. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2634) to amend the Controlled Substances Act with respect to registration requirements for practitioners who dispense narcotic drugs in schedule IV or V for maintenance treatment or detoxification treatment, as amended.

The Clerk read as follows:

H.R. 2634

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 ''Drug Addiction Treatment Act of 2000''.

SEC. 2. AMENDMENT TO CONTROLLED SUBSTANCES ACT.

(a) IN GENERAL.—Section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)) is amended—

(1) in paragraph (2), by striking ''(A) security'' and inserting ''(i) security'', and by striking ''(B) the maintenance'' and inserting ''(ii) the maintenance'';

(2) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively;

(3) by inserting ''(1)'' after ''(g)'';

(4) by striking ''Practitioners who dispense'' and inserting ''Except as provided in paragraph (2), practitioners who dispense''; and

(5) by adding at the end the following paragraph:

''(2)(A) Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner who is a qualifying physician as defined in subparagraph (G), of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

''(B) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a physician are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, the physician submit to the Secretary a notification of the intent of the physician to begin dispensing the drugs or combinations for such purpose, and that the notification contain the following certifications by the physician:

''(i) The physician is a qualifying physician as defined in subparagraph (G).

''(ii) With respect to patients to whom the physician will provide such drugs or combinations of drugs, the physician has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services.

''(iii) In any case in which the physician is not in a group practice, the total number of such patients of the physician at any one time will not exceed the applicable number. For purposes of this clause, the applicable number is 30, except that the Secretary may by regulation change such total number.

''(iv) In any case in which the physician is in a group practice, the total number of such patients of the group practice at any one time will not exceed the applicable number. For purposes of this clause, the applicable number is 30, except that the Secretary may by regulation change such total number, and the Secretary for such purposes may by regulation establish different categories on the basis of the number of physicians in a group practice and establish for the various categories different numerical limitations on the number of such patients that the group practice may have.

''(C) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to narcotic drugs in schedule III, IV, or V or combinations of such drugs are as follows:

''(i) The drugs or combinations of drugs have, under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act, been approved for use in maintenance or detoxification treatment.

''(ii) The drugs or combinations of drugs have not been the subject of an adverse determination. For purposes of this clause, an adverse determination is a determination published in the Federal Register and made by the Secretary, after consultation with the Attorney General, that the use of the drugs or combinations of drugs for maintenance or detoxification treatment requires additional standards respecting the qualifications of physicians to provide such treatment, or requires standards respecting the quantities of the drugs that may be provided for unsupervised use.

''(D)(i) A waiver under subparagraph (A) with respect to a physician is not in effect unless (in addition to conditions under subparagraphs (B) and (C)) the following conditions are met:

''(I) The notification under subparagraph (B) is in writing and states the name of the physician.

''(II) The notification identifies the registration issued for the physician pursuant to subsection (f).

''(III) If the physician is a member of a group practice, the notification states the names of the other physicians in the practice and identifies the registrations issued for the other physicians pursuant to subsection (f).

''(ii) The Secretary shall provide to the Attorney General all information contained in such notifications.

''(iii) Upon receiving information regarding a physician under clause (ii), the Attorney General shall assign the physician involved an identification number under this paragraph for inclusion with the registration issued for the physician pursuant to subsection (f). The identification number so assigned clause shall be appropriate to preserve the confidentiality of patients for whom the physician dispenses narcotic drugs under a waiver under subparagraph (A).

''(E)(i) If a physician is not registered under paragraph (1) and, in violation of the conditions specified in subparagraphs (B) through (D), dispenses narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, the Attorney General may, for purposes of section 304(a)(4), consider the physician to have committed an act that renders the registration of the physician pursuant to subsection (f) to be inconsistent with the public interest.

''(ii)(I) A physician who in good faith submits a notification under subparagraph (B) and reasonably believes that the conditions specified in subparagraphs (B) through (D) have been met shall, in dispensing narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, be considered to have a waiver under subparagraph (A) until notified otherwise by the Secretary.

''(II) For purposes of subclause (I), the publication in the Federal Register of an adverse determination by the Secretary pursuant to subparagraph (C)(ii) shall (with respect to the narcotic drug or combination involved) be considered to be a notification provided

by the Secretary to physicians, effective upon the expiration of the 30-day period beginning on the date on which the adverse determination is so published.

''(F)(i) With respect to the dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, a physician may, in his or her discretion, dispense such drugs or combinations for such treatment under a registration under paragraph (1) or a waiver under subparagraph (A) (subject to meeting the applicable conditions).

''(ii) This paragraph may not be construed as having any legal effect on the conditions for obtaining a registration under paragraph (1), including with respect to the number of patients who may be served under such a registration.

''(G) For purposes of this paragraph:

''(i) The term 'group practice' has the meaning given such term in section 1877(h)(4) of the Social Security Act.

''(ii) The term 'qualifying physician' means a physician who is licensed under State law and who meets one or more of the following conditions:

''(I) The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.

''(II) The physician holds an addiction certification from the American Society of Addiction Medicine.

''(III) The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

''(V) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

''(VI) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

''(VII) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for three years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

''(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Center for Substance Abuse Treatment, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary may issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

''(I) Approval of additional credentialing bodies and the responsibilities of additional credentialing bodies.

''(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

''(ii) Not later than 120 days after the date of the enactment of the Drug Addiction Treatment Act of 2000, the Secretary shall issue a treatment improvement protocol containing best practice guidelines for the treatment and maintenance of opiate-dependent patients. The Secretary shall develop the protocol in consultation with the Director of the National Institute on Drug Abuse, the Director of the Center for Substance Abuse Treatment, the Administrator of the Drug Enforcement Administration, the Commissioner of Food and Drugs, the Administrator of the Substance Abuse and Mental Health Services Administration, and other substance abuse disorder professionals. The protocol shall be guided by science.

''(I) During the 3-year period beginning on the date of the enactment of the Drug Addiction Treatment Act of 2000, a State may not preclude a qualifying physician from dispensing or prescribing drugs in schedule III, IV, or V, or combinations of such drugs, to patients for maintenance of detoxification treatment in accordance with this paragraph unless, before the expiration of that 3-year period, the State enacts a law prohibiting a physician from dispensing such drugs or combinations of drug.

''(J)(i) This paragraph takes effect on the date of the enactment of the Drug Addiction Treatment Act of 2000, and remains in effect thereafter except as provided in clause (iii) (relating to a decision by the Secretary or the Attorney General that this paragraph should not remain in effect).

''(ii) For purposes relating to clause (iii), the Secretary and the Attorney General may, during the 3-year period beginning on the date of the enactment of the Drug Addiction Treatment Act of 2000, make determinations in accordance with the following:

''(I) The Secretary may make a determination of whether treatments provided under waivers under subparagraph (A) have been effective forms of maintenance treatment and detoxification treatment in clinical settings; may make a determination of whether such waivers have significantly increased (relative to the beginning of such period) the availability of maintenance treatment and detoxification treatment; and may make a determination of whether such waivers have adverse consequences for the public health.

''(II) The Attorney General may make a determination of the extent to which there have been violations of the numerical limitations established under subparagraph (B) for the number of individuals to whom a qualifying physician may provide treatment; may make a determination of whether waivers under subparagraph (A) have increased (relative to the beginning of such period) the extent to which narcotic drugs in schedule III, IV, or V or combinations of such drugs are being dispensed or possessed in violation of this Act; and may make a determination of whether such waivers have adverse consequences for the public health.

''(iii) If, before the expiration of the period specified in clause (ii), the Secretary or the Attorney General publishes in the Federal Register a decision, made on the basis of determinations under such clause, that this paragraph should not remain in effect, this paragraph ceases to be in effect 60 days after the date on which the decision is so published. The Secretary shall in making any such decision consult with the Attorney General, and shall in publishing the decision in the Federal Register include any comments received from the Attorney General for inclusion in the publication. The Attorney General shall in making any such decision consult with the Secretary, and shall in publishing the decision in the Federal Register include any comments received from the Secretary for inclusion in the publication.''.

(b) CONFORMING AMENDMENTS.—Section 304 of the Controlled Substances Act (21 U.S.C. 824) is amended—

(1) in subsection (a), in the matter after and below paragraph (5), by striking ''section 303(g)'' each place such term appears and inserting ''section 303(g)(1)''; and

(2) in subsection (d), by striking ''section 303(g)'' and inserting ''section 303(g)(1)''.

SEC. 3. ADDITIONAL AUTHORIZATION OF APPROPRIATIONS REGARDING DEPARTMENT OF HEALTH AND HUMAN SERVICES.

For the purpose of assisting the Secretary of Health and Human Services with the additional duties established for the Secretary pursuant to the amendments made by section 2, there are authorized to be appropriated, in addition to other authorizations of appropriations that are available for such purpose, such sums as may be necessary for fiscal year 2000 and each subsequent fiscal year.

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

The Chair recognizes the gentleman from Virginia (Mr. BLILEY).

GENERAL LEAVE

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material on the bill.

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

There was no objection.

Mr. BLILEY. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, I rise in support of H.R. 2634, the Drug Addiction Treatment Act, a bill I introduced with my colleague from Texas, the gentleman from Texas (Mr. GREEN).

I also would like to acknowledge the other early cosponsors of this bill: the gentleman from Ohio (Mr. OXLEY), the gentleman from Virginia (Mr. BOUCHER), the gentleman from California (Mr. COX), the gentleman from Pennsylvania (Mr. GREENWOOD), the gentleman from North Carolina (Mr. COBLE), the gentleman from Georgia (Mr. NORWOOD), the gentleman from Georgia (Mr. DEAL), the gentleman from New York (Mr. RANGEL), and the gentleman from Michigan (Mr. UPTON). Their assistance in opening up a new

front in the war on drugs will be greatly appreciated by the many American families who have been scourged by drug abuse.

Mr. Speaker, this is a bill that helps those who can least help themselves. Let me relate some of the testimony Mr. Odis Rivers of Detroit, Michigan, shared with the Subcommittee on Health and the Environment of the Committee on Commerce last year. He has been addicted to heroin for 30 years and is undergoing treatment with a drug that this bill would help more physicians prescribe to their patients.

He told the subcommittee that he was back with his wife and family and was enjoying the support of his family. He had won their respect and could again assume his rightful place in their family. As the Detroit Free Press stated on October 3 of last year, this seems like the kind of legislation that should be passed, especially in light of the new University of Michigan research showing that heroin use among teens doubled from 1991 to 1998.

Narcotics traffickers in Colombia, one of the main heroin producing countries for the United States, have been able to broaden their consumer base by offering increasingly pure forms of the drug at lower cost, which has broadened the reach of this drug. Heroin-related emergency room visits have more than quadrupled within the past decade among Americans age 12 to 17. Although the House recently approved $1.3 billion to assist Colombia in drug interdiction, we still have to be concerned about what to do once drugs get through our borders.

This legislation will not solve the drug addiction problem. It does not address the multiplicity of societal concerns that have led to addiction. It does not solve all the problems that keep individuals and families enslaved and encumbered by addiction, but it makes a start.

I ask my colleagues to help someone in their community break from heroin. Join me in voting for H.R. 2634.

Mr. Speaker, I want to also take this opportunity to thank the gentleman from Illinois (Mr. HYDE), the chairman of the Committee on the Judiciary, for his assistance in bringing this legislation to the floor. I am including in the RECORD an exchange of correspondence between our two committees regarding H.R. 2634.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, October 25, 1999.

Hon. TOM BLILEY,
Chairman, House Commerce Committee,
House of Representatives, Washington, DC.

DEAR CHAIRMAN BLILEY: I am writing to you concerning the bill H.R. 2634, the Drug Addiction Treatment Act of 1999.

As you know, this bill contains language which falls within the Rule X jurisdiction of this committee relating to the Controlled Substances Act. I understand that you would like to proceed expeditiously to the floor on this matter. I am willing to waive our committee's right to mark up this bill. However, this, of course, does not waive our jurisdiction over the subject matter on this or similar legislation, or our desire to be conferees on this bill should it be subject to a House-Senate conference committee.

I would appreciate your placing this exchange of letters in the Congressional Record. Thank you for your cooperation on this matter.

Sincerely,

HENRY J. HYDE,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
Washington, DC, October 21, 1999.

Hon. HENRY HYDE,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR HENRY: Thank you for your letter regarding your Committee's jurisdictional interest in H.R. 2634, the Drug Addiction Treatment Act of 1999.

I acknowledge your committee's jurisdiction over this legislation and appreciate your cooperation in moving the bill to the House floor expeditiously. I agree that your decision to forego further action on the bill will not prejudice the Judiciary Committee with respect to its jurisdictional prerogatives on this or similar legislation, and will support your request for conferees on those provisions within the Committee on the Judiciary's jurisdiction should they be the subject of a House-Senate conference. I will also include a copy of your letter and this response in the Committee's report on the bill and the Congressional Record when the legislation is considered by the House.

Thank you again for your cooperation.

Sincerely,

TOM BLILEY,
Chairman.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume, and I want to thank the gentleman from Virginia for turning his attention to the issue of addiction and for providing this body an opportunity to focus on it. Addiction is the number one killer in the United States.

As it happens, the substance that lends addiction that distinction is not heroin but tobacco. Tobacco is responsible for 400,000 deaths a year. Regardless of the substance, though, the message is the same: addiction can kill. The Nation is well served by efforts to combat addiction to killer substances like heroin and tobacco.

I appreciate the gentleman's interest in the heroin treatment initiative contained in this bill. I fully support the spirit of the bill as captured in its title. To win the war against drugs, however, we need to pay as much attention to the demand side of the equation as we do to the supply side. Fighting drugs means fighting drug producers and drug dealers. It also means preventing addiction, and it means treating addiction. In the context of this bill, that means expanding treatment options for heroin addiction.

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Last week, 600,000 Americans used heroin. Last year, 80,000 people were admitted to hospital emergency rooms around the country because of heroin.

There is wide agreement among researchers that heroin is the most underreported of all controlled substances in terms of usage. Some researchers believe as many as three million Americans are heroin abusers. And increasingly, those users are younger and younger.

In 1980, a street bag of heroin was 4 percent pure. Today the average street bag ranges from 40 to 70 percent purity. The drug is stronger. It can be introduced in the body in more ways and still produce a high.

Teenagers who would normally shy away from injecting heroin perceive snorting and inhaling as a safe means of using heroin. They do not think it can kill them. They do not even think it can make an addict of them. They are wrong. Those misconceptions are beginning to show up in the statistics.

Substance abuse counselors are reporting it has been years since they have seen so many cases of heroin addiction among teenagers and young adults.

Buprenorphine can be part of the solution, but there is more to it than that. If we want to fight heroin addiction, if we want to fight drug addiction, we need to reauthorize the Substance Abuse and Mental Health Services Agency, or SAMHSA.

SAMHSA has one of the most difficult jobs of any Federal agency, to reduce the demand for illicit drugs and in that way to save lives.

I am pleased to be an original cosponsor of legislation to reauthorize SAMHSA, H.R. 4867, introduced by my colleague the gentlewoman from California (Mrs. CAPPS).

Mr. Speaker, by reauthorizing SAMHSA this year, we can secure the foundation upon which the success of H.R. 2634 and other legislation devoted to the treatment of drug addiction depends. It is fortunate, then, that the author of H.R. 2634, my respected colleague the gentleman from Virginia (Mr. BLILEY) is in a position to influence whether this body takes action on the bill that the gentlewoman from California (Mrs. CAPPS) has introduced.

The bill of the gentleman from Virginia (Mr. BLILEY) is a modest and a good step. CBO estimates that it may help 10,000 low-income addicts receive treatment. Unfortunately, the need for heroin treatment surpasses that figure 30 fold.

The gentleman from Virginia (Mr. BLILEY) I hope will fulfill the promise of H.R. 2634 by working to ensure committee consideration and passage of the SAMHSA reauthorization bill offered by the gentlewoman from California (Mrs. CAPPS) on a timely basis before we go home.

With all due respect and gratitude to my friend from Virginia, the real drug addiction treatment act is the SAMHSA reauthorization.

Mr. GILMAN. Mr. Speaker, I rise today in support of H.R. 2634, the Drug Addiction Treatment Act of 1999.

H.R. 2634 is designed to amend specific sections of the Controlled Substances Act for practitioners who dispense narcotic drugs as part of a treatment program. In doing this, it

seeks to assist qualified physicians in treating their addicted patients, to speed up approval of narcotic drugs for addiction treatment purposes, and offers treatment options for those Americans for whom other treatment programs are financially out of reach.

This legislation waives the current regulation that physicians obtain the prior approval of the Drug Enforcement Administration, to receive the endorsement of State and regulatory authorities, and dispense only drugs that have been pre-approved by the Food and Drug Administration. This waiver process only applies to those registered physicians who are qualified to dispense controlled substances to treat opiate-dependent patients.

The bill contains a number of safeguards that are designed to prevent abuses of the waiver procedure. The Secretary of Health and Human Services may deny access to the waiver process for any drug the Secretary determines may require more stringent physician qualification standards or more narrowly defined restrictions on the quantities of drugs that may be dispensed for unsupervised use. Physicians also face losing their registration status or even criminal prosecution for violations of the waiver process. Finally, after 3 years, the Attorney General and the Secretary may end availability of the waiver if they determine the process has had adverse public health consequences or to the extent it has led to violations of the Controlled Substances Act.

Mr. Speaker, drug treatment programs form an important component of our national war on drugs. In order for this war to be effective, both demand and supply must be reduced simultaneously. Treatment programs can be an effective method of reducing demand, but require enormous commitment on the part of both doctor and patient. This is especially true for those addicted to opiate narcotics.

This legislation will make it easier for doctors to treat those difficult addiction cases, without permitting gross abuses of the waiver system. The end goal is more successful treatment programs, with shorter durations and lower recidivism rates.

It is important that we utilize all available tools in the war against drugs. For this reason, I urge my colleagues to lend their support to H.R. 2634.

Mr. DINGELL. Mr. Speaker, I rise in support of H.R. 2634, the Drug Addiction Treatment Act. I want to acknowledge the leadership and effort on this issue that has been put forth by my good friend and colleague from the other body, Senator CARL LEVIN. His longstanding interest and acknowledged expertise in the development of effective treatments for drug addiction have been important influences in my deliberations on this matter. I thank him.

Indeed, the language before us contains a number of changes to the bill reported out of the Commerce Committee. These changes reflect provisions adopted and passed by the Senate and represent improvements in the bill.

Mr. Speaker, none of us should leave here thinking that we have done as much as we should to tackle the scourge of drug addiction in this country. Statistics on heroin addiction alone show that interdiction is not completely effective. The advent of narcotic treatments such as buprenorphine are important tools in the panoply of strategies to meet and defeat the drug addiction problem. The bill before us is a modest measure and I challenge us to do more, much more, before we adjourn this session.

Mr. Speaker, my colleague and good friend, Representative CAPPS has introduced legislation to reauthorize programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). I urge swift action on this bill. SAMHSA provides the crucial safety net of programs for those who lack the means to obtain treatment elsewhere. Importantly, SAMHSA's programs address virtually all addiction issues and are not limited to the heroin alone. SAMHSA also provides important prevention programs, unlike the bill before us today. SAMHSA's programs also address co-occurring substance abuse and mental health disorders.

Finally, SAMHSA provides the resources necessary for many of those who are in the ''treatment gap'' to obtain needed services. Today we will hear about stigmas and red tape. In my view, the most significant factor in the treatment gap is lack of adequate resources for those who need treatment. The promise of buprenorphine will be lost on low income persons unless we provide access to treatment for them. The bill before us does not address this important issue, however, Representative CAPPS' bill does, so I hope we will move as expeditiously on that legislation as we are on this legislation. Chairman BLILEY and Chairman BILIRAKIS both promised action on SAMHSA during the hearing and markup of H.R. 2436. Today I remind them of that promise and express my hope that they will take up Representative CAPPS' bill as soon as possible.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of H.R. 2634, and I commend Chairman BLILEY for introducing it and shepherding it to the floor of the House today.

As a family physician, living and working in a district that is medically underserved, I often had to provide coverage to the Methadone Program in our Department of Health. I saw first hand how the use of such drugs could provide an option for treatment which would allow persons suffering from heroin addiction to reconcile with their families, return to work and live productive lives once again.

I also saw how under some circumstances, the need to travel distances on a daily basis to be medicated was in direct conflict with requirements in the workplace, and how it hampered the full reentry of some patients into society.

Drug addiction plagues many in our communities. It destroys individuals, families and undermines those communities. IV drug use, often associated with heroin use, also transmits the HIV virus and thus contributes to the scourge of AIDS.

Today, addicted persons seeking treatment are often turned away. This bill will enable more people to receive treatment, and it will save lives, heal families and support wholesome communities.

I am pleased to support H.R. 2634, and I ask my colleagues to support its passage.

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

Mr. BLILEY. Mr. Speaker, I have no further requests for time, and I urge adoption of the legislation, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. ISAKSON). The question is on the motion offered by the gentleman from Virginia (Mr. BLILEY) that the House suspend the rules and pass the bill, H.R. 2634, as amended.

The question was taken.

Mr. BLILEY. 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.

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INTERNATIONAL PATIENT ACT OF 2000

Mr. SMITH of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2961) to amend the Immigration and Nationality Act to authorize a 3-year pilot program under which the Attorney General may extend the period for voluntary departure in the case of certain nonimmigrant aliens who require medical treatment in the United States and were admitted under the visa waiver pilot program, and for other purposes, as amended.

The Clerk read as follows:

H.R. 2961

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 ''International Patient Act of 2000''.

SEC. 2. THREE-YEAR PILOT PROGRAM TO EXTEND VOLUNTARY DEPARTURE PERIOD FOR CERTAIN NONIMMIGRANT ALIENS REQUIRING MEDICAL TREATMENT WHO WERE ADMITTED UNDER VISA WAIVER PILOT PROGRAM.

Section 240B(a)(2) of the Immigration and Nationality Act (8 U.S.C. 1229c(a)(2)) is amended to read as follows:

''(2) PERIOD.—

''(A) IN GENERAL.—Subject to subparagraph (B), permission to depart voluntarily under this subsection shall not be valid for a period exceeding 120 days.

''(B) 3-YEAR PILOT PROGRAM WAIVER.—During the period October 1, 2000, through September 30, 2003, and subject to subparagraphs (C) and (D)(ii), the Attorney General may, in the discretion of the Attorney General for humanitarian purposes, waive application of subparagraph (A) in the case of an alien—

''(i) who was admitted to the United States as a nonimmigrant visitor (described in section 101(a)(15)(B)) under the provisions of the visa waiver pilot program established pursuant to section 217, seeks the waiver for the purpose of continuing to receive medical treatment in the United States from a physician associated with a health care facility, and submits to the Attorney General—

''(I) a detailed diagnosis statement from the physician, which includes the treatment being sought and the expected time period the alien will be required to remain in the United States;

''(II) a statement from the health care facility containing an assurance that the alien's treatment is not being paid through any Federal or State public health assistance, that the alien's account has no outstanding balance, and that such facility will notify the Service when the alien is released or treatment is terminated; and

''(III) evidence of financial ability to support the alien's day-to-day expenses while in the United States (including the expenses of any family member described in clause (ii))