are narrow, yet essential, improvements to our health care system that may not only change the lives of people with juvenile diabetes but also will reduce costs in our health care system.

The total annual cost of diabetes in 2002 was estimated to be $132 billion. Of that, $23 billion was due to the cost care for complications of diabetes. This is exactly why we need to use new procedures like islet cell transplantation to improve lives and reduce the cost of health care in the United States.

We are at a time of extraordinary opportunity in the field of juvenile diabetes research, and pancreatic islet cell transplantation is just one of the new procedures that gives us great hope. The gentleman from Washington (Mr. NETHERCUTT) and I have been the co-chairs of the Congressional Diabetes Caucus for many years now, and we are pleased to say it is still the largest caucus in Congress. We have seen the technologies improve, and we have worked to improve the coordination and Federal support for diabetes programs. The Pancreatic Islet Cell Transplantation Act continues that work.

Like so many of my colleagues, I support improved scientifically based efforts that will improve patients' lives and even eradicate this disease. Since the science in this area is developing at a rapid pace, additional efforts are needed to ensure that Federal policies and regulatory actions support the momentum.

I want to add my thanks to the gentleman from Texas (Chairman BARTON) and for the gentleman from Michigan (Mr. DINGELL) as well as the Committee on Energy and Commerce staff on both sides of the aisle for their hard work and diligence on this and all of the health bills being considered today.

□ 1430

Their leadership provides exactly the kind of bipartisan cooperation that we need to address significant issues like improving our health care system, that Congress faces today.

I also want to thank the volunteers of the Juvenile Diabetes Research Foundation and the American Diabetes Association. These two organizations have been tireless, and they are to be commended.

Finally, Mr. Speaker, I would like to thank you for all of your hard work in this area over the years.

Pancreatic islet cell transplantation is an incredible innovation in medicine. I urge all of my colleagues to support this bill.

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

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me in summary again commend the gentlewoman from Colorado (Ms. DEGETTE), the gentleman from Michigan (Mr. DINGELL) and all the folks on the minority side that worked with us on this. I want to thank again the gentleman from Washington (Mr. NETHERCUTT) for his work.

This bill is going to pass on suspension, which shows how noncontroversial and bipartisan this particular issue is. But this is a bill that is worthy of considerable celebration because if you have a family member that has diabetes and you have to watch and sometimes help them get their insulin injections, the ability to get an islet cell transplant revolutionizes their life. It is just amazing.

Our problem is that there just are not enough organ donations to make it possible to do this for many people. Hopefully, this legislation will make it possible to get more donations and, over time, perhaps even do the research that can result in being able to replicate the islet cells so that every diabetic in the country that wants one of these transplants can get that.

So I cannot say in stronger terms how happy I am to bring this to the floor, and I would urge unanimous adoption of the bill.

Mr. NETHERCUTT. Mr. Speaker, I rise in strong support of the Pancreatic Islet Cell Transplantation Act and urge my colleagues to pass this bill

As the parent of a daughter with Type 1, or juvenile diabetes, I can tell you that it is a terrible disease. People with diabetes must contend with daily insulin injections and blood tests to monitor glucose levels. Hanging above this constant management is the threatening cloud of complications, such as kidney failure, blindness or amputation that this disease so often brings.

The legislation that we consider today reflects an extraordinary opportunity in the field of juvenile diabetes research. Pancreatic islet transplantation has been hailed as the most important advance in diabetes research since the discovery of insulin in 1921. The procedure, which involves transplanting insulin-producing cells into an individual with juvenile diabetes, has been performed on over 300 individuals, and the majority of them no longer need to take insulin to stay alive. While significant research remains to be done to expand this procedure to all who suffer with juvenile diabetes, its promise is incredibly exciting for families like mine.

My bill seeks to remove some of the non-scientific barriers currently before the scientists racing to perfect this procedure. A shortage of donor pancreata is one of the major obstacles to higher transplant rates. In 2001, approximately 1,800 pancreata were donated and only 500 were available for islet cell transplantation and research. At the same time, more than one million people suffer from juvenile diabetes. Current Federal regulations do not credit organ procurement organizations (OPOs) for harvesting pancreases for islet cell transplantation toward their certification or re-certification. The Pancreatic Islet Cell Transplantation Act alters these regulations to credit OPOs for pancreata used for islet cell transplantation or research.

This legislation provides help for an extremely promising procedure, that in turn offers a great deal of hope to the millions of Americans with juvenile diabetes. It gives me great pride to have introduced this bill, and I urge my colleagues to support this legislation.

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

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

The SPEAKER pro tempore (Mr. FOSSELLA). The question is on the motion offered by the gentleman from Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 3858.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

ASTHMATIC SCHOOLCHILDREN'S TREATMENT AND HEALTH MANAGEMENT ACT OF 2004

Mr. BARTON of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2023) to give a preference regarding States that require schools to allow students to self-administer medication to treat that student's asthma or anaphylaxis, and for other purposes, as amended.

The Clerk read as follows:

H.R. 2023

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 ''Asthmatic Schoolchildren's Treatment and Health Management Act of 2004''.

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.

(2) In 1980, 6,700,000 Americans had asthma.

(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.

(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.

(5) In 2000, there were 1,800,000 asthma-related visits to emergency departments (more than 728,000 of these involved children under 18 years of age).

(6) In 2000, there were 465,000 asthma-related hospitalizations (214,000 of these involved children under 18 years of age).

(7) In 2000, 4,487 people died from asthma, and of these 223 were children.

(8) According to the Centers for Disease Control and Prevention, asthma is a common cause of missed school days, accounting for approximately 14,000,000 missed school days annually.

(9) According to the New England Journal of Medicine, working parents of children with asthma lose an estimated $1,000,000,000 a year in productivity.

(10) At least 30 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 18 States expand this protection to epinephrine auto-injectors.

(11) Tragic refusals of schools to permit students to carry their inhalers and auto-injectable epinephrine have occurred, some resulting in death and spawning litigation.

(12) School district medication policies must be developed with the safety of all students in mind. The immediate and correct use of asthma inhalers and auto-injectable epinephrine are necessary to avoid serious respiratory complications and improve health care outcomes.

(13) No school should interfere with the patient-physician relationship.

(14) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within

minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

(15) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.

SEC. 3. PREFERENCE FOR STATES THAT ALLOW STUDENTS TO SELF-ADMINISTER MEDICATION TO TREAT ASTHMA AND ANAPHYLAXIS.

(a) AMENDMENTS.—Section 399L of the Public Health Service Act (42 U.S.C. 280g) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following:

''(d) PREFERENCE FOR STATES THAT ALLOW STUDENTS TO SELF-ADMINISTER MEDICATION TO TREAT ASTHMA AND ANAPHYLAXIS.—

''(1) PREFERENCE.—The Secretary, in making any grant under this section or any other grant that is asthma-related (as determined by the Secretary) to a State, shall give preference to any State that satisfies the following:

''(A) IN GENERAL.—The State must require that each public elementary school and secondary school in that State will grant to any student in the school an authorization for the self-administration of medication to treat that student's asthma or anaphylaxis, if—

''(i) a health care practitioner prescribed the medication for use by the student during school hours and instructed the student in the correct and responsible use of the medication;

''(ii) the student has demonstrated to the health care practitioner (or such practitioner's designee) and the school nurse (if available) the skill level necessary to use the medication and any device that is necessary to administer such medication as prescribed;

''(iii) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and

''(iv) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan formulated under clause (iii) and other documents related to liability.

''(B) SCOPE.—An authorization granted under subparagraph (A) must allow the student involved to possess and use his or her medication—

''(i) while in school;

''(ii) while at a school-sponsored activity, such as a sporting event; and

''(iii) in transit to or from school or school-sponsored activities.

''(C) DURATION OF AUTHORIZATION.—An authorization granted under subparagraph (A)—

''(i) must be effective only for the same school and school year for which it is granted; and

''(ii) must be renewed by the parent or guardian each subsequent school year in accordance with this subsection.

''(D) BACKUP MEDICATION.—The State must require that backup medication, if provided by a student's parent or guardian, be kept at a student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

''(E) MAINTENANCE OF INFORMATION.—The State must require that information described in subparagraphs (A)(iii) and (A)(iv) be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection creates a cause of action or in any other way increases or diminishes the liability of any person under any other law.

''(3) DEFINITIONS.—For purposes of this subsection:

''(A) The terms 'elementary school' and 'secondary school' have the meaning given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965.

''(B) The term 'health care practitioner' means a person authorized under law to prescribe drugs subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act.

''(C) The term 'medication' means a drug as that term is defined in section 201 of the Federal Food, Drug, and Cosmetic Act and includes inhaled bronchodilators and auto-injectable epinephrine.

''(D) The term 'self-administration' means a student's discretionary use of his or her prescribed asthma or anaphylaxis medication, pursuant to a prescription or written direction from a health care practitioner.''.

(b) APPLICABILITY.—The amendments made by this section shall apply only with respect to grants made on or after the date that is 9 months after the date of the enactment of this Act.

SEC. 4. SENSE OF CONGRESS COMMENDING CDC FOR ITS STRATEGIES FOR ADDRESSING ASTHMA WITHIN A COORDINATED SCHOOL HEALTH PROGRAM.

The Congress—

(1) commends the Centers for Disease Control and Prevention for identifying and creating ''Strategies for Addressing Asthma Within a Coordinated School Program'' for schools to address asthma; and

(2) encourages all schools to review these strategies and adopt policies that will best meet the needs of their student population.

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

The Chair recognizes the gentleman from Texas (Mr. BARTON).

GENERAL LEAVE

Mr. BARTON of Texas. 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. 2023, as amended.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I yield myself of such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 2023, the Asthmatic Schoolchildren's Treatment and Health Management Act, sponsored by the Energy and Commerce subcommittee chairman, the gentleman from Florida (Mr. STEARNS).

Over the past 15 years, the number of Americans diagnosed with asthma has nearly doubled to an estimated 17 million people, including 5 million children. The Federal Government has invested significant resources to strengthen and improve asthma research and prevention activities. The Department of Health and Human Services fiscal 2005 budget request includes approximately $321 million for direct asthma programs.

When asthma strikes, airways in the lungs become inflamed and constricted, causing coughing, wheezing and difficulty breathing. Each year, nearly half a million Americans are hospitalized and, unfortunately and sadly, more than 5,000 die from asthma. Several medications, when properly administered in a timely fashion, are now available to treat asthma and/or anaphylaxis.

Unfortunately, some schools do not permit students to self-administer medication for asthma even though the parent or guardian of the student has authorized the use of the medication and it is recommended by a health care provider, resulting in an unnecessary delay of potentially life-saving treatments.

H.R. 2023 directs the Secretary of Health and Human Services to give preference when making asthma-related grants to States that require schools to allow students to self-administer medications. H.R. 2023 does not federally mandate that States allow children to carry prescribed asthma medication in schools. The intent of the bill is to incentivize States to do the right thing by granting preference for asthma-related health program dollars to the States that have regulations that put the parents' and the children's safety first.

Mr. Speaker, I can say, as one of the founding members of Asthma Awareness Day here on Capitol Hill, I am very proud that now as chairman of the Committee on Energy and Commerce, with the strong support and leadership of the gentleman from Florida (Mr. STEARNS), we can bring this bill forward. I would urge its adoption.

Mr. Speaker, I ask unanimous consent to yield the balance of my time to manage the bill to the subcommittee chairman, the gentleman from Florida (Mr. STEARNS).

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

There was no objection.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, millions of Americans, including my wife, suffer from asthma. In a classroom of 30 children, on the average, three are likely to have asthma. The disease killed more than 200 American children in the year 2000. Some States, however, prohibit children from carrying emergency asthma medicine to school. Some of these prohibitions occur despite the fact that parents have authorized the medication's use. This creates an unnecessary delay in administering these medications, when it only takes seconds for an asthma attack sometimes to turn deadly.

The ASTHMA Act, H.R. 2023, encourages States to modernize their laws. I commend my friend the gentleman from Florida (Mr. STEARNS) for his leadership on this legislation and my friend, the gentleman from New York (Mr. TOWNS), for introducing the proposal.

The Centers for Disease Control and Prevention has done terrific work in examining and recommending strategies for combating asthma in school-

based situations and has laid out six strategies for addressing asthma in schools. This bill also commends those efforts.

Allowing children to self-administer their asthma medication will save lives and will make our schools healthier and safer. I am pleased to support this important legislation.

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

Mr. Speaker, I am proud also to author this bill, H.R. 2023, the Asthmatic Student Treatment and Health Management Act, ASTHMA, with my colleague, the gentleman from Rhode Island (Mr. KENNEDY). He and I have been working together on this for some time, and we are pleased it came to the House floor today. It has been a long haul.

I also want to thank the gentleman from Texas (Chairman BARTON) for his early support and providing the leadership in this whole series of legislative initiatives. We introduced this bill, the gentleman from Rhode Island (Mr. KENNEDY) and I, in 2003 on Asthma Awareness Day. Frankly, I think it has been building momentum ever since.

This bill provides incentives for States to guarantee students can carry and use prescribed asthma medication while they are at school. It is not a mandate, and, frankly incurs no new spending.

The ''zero tolerance'' movement of the 1980s and 1990s had the unintended consequence of depriving students of immediate access to their prescribed medication. Often there is a signaling effect in the States or industry merely from the existence of Federal legislation, sort of a chilling effect. I think our bill elevated the conversation here in the United States in school boards and State legislatures.

Because of this discussion, we now have 31 ''asthma-friendly'' States, such as my own State of Florida. Furthermore, of these 31, 19 extend their protection even further to anaphylaxis medication, like epinephrine autoinjectors. On Asthma Awareness Day, May 7, 2003, when we first started this, at that time there were only 20 States, and only nine with this extra protection.

As mentioned earlier, over 6.3 million children under the age of 18 suffer from asthma, probably more than that when you realize a lot of people do not even admit to having asthma. It is the most common cause of missed school days, 14 million annually. It costs us tremendously in lost time, learning, lost productivity and earnings of parents, and medical expenses, including costly emergency room visits, not to mention the enormous amount of stress for people involved, the parents and children.

September 22, 2003, a Newsweek magazine article cover story, as you will remember, said, ''Your Child's Health and Safety: The Latest on Allergies and Asthma.'' ''The Allergy Epidemic'' pointed out, ''We have conquered most childhood infections, but,'' and this is what is important, ''extreme reactions to everyday substances still pose a new threat.''

We read about David Adams of Georgia, whose acute allergic reaction to peanuts was stanched by a quick epinephrine injection, ''never sets foot outside his home without an emergency supply of epinephrine.''

This ''Fighting for Air'' article states, ''Asthma among children has more than doubled over the past 20 years,'' and at Chicago's Hughes Elementary School, ''at this school of 500 students, an astonishing one-third have asthma.'' Second grader Zeron Moody ''just wants to play without gasping'' for air.

When asthma attacks, every minute counts. Sadly, there have been tragedies when a school child is prevented from swift access to his or her asthma medication. A student who must go to the nurse's office, even if there is a school nurse, to get his or her prescribed, life-saving medication, just may run out of time for the initial treatment that could save his or her life.

There is a 2002 article in a magazine called Reason entitled ''Asthma Attack: When Zero Tolerance Collides with Children's Health.'' I just want to share the horror of a 1991 death of a New Orleans high school student, Catrina Lewis, who was simply delayed by security guards before being allowed to get to her inhaler from the office. When finally it did not help, she asked the school staff to call an ambulance. Instead, they spent a half-hour trying to call her mother first.

Catrina's sister, another student, finally called 911, but unfortunately, tragically, the emergency help arrived too late. Catrina's death resulted in more than heartbreak, but a legal judgment against the principal, the counselor and school board. Obviously, in this case no one comes out the winner.

Medical providers prescribe safe, legal treatment, along with instructions on how to self-administer to patients diagnosed with asthma and severe allergies. Along with parental support, it just makes good medical sense to allow a student to treat him or herself and avoid this possible tragedy in the classroom.

I would like to remind young people with asthma in this country that throughout history there have been people we know or believe had asthma, but they still accomplished great things; not because they had asthma, but because they did not let it stop them from finding greatness, achievement.

In the past 3 years, I have shared stories about President Theodore Roosevelt and the Italian composer, priest and musician, Antonio Vivaldi. In Congress, for Asthma Awareness Day we hosted famous athletes who currently have and suffer from asthma. But, frankly, they do not let it slow them down, and they still pursue their career: Jerome Bettis of the Pittsburgh Steelers, who just last Sunday scored two touchdowns, I say to my colleagues; and Jackie Joyner-Kersee, Olympic heptathlete, most of us do not know what that is, but that is an individual that competes in seven track and field events.

I would also like to point out another sober but timely point that there may arise emergencies where a schoolchild with asthma simply, simply needs to have his or her vital medication close at hand and not locked in a desk drawer across the campus. We sadly just never know these days when a homeland security event might call for a lockdown at a school, for students to ''shelter in place.''

If this happens, that is why this bill is important. We want every child to have his or her lifesaving medication on their person and not in a shelter-in-place, in a lockdown position.

In conclusion, Mr. Speaker, H.R. 2023 is an important step for the health of school children, for parental rights, and for trust in the physician-patient-parent relationship and judgment.

□ 1445

Again, I appreciate the support of my colleague, the gentleman from Rhode Island (Mr. KENNEDY), and I appreciate the gentleman from Texas (Chairman BARTON) for moving this bill, and the gentleman from Florida (Chairman BILIRAKIS) for marking it up in the Subcommittee on Health. We made great progress. We need the Senate to follow through, and we need to pass this bill today, and I encourage its swift passage in the Senate.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield 7 minutes to the gentleman from Rhode Island (Mr. KENNEDY), my friend.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I rise today as the lead Democratic cosponsor of the ASTHMA Act of 2003, and I want to acknowledge my good friend and partner, the gentleman from Florida (Mr. STEARNS), for his excellent leadership on this matter. As my colleagues have just heard him speak, he has spoken very eloquently to the case that we are making through this legislation.

I think he illustrated better than anything else the reason why we are pushing this legislation when he talked about the story of Catrina Lewis. We in Rhode Island, and those stories are happening all over the country; in Rhode Island, we have a family, the father, Walter Stone, and the mother, Lynn Stone, lost their daughter, Morgan. She was a mild asthmatic. She was attending college and was killed when her asthma overcame her and she was not able to gain access to her medications.

This is a life-and-death issue. Unfortunately, many States have made it a liability for those students to carry their inhalers to school when those students need their medications. If

they have not registered them in the nurse's office, for example, they are subject to all kinds of punishment. Then again, if they need their medication, as those of us who have asthma, like myself, know very well, it can come on you very quickly; and if you do not have your medication available, you can have a much worse time of it. Tragically, as we have seen in Catrina Lewis's case and in Morgan Stone's case, it can be fatal.

The gentleman from Florida (Mr. STEARNS), my good colleague, was talking about the fact that we have 5,000 people die every year of asthma. This is quite extraordinary when people consider that asthma must not be that big a deal because when people suffer from asthma, it does not look like they are suffering. That is the biggest impediment for people in this country when approaching asthma, the fact that most people, when seeing an asthmatic, do not see the suffering that an asthmatic goes through when they are having an asthma attack, or do not see the suffering that someone is going through when they have an anaphylactic shock attack because of allergies to food.

Many times people do not take this seriously, and it is for just that reason that we need to pass this legislation. It is because many school districts do not take this seriously that we have had the situation where too many young people have had to go through unspeakable suffering as a result of an asthma attack that could have been treated, or they have even suffered death because of the fact that they did not have access to their medications. That is why we need to pass this legislation.

We have heard eloquently from the gentleman from Florida (Mr. STEARNS) about the statistics. But the fact remains, with all of the statistics, it is important that people keep in mind that asthma is the single leading cause of missed school days in this country.

Unfortunately, more and more children suffering from asthma are uninsured and do not have access to medications, so we also need to talk about that. Unfortunately, that cannot be incorporated in this legislation, but I know the gentleman from Florida (Mr. STEARNS) and I both will work hard to make sure that asthma medication is available to our children who are not otherwise covered by health insurance. And the reason for that is simple: Our children are making the emergency room their primary source of medical care when they have asthma attacks and, as any physician or parent can tell us, this is the worst kind of health care policy we can have in this country.

We need to do more through the Centers for Disease Control to alert families about asthma and to educate families about how to help them manage their child's asthma if their children have asthma. These things can make an enormous difference in a family's life, and certainly those are also objectives that we need to follow as well.

Mr. Speaker, I know the gentleman from Florida (Mr. STEARNS) and I both owe a special debt of gratitude to Nancy Sanders, who is President and founder of the Allergy and Asthma Network of Mothers of Asthmatics. She has really encapsulated all of these issues through her advocacy, and she speaks on behalf of all mothers of asthmatics when she testifies as she does, and her partner in this effort, Marissa Magnetti, who has also worked very hard to get this bill to the floor. I want to thank both of them for their good work in getting this bill to the floor.

Mr. Speaker, I want to thank once again my colleagues in the Congress who have been helping us, the gentleman from Texas (Mr. BARTON) for his work in passing this in the committee; and of course, I want to thank the gentleman from Florida (Mr. STEARNS) for his good work and partnership on this legislation.

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

Mr. Speaker, I want to thank my colleague also for mentioning Nancy Sanders, because I was going to save the best for last, Nancy Sanders, the director of Mothers of Asthmatics, Allergy and Asthma Network; without her energy and her time, we probably would not be here today.

So in large measure, this is a case where government is acting, Congress is acting, but it is because of her and all her volunteers and supporters have made this a major objective and mission for their actions to try and bring to bear all of the resources of the private sector so that we in the government are aware of this problem.

I know from some of the hearings that we have had, that both the gentleman from Rhode Island (Mr. KENNEDY) and I have shared, and we have had many panels come out and speak, all of this was organized by Nancy Sanders. So it is to her credit this bill is on the floor today, because of her hard work.

So I appreciate the gentleman from Rhode Island (Mr. KENNEDY) bringing that to the attention of the floor, and I want to echo that, how important it is to have Nancy Sanders.

Mr. KENNEDY of Rhode Island. Mr. Speaker, will the gentleman yield?

Mr. STEARNS. I yield to the gentleman from Rhode Island.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I thank my colleague for yielding.

She is working, as all of us are, on a number of these other agenda items in helping to assist those who suffer from asthma and allergy attacks. We have worked on more notification for families when purchasing food products to know what is in those food products so that they can be alerted to any food type that may trigger anaphylactic shock. And I know that these and many other issues are ones that we are going to need to continue to work for in the years ahead.

I thank my colleague for his effort on this and many others of these issues.

Mr. STEARNS. Mr. Speaker, reclaiming my time, I would just give a concluding remark. Not often when we come to the House floor do we have legislation that will save lives. I had this experience when I was working on the defibrillator bill, which the gentleman from Ohio (Mr. BROWN) is going to offer later on, which is another one of those bills that will actually save lives. And this is one that will save lives, not to mention the huge amount of stress that will be alleviated by parents' knowing that their children will have their medication with them at school.

Ms. JACKSON-LEE of Texas. Mr. Speaker, H.R. 2023, the Asthmatic Schoolchildren's Treatment and Health Management Act of 2003, provides incentives to States to help guarantee the rights of students to carry and use prescribed lifesaving asthma and anaphylaxis medications while at school.

Many students attend schools in States where State and/or local statute prohibits them from carrying their prescribed asthma medication on their person. Worse, anaphylaxis, including the loss of breathing, can accompany a severe asthmatic attack. In an onset of asthma or an anaphylactic attack, every minute counts, and a schoolchild who has to go to a teacher's desk or school nurse's office to get his or her asthma medication may not have sufficient time to initiate treatment.

I am pleased to be a cosponsor of this legislation, and just in the past year and a half since we introduced H.R. 2023, many States are passing laws protecting these students. We now have 31 States that permit students to possess and self-administer asthma medication, such as albuterol inhalers. Of these 31, 19 extend that protection even further to include anaphylaxis medication, such as epinephrine auto-injectors. A year and a half ago, there were only 20 States with statutes that protected students to possess and self-administer inhalers, and only 9 of those allowed permission for epinephrine auto-injectors. Great progress has been made, and your vote for H.R. 2023 can only encourage further success.

In my State of Texas, approximately 900,000 adults, or 6 percent of the population, currently have asthma. Children are particularly hard hit in having asthma—which really can take away the joy of being a child.

H.R. 2023 encourages states to pass asthma-friendly legislation, without new spending, without mandates. This bill directs the Secretary of Health and Human Services to give preference to a State's asthma and anaphylaxis medication statutes when awarding grants for asthma-related programs under its Department (such as Centers for Disease Control and Prevention studies). It offers a gentle incentive for States to take this easy, healthy step for its young citizens. My State of Texas could greatly benefit from such an incentive, as we have a high asthma rate and still do not guarantee the rights of children to carry their own asthma medication.

Mr. ENGEL. Mr. Speaker, I rise in support of H.R. 2023, the Asthmatic Schoolchildren's Treatment and Health Management Act of 2004. As a cosponsor of this important legislation, I look forward to its quick enactment. Asthma has had a tremendous impact on our

Nation's health. I represent the Bronx, Westchester and Rockland County in New York, and our community has been hit very hard by asthma, especially our children. My family has experienced first-hand the effects of asthma. My wife has asthma and two of my kids do as well. So I know how important it is that people, especially children, have access to care and have the medicine they need when they need it.

According to the NYC Department of Health in the Bronx, about 25 percent of children in the Bronx have asthma, as opposed to 15 percent nationwide. Hospitalization rates for children are around ten times higher than the national average. The Bronx, in particular, leads New York City in asthma-related hospitalizations and deaths. Audrey Dregante, a Nurse Practitioner at Bronx Lebanon Hospital Pediatric Asthma Center has stated that ''Pediatric Asthma is an epidemic in the Bronx.''

There are many factors contributing to asthma that can easily be addressed and would save lives and greatly enhance the quality of life for so many suffering with asthma. Some of the factors contributing to the disease are inadequate housing conditions, such as mold in homes, dust mites and insects, and the lack of proper ventilation. The poor are less likely to have health care and use emergency room care as their primary care provider, and are not getting the proper treatment. Low-birth weight babies are surviving in greater numbers and problems with lung development may be leading to the rise in asthma cases. Early diagnosis and treatment is critical in these instances, as well as pre-natal care for the poor. The increasing amounts of pollution and congestion in urban areas caused by traffic and diesel-powered trucks and buses increase the risk for asthma.

Children in particular have a difficult time with asthma and, as we know, proper treatment and control of the disease in crucial. the legislation before us today seeks to rectify one situation that is preventing children from even carrying their asthma medication. Amazingly, many states do not allow kids to self-administer their asthma medications in school, which can lead to severe conditions if proper treatment is not available in time. New York does allow kids to carry and administer their asthma medication. I believe it is irrational and irresponsible to prohibit children from having their medication readily available. H.R. 2023 would encourage schools to allow children to carry their asthma medication by giving those schools preference when awarding public health and asthma-related grants. I think this is positive legislation that will encourage school districts to allow their children to carry and self-administer their asthma medicine, which will improve their condition and could save their lives. I urge my colleagues to support this legislation.

Mr. DAVIS of Illinois. Mr. Speaker, I rise today in support of H.R. 2023, the Asthmatic Schoolchildren's Treatment and Health Management Act. Nearly one-third of all people with asthma in our Nation are children under the age of 18, according to the American Lung Association. This figure translates to more than 6.3 million children. Asthma is now the most common, serious, chronic disease among children, accounting for 14 million absences from school each year.

I commend this legislation and believe it is great to allow students to self-administer medication to treat that student's asthma. We are encouraging the child to control their condition with correct management of it as well as giving them the responsibility to go get their nebulizer for a breathing treatment or get their inhaler when they know they need it. However, we still need to do more for our asthmatic children through education and outreach. Doctors say that asthma is a disease that can be managed, treated and prevented. Yet across our country, in cities like Chicago, there are no centralized asthma programs, and many States do not keep an up-to-date count of how many children have the disease.

We have seen asthma continue to strike black children the hardest, especially those who live in low-income areas. The 2002 National Health Interview Survey, a project of the CDC, found that 12 percent of all children under age 18 were asthmatic, and half had suffered an attack in the previous year. Black and low-income families get it far more often: 18 percent of black children had been diagnosed with asthma, and 9 percent had suffered attacks, versus 10 and 4 percent for Latino children, and 11 and 5 percent for whites. Due to a lack of health care, crowded housing, and more exposure to asthma triggers such as cockroach feces and dust mites, the asthma rate was also higher for children from families whose incomes were less than $20,000 a year.

Although, most children have mild to moderate problems, and their illness can be controlled by treatment at home, too many of our asthmatic children are ending up in our emergency rooms. The CDC reports that in 1999, 658,000 pediatric emergency room visits were due to asthma. The estimated annual rate for emergency room visits among children 5 years old or younger is 137.1 per 10,000 persons—the highest rate of all age groups. Asthma cost more than $4.6 billion in medical care and time lost from school or work. African Americans have nearly four times the asthma related emergency room visits as whites and are more than three times as likely than whites to be hospitalized for asthma.

Mr. Speaker, unfortunately, Chicago, where I reside, is commonly called an epicenter of the Nation's asthma epidemic. I believe that my State of Illinois, Chicago and our Congress need to encourage that more is done to help our asthmatic children, like education and, as the doctors suggest, managing, treating and prevention of this disease as a way to keep more of our kids out of the emergency rooms.

Mrs. CHRISTENSEN. Mr. Speaker, I rise today to join my colleague Congressman CLIFF STEARNS of Florida in the passage of H.R. 2023, the Asthmatic Schoolchildren's Treatment and Health Management Act of 2004. Mr. Speaker, as a medical doctor I know of nothing more important to a patient than the ability to access his/her medication. The bill before us today underscores this critical component in the continuum of care as it relates to asthma and school-age children.

I am grateful to Mr. STEARNS for introducing this important piece of legislation and will be working forward to its impact in African American and medically underserved communities. As you know, Mr. Speaker, asthma is the 6th-ranking chronic condition in the U.S., and the leading serious chronic illness of children in the U.S., and has a significant impact on African Americans. Not only do African Americans have a higher asthma prevalence rate than Caucasians, but they are also more likely to be hospitalized or die due to asthma.

Data released in 2003 by the Centers for Disease Control and Prevention stated that the lifetime prevalence rate is 29 percent higher in African Americans than in Caucasians. The asthma attack prevalence rate in African Americans is 37 percent higher than in Caucasians, and the asthma attack prevalence rates in African-Americans are highest among children under the age of 5.

The CDC also noted that African Americans have nearly four times the asthma-related emergency room visits than Caucasians and that African Americans are more than three times more likely than Caucasians to be hospitalized for asthma. Finally, African Americans are three times more likely than Caucasians to die from asthma and more African American women die from asthma than any other group.

A recent study by Guido R. Zanni and Jeannette Wick, entitled Counseling Inner-City Youth with Asthma, found that approximately 1 in 13 school-age children is affected—an increase of 72.3 percent since the 1980s. Asthma-related absenteeism amounted to 14 million missed school days in 2000.

The researchers noted that the inner cities have unique challenges with asthma-causing agents: Tobacco and cooking smoke, indoor allergens, bioaerosols and other air pollutants, respiratory infections, and stress. Up to 59 percent of inner-city pediatric asthma sufferers live in homes with environmental tobacco smoke. Sensitivity to allergens is typical of pediatric asthma. Most inner-city children (94 percent are highly sensitive to inhalant allergens, and 76 percent are sensitive to 3 or more allergens. Approximately 36 percent have cockroach sensitization. Combining cockroach sensitization with regular exposure significantly increases asthma-related hospitalizations, emergency room visits, school absenteeism, and lost sleep.

The researchers noted some of the causes of nonadherence to asthma medication regimens by school-age children are created by parental health beliefs, the use of multiple care providers, the lack of a comprehensive asthma-management plan, psychosocial stressors, inadequate attention to triggers and early warning signals, and inadequate environmental allergen control. They also noted that many schools have a zero-tolerance drug policy, forcing students to smuggle and take their asthma medications discreetly or leave their medications at home.

Mr. Speaker, I believe that H.R. 2023 is a step in the right direction towards eliminating health disparities by making grants available to States, with a preference to States that require public elementary and secondary schools to allow students to self-administer medication to treat that student's asthma or anaphylaxis under specified conditions.

Again, Mr. Speaker, I believe that this bill is a measure that safeguards the health of children with asthma and urge my colleagues to support it.

Mr. ENGEL. Mr. Speaker, asthma has had a tremendous impact on our Nation's health. I

represent the Bronx, Westchester and Rockland County in New York, and we have been hit very hard by asthma, especially our children.

According to the NYC Department of Health, in the Bronx about 25 percent of children have asthma, as opposed to 15 percent Nationwide; hospitalization rates for children are around ten times higher than the national average; and the Bronx, in particular, leads New York City in asthma-related hospitalizations and deaths. Audrey Dregante, a nurse practitioner at Bronx Lebanon Hospital, Pediatric Asthma Center has stated that "Pediatric Asthma is an epidemic in the Bronx."

There are many factors contributing to asthma that can easily be addressed and would save lives and greatly enhance the quality of life for so many suffering with asthma. Many of these factors have to do with the economic status of those with asthma and the fact that they are not educated on the treatments available. Some of the factors contributing to the disease are inadequate housing conditions—impoverished conditions such as mold in homes, dust mites and insects, and the lack of proper ventilation; the poor are less likely to have health care and use emergency room care as their primary care provider and are not getting the proper treatment; low-birth weight babies are surviving in greater numbers, and problems with lung development may be leading to the rise in asthma cases—early diagnosis and treatment is critical in these instances, as well as pre-natal care for the poor; and the increasing amounts of pollution and congestion in urban areas caused by traffic and diesel-powered trucks and buses.

Children in particular have a difficult time with asthma and, as we know, proper treatment and control of the disease is crucial. The legislation before us today seeks to rectify one situation that is preventing children from even carrying their asthma medication. Amazingly, many States do not allow kids to self-administer their asthma medications in school, which can lead to severe conditions if proper treatment is not available in time.

New York does allow kids to carry and administer their asthma medication. I believe it is irrational and irresponsible to prohibit children from having their medication readily available. H.R. 2023 would encourage schools to allow children to carry their asthma medication by giving those schools preference when awarding public health and asthma-related grants.

I think this is positive legislation that will encourage school districts to allow their children to carry and self-administer their asthma medicine, which will improve their condition and could save their lives. I urge my colleagues to support this legislation.

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

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

The SPEAKER pro tempore (Mr. FOSSELLA). The question is on the motion offered by the gentleman from Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 2023, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MAMMOGRAPHY QUALITY STANDARDS REAUTHORIZATION ACT OF 2004

Mr. BARTON of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H. R. 4555) to amend the Public Health Service Act to revise and extend provisions relating to mammography quality standards, as amended.

The Clerk read as follows:

H.R. 4555

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 ''Mammography Quality Standards Reauthorization Act of 2004''.

SEC. 2. TEMPORARY RENEWAL AND LIMITED PROVISIONAL CERTIFICATE.

Section 354 of the Public Health Service Act (42 U.S.C. 263b) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''or a temporary renewal certificate'' after ''certificate''; and

(ii) in clause (i), by striking ''subsection (c)(1)'' and inserting ''paragraphs (1) or (2) of subsection (c)'';

(B) in subparagraph (B)—

(i) in the matter preceding clause (i), by inserting ''or a limited provisional certificate'' after ''certificate''; and

(ii) in clause (i), by striking ''subsection (c)(2)'' and inserting ''paragraphs (3) and (4) of subsection (c)''; and

(C) in the flush matter at the end, by striking ''provisional certificate'' and inserting ''temporary renewal certificate, provisional certificate, or a limited provisional certificate''; and

(2) in subsection (c)—

(A) by redesignating paragraph (2) as paragraph (4); and

(B) by inserting after paragraph (1) the following:

''(2) TEMPORARY RENEWAL CERTIFICATE.—The Secretary may issue a temporary renewal certificate, for a period of not to exceed 45 days, to a facility seeking reaccreditation if the accreditation body has issued an accreditation extension, for a period of not to exceed 45 days, for any of the following:

''(A) The facility has submitted the required materials to the accreditation body within the established time frames for the submission of such materials but the accreditation body is unable to complete the reaccreditation process before the certification expires.

''(B) The facility has acquired additional or replacement equipment, or has had significant personnel changes or other unforeseen situations that have caused the facility to be unable to meet reaccreditation timeframes, but in the opinion of the accreditation body have not compromised the quality of mammography.

''(3) LIMITED PROVISIONAL CERTIFICATE.—The Secretary may, upon the request of an accreditation body, issue a limited provisional certificate to an entity to enable the entity to conduct examinations for educational purposes while an onsite visit from an accreditation body is in progress. Such certificate shall be valid only during the time the site visit team from the accreditation body is physically in the facility, and in no case shall be valid for longer than 72 hours. The issuance of a certificate under this paragraph, shall not preclude the entity from qualifying for a provisional certificate under paragraph (4).''.

SEC. 3. NATIONAL ADVISORY COMMITTEE.

Section 354(n) of the Public Health Service Act (42 U.S.C. 263b(n)) is amended—

(1) in paragraph (2), by striking subparagraph (C) and all that follows and inserting the following:

''(C) other health professionals,

whose clinical practice, research specialization, or professional expertise include a significant focus on mammography. The Secretary shall appoint at least 4 individuals from among national breast cancer or consumer health organizations with expertise in mammography, at least 2 industry representatives with expertise in mammography equipment, and at least 2 practicing physicians who provide mammography services.''; and

(2) in paragraph (4), by striking ''biannually'' and inserting ''annually''.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

Subparagraphs (A) and (B) of section 354(r)(2) of the Public Health Service Act (42 U.S.C. 263b(r)(2)(A) and (B)) are amended by striking ''2002'' each place it appears and inserting ''2007''.

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

The Chair recognizes the gentleman from Texas (Mr. BARTON).

GENERAL LEAVE

Mr. BARTON of Texas. 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 this legislation.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of H.R. 4555, the Mammography Quality Standards Act. I want to commend my good friend and ranking minority member, the gentleman from Michigan (Mr. DINGELL) for bringing the bill forward.

It is particularly fitting that the House is considering this bill today, as the month of October is formally recognized as National Breast Cancer Awareness Month. It is estimated that this year over 200,000 women will be diagnosed with breast cancer. Like many other diseases, early detection of breast cancer is critical to saving lives. Right now, mammograms are the best screening tool available to women to help detect breast cancer at an early age.

In 1992, Congress enacted the Mammography Quality Standards Act to ensure that all women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages. The MQSA provides that screening and diagnostic services must be accredited and certified by the Food and Drug Administration. H.R. 4555 reauthorizes the Act through fiscal year 2007.

The bill includes a new provision to permit the Secretary of Health and Human Services to issue a temporary renewal certificate or a limited provisional certificate to any facility seeking reaccreditation under MQSA. The legislation also permits the Secretary to appoint individuals with expertise in