□ 1710

So if this plague of methamphetamine has not come to your hometown, unfortunately, it will soon, and it's something that requires a Federal component.

This is a good bill. I urge the entire House to stand together and pass this piece of legislation, thanking the committees of jurisdiction and the original sponsor, Mr. BART GORDON of Tennessee.

Mr. PALLONE. Mr. Speaker, I continue to reserve.

Mr. WHITFIELD. When you talk to law enforcement officers anywhere in America today, they will tell you that about 80 percent of the crimes committed in America are the direct result of some type of drug. Methamphetamine is certainly one of those.

In Kentucky, we have the Pennyrile Drug Task Force. And when I think about the passage of this legislation, I think of a gentleman named Cheyenne Albro who started that task force and who was a true leader in combatting methamphetamine and who, unfortunately, died a couple of weeks ago, but I know he would be very proud of this act.

I would urge that this legislation be adopted.

Mr. SENSENBRENNER. Mr. Speaker, in 2006, Congress took significant steps to reduce methamphetamine production and distribution by passing the Combat Methamphetamine Epidemic Act. Today, the House will consider H.R. 2923, the Combat Methamphetamine Enhancement Act, which will address problems that the Drug Enforcement Administration (DEA) has identified in the implementation of the Combat Methamphetamine Epidemic Act. H.R. 2923 aims to strengthen enforcement measures and ensure that retailers are in full compliance with the law.

Prior to passage of the Combat Methamphetamine Epidemic Act, it was common practice for methamphetamine dealers to go into stores, load up shopping carts with cold medicines, break open the blister packs, and use the pseudoephedrine and ephedrine to make methamphetamine. The Combat Methamphetamine Epidemic Act stopped this practice, by requiring that cold medicines containing pseudoephedrine and ephedrine be placed behind a pharmacy counter, requiring signature and proof of identification before purchase, and limiting how much of these medicines a person can buy in a day or month. However, the law contains a loophole that allows retailers to continue to sell products containing pseudoephedrine and ephedrine without showing that their employees are complying with the law's requirement.

H.R. 2923 will require retailers of pseudoephedrine and ephedrine products to verify with the DEA that they have trained their staff in the requirements of the Combat Methamphetamine Epidemic Act. If they don't, they simply won't be able to purchase pseudoephedrine products from distributors. The DEA needs every resource available to enforce the tough drug laws already on the books. This measure will curb drug manufacturers' access to ephedrine or pseudoephedrine, while keeping these products available to responsible consumers.

Over the past decade, methamphetamines have emerged as one of the most dangerous homegrown drugs. Ranking as one of the most widely used illicit drugs in the world, it has become the most prevalent drug problem in many Western and Midwestern states, and is emerging on the East Coast. Congress made great efforts in the fight against methamphetamines with the enactment of the Combat Methamphetamine Epidemic Act. However, while many of the provisions in the comprehensive legislation have had positive results, including a sharp decline in national methamphetamine lab seizures; manufacturers, traffickers and abusers continue to search for loopholes in the law.

H.R. 2923 is a common sense bill, designed to strengthen the implementation of the Combat Methamphetamine Epidemic Act. This bill would create incentives to ensure that the verification process of the law is made both effective and enforceable. I urge my colleagues to support this legislation.

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

Mr. PALLONE. Mr. Speaker, I yield back the balance of my time and ask that the bill pass.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 2923, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

FAMILY HEALTH CARE ACCESSIBILITY ACT OF 2010

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1745) to amend the Public Health Service Act to provide liability protections for volunteer practitioners at health centers under section 330 of such Act, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1745

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 ''Family Health Care Accessibility Act of 2010''.

SEC. 2. LIABILITY PROTECTIONS FOR HEALTH PROFESSIONAL VOLUNTEERS AT COMMUNITY HEALTH CENTERS.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following:

''(q)(1) For purposes of this section, a health professional volunteer at an entity described in subsection (g)(4) shall, in providing a health professional service eligible for funding under section 330 to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

''(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a health professional volunteer at an entity described in subsection (g)(4) if the following conditions are met:

''(A) The service is provided to the individual at the facilities of an entity described in subsection (g)(4), or through offsite programs or events carried out by the entity.

''(B) The entity is sponsoring the health care practitioner pursuant to paragraph (3)(B).

''(C) The health care practitioner does not receive any compensation for the service from the individual or from any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the entity described in subsection (g)(4) for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

''(D) Before the service is provided, the health care practitioner or the entity described in subsection (g)(4) posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection.

''(E) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

''(3) Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4) and subject to the following:

''(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

''(B) With respect to an entity described in subsection (g)(4), a health care practitioner is not a health professional volunteer at such entity unless the entity sponsors the health care practitioner. For purposes of this subsection, the entity shall be considered to be sponsoring the health care practitioner if—

''(i) with respect to the health care practitioner, the entity submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

''(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

''(C) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a health professional volunteer at such entity, this subsection applies to the health care practitioner (with respect to services performed on behalf of the entity sponsoring the health care practitioner pursuant to subparagraph (B)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

''(D) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

''(4)(A) Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

''(B) Not later May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of health professional volunteers, will be paid pursuant to this section during the calendar year that begins in the following fiscal year. Subsection (k)(1)(B) applies to the estimate under the preceding sentence regarding health

professional volunteers to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

''(C) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

''(5)(A) This subsection takes effect on October 1, 2011, except as provided in subparagraph (B).

''(B) Effective on the date of the enactment of this subsection—

''(i) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (3)(B); and

''(ii) reports under paragraph (4)(B) may be submitted to the Congress.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Kentucky (Mr. WHITFIELD) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material in the RECORD.

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

There was no objection.

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

Mr. Speaker, I rise today in strong support of H.R. 1745, the Family Health Care Accessibility Act. The bill is authored by my colleagues on the Energy and Commerce Committee, Mr. MURPHY of Pennsylvania and Mr. GREEN of Texas, and obviously it enjoys strong bipartisan support.

The bill would provide liability protections for health care workers who volunteer to work at community health centers. Very similar protections are already provided for the employees and contractors of such centers. The bill, as introduced, would have provided such protection only to physicians and psychologists, but the committee adopted an amendment that expanded coverage to all health care workers who are volunteers at CHCs so long as they are working within their appropriate scope of practice and licensure and are performing work that is appropriate to the center.

CBO has estimated that the bill will not affect mandatory spending or revenue and is not subject to the PAYGO rules. Versions of this legislation have passed in the House in previous years, so I hope this bill will become law.

Again, I want to thank Mr. MURPHY and Mr. GREEN for all their hard work on this legislation. As well, I want to express my appreciation to our minority leaders on health legislation in the committee, Mr. SHIMKUS and Mr. BARTON, for their support and commitment in getting this bill to the floor.

I urge my colleagues to support the bill.

I reserve the balance of my time.

Mr. WHITFIELD. I also want to thank Mr. GREEN of Texas and Mr. MURPHY for their leadership on this issue.

All of us recognize the importance of community health centers. They are spreading throughout the country and they are playing an important role in providing primary health care for the American people.

At this time I would like to yield 5 minutes to one of the real leaders in this area, Mr. MURPHY of Pennsylvania.

Mr. TIM MURPHY of Pennsylvania. Mr. Speaker, community health centers provide a neighborhood medical home that is both high quality and lower cost. They are more than just a doctor's office; they are a place where a child can see a pediatrician and an adult can see an internist. You can get dental care, mental health services, or prenatal care. You can go there when you are getting a cold instead of running up big costs at an emergency room.

The doctors, dentists, nurse practitioners, and other medical professionals are under one roof; and they coordinate your care, working as a team for your family's health in a one-stop wellness center, and the costs per patient are far, far below the costs one would pay if you went to a hospital or private practice. That coordinated effort saves a lot of money through preventative care, keeping you up with immunizations and providing quality medical intervention when you need it at one of these 1,250 nonprofit community health centers.

In our Nation's $2.4 trillion health care system, the community health centers are credited with saving nearly $25 billion each year. Families save money and Medicaid saves money. On average, a person using a community health center saves $1,100 per year on health care costs, according to a recent study by George Washington University. That's the good news. The sad news is that there is a serious shortage of health care providers at these centers, and no matter now great the center, if there are long delays because of the shortage, then health care delayed is health care denied.

Health centers located in medically underserved urban or rural areas report a 27 percent shortage of dentists, a 26 percent shortage of OB/GYNs that could be providing prenatal care, and a 13 percent shortage of family physicians. The centers simply do not have enough money to hire the additional staff required to cover the growing patient needs, but there is an answer.

Many health professionals, especially part-time workers or highly qualified, semi-retired medical providers are willing and able, but not allowed to do so. That's right. They want to volunteer their time, but they cannot. They cannot because the centers are not able to cover the costs of medical liability insurance for the doctors and nurses.

Medical liability insurance can cost tens of thousands of dollars, and, in some cases, well over $100,000 per year per doctor, and the clinics simply cannot cover that expense. Here's why: Practitioners employed by the community health centers are covered by the Federal Torts Claim Act, which extends Federal liability protection to those volunteer doctors. Oddly enough, the opposite applies at free clinics, where volunteers are covered by the FTCA, while those who are employed at free clinics are not covered.

The Congressional Budget Office said that medical liability insurance costs pose a ''significant barrier'' for many providers who otherwise would be eager to volunteer at health centers. This bill, H.R. 1745, fixes this disparity and opens the door for volunteer providers at clinics all over America. This bill, which I introduced with Representative GENE GREEN, will eliminate the barriers for millions of patients seeking care in these neighborhood health care homes and will allow thousands of practitioners to volunteer their expertise for high-quality, low-cost patient care.

The Congressional Budget Office estimated that the cost of this bill could be as little as $5 million a year for 5 years, and, in return, the clinics receive hundreds of millions of dollars worth of free health care services for those living in underserved communities. And because this funding is part of the health centers program's annual appropriations, this funding is not a scored cost. The dedicated health center fund means that the slight additional cost to the FTCA program will require no new appropriations. I repeat: The slight additional cost will require no new annual appropriations.

I am grateful for the support of my colleagues—Representative GENE GREEN, FRANK PALLONE, JOHN SHIMKUS, PHIL GINGREY, Ranking Member JOE BARTON, and Chairman HENRY WAXMAN—for working with me on this legislation, and also my staff—Brad Grantz and Susan Mosychuk.

Mr. Speaker, we in Congress have a chance to do something to expand care to millions of Americans with this act without raising the health care bills for families. This is an example of real bipartisan reform that helps people get the health care they need when they need it close to home at an affordable cost. Isn't that what we all want with health care?

So let's say ''yes'' to community health centers, ''yes'' to families, ''yes'' to doctors who want to volunteer their care, ''yes'' to affordable and accessible care to millions of families, and please say ''yes'' to H.R. 1745, the Family Health Care Accessibility Act.

Mr. PALLONE. Mr. Speaker, I yield such time as he may consume to my colleague from Texas, Representative GREEN. But before I do that, let me just

say that he has been an outstanding leader on community health centers. He sponsored the bill that reauthorized the community health centers, and he is always looking out for ways to improve what goes on there.

□ 1720

Mr. GENE GREEN of Texas. I thank the chairman of the Health Subcommittee for those kind words but also for this legislation. I would also like to thank the full committee chair, HENRY WAXMAN; and our ranking member, JOE BARTON; along with our ranking member on our subcommittee, Congressman SHIMKUS from Illinois, for the support of this bill; and all of the Members on the Energy and Commerce Committee.

I rise in strong support of H.R. 1745, the Family Health Care Accessibility Act. H.R. 1745 will extend Federal Tort Claim coverage for licensed volunteer practitioners for section 330 services provided under the Public Health Service Act in community health centers.

This legislation will allow licensed practitioners to volunteer and provide them adequate tort claims protection equal to employees of the community health centers.

A March 2006 study in the Journal of the American Medical Association found community health centers had a 13 percent vacancy rate for family physicians, 9 percent for internists, a 20 percent vacancy rate for OB–GYNs, an 8 percent vacancy rate for podiatrists, a 22 percent vacancy rate for psychiatrists, and an 18 percent vacancy rate for dentists. If we rely on community health centers as medical homes, we need to increase the number of health care providers—including volunteer practitioners. So many qualified individuals want to volunteer their time but are afraid to do so because they do not have Federal Tort Claim protection and the Government Accountability Office has found that doctors and nurses choose not to volunteer their skills at community health centers because medical liability insurance is too costly for individuals to purchase on their own.

We can address the workforce shortage in health centers by clarifying that medical malpractice coverage is provided to clinicians who wish to volunteer their time working at the community health center.

I want to thank Congressman MURPHY from Pennsylvania for sponsoring the legislation. Again, this will mark the third time we've worked together to pass this legislation in the House. It was in the health care reform bill, but the Senate did not include it in their version.

Again, Mr. Speaker, I want to thank the House, and hopefully we'll pass this bill today again and give the Senate another opportunity.

Mr. WHITFIELD. Mr. Speaker, I think all of our speakers have explained very clearly why we need to support this legislation. I urge all of our Members to support it.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I also urge passage of the bill.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 1745, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. TIM MURPHY of Pennsylvania. 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.

NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING REAUTHORIZATION ACT OF 2010

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5710) to amend and reauthorize the controlled substance monitoring program under section 399O of the Public Health Service Act, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5710

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 ''National All Schedules Prescription Electronic Reporting Reauthorization Act of 2010''.

SEC. 2. AMENDMENT TO PURPOSE.

Paragraph (1) of section 2 of the National All Schedules Prescription Electronic Reporting Act of 2005 (Public Law 109–60) is amended to read as follows:

''(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that—

''(A) health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

''(B) appropriate law enforcement, regulatory, and State professional licensing authorities have access to prescription history information for the purposes of investigating drug diversion and prescribing and dispensing practices of errant prescribers or pharmacists; and''.

SEC. 3. AMENDMENTS TO CONTROLLED SUBSTANCE MONITORING PROGRAM.

Section 399O of the Public Health Service Act (42 U.S.C. 280g–3) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking ''or'';

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

(C) by adding at the end the following:

''(C) to maintain and operate an existing State-controlled substance monitoring program.'';

(2) by amending subsection (b) to read as follows:

''(b) MINIMUM REQUIREMENTS.—The Secretary shall maintain and, as appropriate, supplement or revise (after publishing proposed additions and revisions in the Federal Register and receiving public comments thereon) minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).'';

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in the matter preceding clause (i), by striking ''(a)(1)(B)'' and inserting ''(a)(1)(B) or (a)(1)(C)'';

(ii) in clause (i), by striking ''program to be improved'' and inserting ''program to be improved or maintained''; and

(iii) in clause (iv), by striking ''public health'' and inserting ''public health or public safety'';

(B) in paragraph (3)—

(i) by striking ''If a State that submits'' and inserting the following:

''(A) IN GENERAL.—If a State that submits'';

(ii) by inserting before the period at the end ''and include timelines for full implementation of such interoperability''; and

(iii) by adding at the end the following:

''(B) MONITORING OF EFFORTS.—The Secretary shall monitor State efforts to achieve interoperability, as described in subparagraph (A).'';

(C) in paragraph (5)—

(i) by striking ''implement or improve'' and inserting ''establish, improve, or maintain''; and

(ii) by adding at the end the following: ''The Secretary shall redistribute any funds that are so returned among the remaining grantees under this section in accordance with the formula described in subsection (a)(2)(B).'';

(4) in the matter preceding paragraph (1) in subsection (d), by striking ''In implementing or improving'' and all that follows through ''(a)(1)(B)'' and inserting ''In establishing, improving, or maintaining a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subparagraph (B) or (C) of subsection (a)(1)'';

(5) in subsections (e), (f)(1), and (g), by striking ''implementing or improving'' each place it appears and inserting ''establishing, improving, or maintaining'';

(6) in subsection (f)—

(A) in paragraph (1)(B) by striking ''misuse of a schedule II, III, or IV substance'' and inserting ''misuse of a controlled substance included in schedule II, III, or IV of section 202(c) of the Controlled Substance Act''; and

(B) by adding at the end the following:

''(3) EVALUATION AND REPORTING.—Subject to subsection (g), a State receiving a grant under subsection (a) shall provide the Secretary with aggregate data and other information determined by the Secretary to be necessary to enable the Secretary—

''(A) to evaluate the success of the State's program in achieving its purposes; or

''(B) to prepare and submit the report to Congress required by subsection (k)(2).

''(4) RESEARCH BY OTHER ENTITIES.—A department, program, or administration receiving nonidentifiable information under paragraph (1)(D) may make such information available to other entities for research purposes.'';

(7) by redesignating subsections (h) through (n) as subsections (i) through (o), respectively;

(8) in subsections (c)(1)(A)(iv) and (d)(4), by striking ''subsection (h)'' each place it appears and inserting ''subsection (i)'';

(9) by inserting after subsection (g) the following:

''(h) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving a grant under subsection (a) shall take steps to—

''(1) facilitate prescriber use of the State's controlled substance monitoring system; and

''(2) educate prescribers on the benefits of the system both to them and society.'';

(10) by amending subsection (l), as redesignated, to read as follows:

''(l) PREFERENCE.—Beginning 3 years after the date on which funds are first appropriated to