the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1702

At the request of Mr. CARDIN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 1702 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1729

At the request of Mr. GARDNER, his name was added as a cosponsor of amendment No. 1729 proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1972

At the request of Mr. TESTER, the name of the Senator from Arizona (Ms. SINEMA) was added as a cosponsor of amendment No. 1972 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2174

At the request of Mr. TILLIS, the name of the Senator from Connecticut (Mr. BLUMENTHAL) was added as a cosponsor of amendment No. 2174 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2244

At the request of Mr. CORNYN, the name of the Senator from Texas (Mr. CRUZ) was added as a cosponsor of amendment No. 2244 proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2252

At the request of Mr. SCHATZ, the names of the Senator from Delaware (Mr. COONS), the Senator from Vermont (Mr. LEAHY), the Senator from New York (Mrs. GILLIBRAND), the Senator from California (Mrs. FEINSTEIN), the Senator from New Mexico (Mr. HEINRICH), the Senator from Massachusetts (Mr. MARKEY), the Senator from Massachusetts (Ms. WARREN) and the Senator from Delaware (Mr. CARPER) were added as cosponsors of amendment No. 2252 proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2455

At the request of Ms. CORTEZ MASTO, the name of the Senator from Maine (Mr. KING) was added as a cosponsor of amendment No. 2455 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2457

At the request of Mr. MERKLEY, the names of the Senator from Michigan (Ms. STABENOW), the Senator from Pennsylvania (Mr. CASEY), the Senator from New Mexico (Mr. UDALL), the Senator from New Hampshire (Mrs. SHAHEEN), the Senator from Virginia (Mr. KAINE), the Senator from Minnesota (Ms. SMITH), the Senator from New York (Mr. SCHUMER), the Senator from California (Mrs. FEINSTEIN), the Senator from Maryland (Mr. CARDIN), the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from Vermont (Mr. LEAHY), the Senator from Montana (Mr. TESTER), the Senator from Hawaii (Mr. SCHATZ), the Senator from Nevada (Ms. CORTEZ MASTO), the Senator from Virginia (Mr. WARNER), the Senator from New Jersey (Mr. MENENDEZ), the Senator from Nevada (Ms. ROSEN) and the Senator from New Hampshire (Ms. HASSAN) were added as cosponsors of amendment No. 2457 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 2477

At the request of Mr. LEE, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of amendment No. 2477 intended to be proposed to S. 4049, an original bill to authorize appropriations for fiscal year 2021 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself and Ms. SMITH):

S. 4233. A bill to establish a payment program for unexpected loss of markets and revenues to timber harvesting and timber hauling businesses due to the COVID–19 pandemic, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Ms. COLLINS. Mr. President, I rise to introduce a bill with my colleague, Senator SMITH that will help the hard-working loggers across this Nation whose operations have suffered serious losses directly due to the pandemic. In Maine alone, logging has a roughly $650 million annual economic impact, and is the backbone of the forest products economy. The industry is made up of countless multi-generational family businesses, whose survival is being seriously threatened.

In Maine and in many places across the Country, the logging industry first felt the effects of COVID–19 in January as exports to foreign markets were significantly limited if not eliminated entirely. Declines in demand for paper products and other wood fiber based products caused by the COVID–19 pandemic have prompted shutdowns, slowdowns, and closures across the globe. As a result, Maine has seen declining demand for wood from mills across the board, and low prices and quotas driven by that lack of demand. And while timber prices have remained relatively stable, mills have drastically reduced their processing capacity—resulting in a ripple effect that has hit loggers and timber hauling companies hard.

The Professional Logging Contractors of Maine projects at least a 20 percent reduction in the annual harvest, which would threaten more than 600 jobs and represent the potential loss of $86 million in economic activity in my State. The explosion of a pulp digester earlier this year at a mill in Jay, coupled with the recent shutdown of a paper machine at another mill in Westbrook, have compounded the harm imposed by the pandemic.

Although the industry is certainly not alone in its struggles during this time, it faces unique challenges, including high capital costs relative to payroll and the fact that payroll costs do not reflect the amounts paid to independent contractors. And unlike some of our farmers who have been able to access direct payments from USDA and our fishermen who were allocated relief funding in the CARES Act, our forestry professionals have not been provided targeted assistance.

The legislation we are introducing today would direct the Secretary of Agriculture to provide financial assistance to loggers and timber hauling businesses that have experienced at least a 10 percent loss in revenues from January 2020 through July 2020 as compared to the same timeframe last year. The amount would be equal to 10 percent of 2019 gross revenues and could only be used for operating expenses, including payroll. I am grateful for the American Logging Council's support of our legislation, and urge my colleagues

to join in this effort to support one of our country's core economic drivers.

Loggers and forestry industry professionals were rightfully deemed essential workers during this public health crisis, and we must ensure that they receive the support necessary to emerge from this downturn.

By Mr. REED (for himself, Ms. MURKOWSKI, Mr. JONES, and Mr. TILLIS):

S. 4237. A bill to extend zero interest rate benefits and payment suspension to all Federal student loan borrowers, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, today, along with Senator MURKOWSKI, we are introducing legislation to provide relief to all Federal student loan borrowers during this public health and economic crisis. The bipartisan Student Loan Fairness Act, which is also cosponsored by Senators MURKOWSKI, JONES, and TILLIS, will correct an inequity in the CARES Act that left out millions of Federal student loan borrowers from benefits to ease the burden of repayment as we continue to fight COVID–19.

The CARES Act benefits are restricted to borrowers of student loans that are held by the Federal government. This leaves out the borrowers whose Federal Family Education Loans (FFEL) are still held by commercial and State agency lenders, and those with Perkins Loans that are administered by institutions of higher education. In fact, nearly 6 million borrowers were left out under the FFEL Program and another 1.9 million under the Perkins Loan Program. This disparate treatment by loan type is as confusing as it is unfair.

In April, a broad group of more than two dozen organizations representing educators, borrower advocates, veterans, lenders, guaranty agencies, and student loan servicers implored Congress to remedy this inequity. They wrote, ''A Federal loan borrower—regardless of the origination of that loan, be it Part B, D, E, commercial, or government-held—should receive equal, immediate, and critical support in this unprecedented time . . . Already, borrowers are confused as to why their Federal loans are treated differently than others.''

The Student Loan Fairness Act will extend the CARES Act relief to these borrowers by covering the cost of interest and suspending monthly payments for the period of March 13 through September 30, 2020, and suspending all involuntary collection, such as administrative wage garnishment or offsets from tax refunds, for this period.

This legislation is one component of what should be a comprehensive package of student loan debt relief. As the crisis continues, we should extend the repayment relief until health and economic conditions improve sufficiently for borrowers to be able to begin repayment. Additionally, we should forgive at least $10,000 of debt for each student loan borrower to help speed the recovery and reduce the drag of the roughly $1.6 trillion in outstanding student loan debt on economic prospects for over 40 million Americans. Going forward, we must reduce the need for student loan borrowing by expanding need-based grants, such as the Pell Grant, and ensuring that states and institutions do their part to lower the cost to students and families.

We should work together to build on the important steps Congress took to provide relief to student loan borrowers in the CARES Act. However, we need to ensure that all Federal student loan borrowers have access to this relief. I hope that my colleagues will join us in cosponsoring the Student Loan Fairness Act and pushing for its inclusion in the next COVID–19 relief package.

By Mrs. LOEFFLER (for herself, Mrs. BLACKBURN, and Mr. COTTON):

S. 4238. A bill to amend title 18, United States Code, relating to criminal street gangs, and for other purposes; to the Committee on the Judiciary.

Mrs. LOEFFLER. Mr. President, this spring, 14-year-old Janina Valenzuela was riding a bike with a friend in Marietta, GA, when she was killed as part of an initiation into an MS–13 gang. In 2016, Christopher Dean was brutally murdered by gang members in Atlanta. The D.A. called it ''the most horrific death'' in recent history. His murder left two children without a father. In 2010, 11-year-old Nicholas Sheffey was shot and killed sleeping in his bed during a drive-by shooting in Chamblee, GA. These are just three of the too many lives that have been lost, tragically cut short due to senseless gang violence.

In Georgia, there are over 71,000 known gang members representing a variety of gangs, including the Ghostface Gangsters, an all-White gang in Georgia; the Gangster Disciples, which formed in Chicago and quickly spread to Georgia; and the Aryan Brotherhood, a White supremacy gang.

Nationwide, there are more than 1.4 million members and 33,000 gangs across the U.S. According to the most recent National Gang Report, half of law enforcement officials reported that gang-related violence has increased in each of their jurisdictions. Thankfully, President Trump and Georgia leaders have taken strong action to address the rising tide of gang violence and to end the cycles of violence that they cause.

For the first time ever, the Department of Justice has brought terrorism charges against a member of the MS–13 gang, taking action against their leader and 21 other gang members.

Under the leadership of Georgia Governor Brian Kemp and Attorney General Chris Carr, my home State of Georgia has led the way on confronting gang violence, passing legislation that gives prosecutors the tools they need to disrupt and dismantle these terrible gang networks.

Today, I am introducing the Cracking Down on Gangs and Deporting Criminals Act to apply Georgia's anti-gang, pro-community measures across our country. This legislation, based on the Georgia law that Attorney General Carr has called ''one of the strongest statutes in the Nation,'' aims to deter and punish criminals who set out to destroy lives and communities. This includes violent crimes like the murders of Janina, Christopher, and Nicholas.

In addition to violence, gangs run elaborate drug operations. One recent bust in Pickens County last month resulted in the arrest of nearly 50 individuals. Law enforcement confiscated nearly $2 million worth of methamphetamine from a drug ring run by three gangs.

They deal in the abhorrent world of human trafficking. A study in San Diego County found that an astounding 85 percent of those involved in human trafficking were actively involved in gangs.

Current Federal gang statute has three strict criteria that are difficult for prosecutors to meet in order to hold someone accountable for their participation in a street gang. The legislation I am introducing today will make it easier for Federal prosecutors to seek harsh sentences for gang activity. It will facilitate the removal of criminal gang members who are in our country illegally, and it would create a national gang database, making it easier to eradicate these gang networks.

We need to take action now to take violent gang members off of our streets. Across the country, violence is skyrocketing in our cities, while radicals call to defund and abolish the police. The troubling decline in support for law enforcement, coupled with the effects of the pandemic and recent unrest, threatens the further spread of gang violence across communities in America.

The Cracking Down on Gangs and Deporting Criminals Act will help keep our communities safe and support law enforcement in their work to root out gang activity. No family should have to go through what Janina, Christopher, and Nicholas did. Parents should be able to send their children outdoors and off to school without worrying that they won't make it home, and children shouldn't fear that their parents won't return home. It is time that we hold gang members accountable for their vile and evil actions and keep the American public safe.

By Mr. DURBIN:

S. 4242. A bill to establish programs related to prevention of prescription opioid misuse, and for other purposes; to the Committee on Finance.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 4242

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 ''Addiction Prevention and Responsible Opioid Practices Act''.

SEC. 2. EXCISE TAX ON OPIOID PAIN RELIEVERS.

(a) IN GENERAL.—Subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 4192. OPIOID PAIN RELIEVERS.

''(a) IN GENERAL.—There is hereby imposed on the manufacturer or producer of any taxable active opioid a tax equal to the amount determined under subsection (b).

''(b) AMOUNT DETERMINED.—The amount determined under this subsection with respect to a manufacturer or producer for a calendar year is 1 cent per milligram of taxable active opioid in the production or manufacturing quota determined for such manufacturer or producer for the calendar year under section 306 of the Controlled Substances Act (21 U.S.C. 826).

''(c) TAXABLE ACTIVE OPIOID.—For purposes of this section—

''(1) IN GENERAL.—The term 'taxable active opioid' means any controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802), as in effect on the date of the enactment of this section) manufactured in the United States which is opium, an opiate, or any derivative thereof.

''(2) EXCLUSIONS.—

''(A) OTHER INGREDIENTS.—In the case of a product that includes a taxable active opioid and another ingredient, subsection (a) shall apply only to the portion of such product that is a taxable active opioid.

''(B) DRUGS USED IN ADDICTION TREATMENT.—The term 'taxable active opioid' shall not include any controlled substance (as so defined) which is used exclusively for the treatment of opioid addiction as part of a medication-assisted treatment.''.

(b) CLERICAL AMENDMENTS.—

(1) The heading of subchapter E of chapter 32 of the Internal Revenue Code of 1986 is amended by striking ''**Medical Devices**'' and inserting ''**Other Medical Products**''.

(2) The table of subchapters for chapter 32 of such Code is amended by striking the item relating to subchapter E and inserting the following new item:

''SUBCHAPTER E. OTHER MEDICAL PRODUCTS''.

(3) The table of sections for subchapter E of chapter 32 of such Code is amended by adding at the end the following new item:

''Sec. 4192. Opioid pain relievers.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after the date of the enactment of this Act.

SEC. 3. OPIOID CONSUMER ABUSE REDUCTION PROGRAM.

(a) OPIOID TAKE-BACK PROGRAM.—Section 302 of the Controlled Substances Act (21 U.S.C. 822) is amended by adding at the end the following:

''(h)(1) The Attorney General shall establish a national take-back program for the safe and environmentally responsible disposal of controlled substances.

''(2) In establishing the take-back program required under paragraph (1), the Attorney General—

''(A) shall consult with the Secretary and the Administrator of the Environmental Protection Agency; and

''(B) may coordinate with States, law enforcement agencies, water resource management agencies, manufacturers, practitioners, pharmacists, public health entities, transportation and incineration service contractors, and other entities and individuals, as appropriate.

''(3) The take-back program established under paragraph (1)—

''(A) shall—

''(i) ensure appropriate geographic distribution so as to provide—

''(I) reasonably convenient and equitable access to permanent take-back locations, including not less than 1 disposal site for every 25,000 residents and not less than 1 physical disposal site per town, city, county, or other unit of local government, where possible; and

''(II) periodic collection events and mail-back programs, including public notice of such events and programs, as a supplement to the permanent take-back locations described in subclause (I), particularly in areas in which the provision of access to such locations at the level described in that subclause is not possible;

''(ii) establish a process for the accurate cataloguing and reporting of the quantities of controlled substances collected; and

''(iii) include a public awareness campaign and education of practitioners and pharmacists; and

''(B) may work in coordination with State and locally implemented public and private take-back programs.

''(4) From time to time, beginning in the second calendar year that begins after the date of enactment of this subsection, the Secretary of the Treasury shall transfer from the general fund of the Treasury an amount equal to one-half of the total amount of taxes collected under section 4192 of the Internal Revenue Code of 1986 to the Attorney General to carry out this subsection. Amounts transferred under this subparagraph shall remain available until expended.''.

(b) FUNDING OF SUBSTANCE ABUSE PROGRAMS.—From time to time, beginning in the second calendar year that begins after the date of enactment of this Act, the Secretary of the Treasury shall transfer from the general fund of the Treasury an amount equal to one-half of the total amount of taxes collected under section 4192 of the Internal Revenue Code of 1986, as added by this Act, to the Director of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration for programs of the Center, including the Block Grants for Prevention and Treatment of Substance Abuse program under subpart II of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.) and Programs of Regional and National Significance. Amounts transferred under this subsection shall remain available until expended.

SEC. 4. GAO STUDY.

Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall—

(1) conduct a study examining the coverage offered under commercial health insurance plans and reimbursement rates under the Medicare program and State Medicaid plans with respect to—

(A) substance use disorder treatment services, as compared to other health services, and how any disparity identified under this paragraph may contribute to differences in salary and turnover among substance abuse disorder providers; and

(B) rates of coverage or reimbursement, as applicable, for substance abuse disorder services provided via telehealth, as compared to such services provided in-person; and

(2) provide recommendations with respect to addressing any disparities identified under subparagraph (A) or (B) of paragraph (1) in order to bolster retention of substance abuse disorder providers and the provision of substance abuse disorder services.

SEC. 5. EXPANDING ACCESS TO SUBSTANCE USE DISORDER AND MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH UNDER THE MEDICARE PROGRAM.

Section 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m(m)(7)) is amended—

(1) in the paragraph heading, by inserting ''AND MENTAL HEALTH SERVICES'' after ''SUBSTANCE USE DISORDER SERVICES'';

(2) by inserting ''or, on or after the first day after the end of the public health emergency described in section 1135(g)(1)(B), to an eligible telehealth individual for purposes of diagnosis of a substance use disorder or diagnosis or treatment of a mental health disorder, as determined by the Secretary,'' after ''as determined by the Secretary,''.

SEC. 6. ENSURING PARITY FOR MENTAL HEALTH AND ADDICTION TREATMENT SERVICES.

Title V of the Public Health Service Act (42 U.S.C. 290ll et seq.) is amended—

(1) in part K, by redesignating section 550 (42 U.S.C. 290ee–10), relating to sobriety treatment and recovery teams, as section 553 and transferring such section to appear after section 552 in part D; and

(2) by adding at the end of such part D the following:

''SEC. 554. COMPLIANCE WITH MENTAL HEALTH AND ADDICTION TREATMENT PARITY.

''(a) IN GENERAL.—The Secretary, in coordination with the Secretary of Labor, shall award grants to, or enter into cooperative agreements with, States to ensure that health insurance issuers in the State comply with section 2726.

''(b) USE OF GRANT.—A State shall use amounts received under a grant or cooperative agreement under this section to—

''(1) establish clear guidelines for parity compliance for mental health and substance use disorder benefits;

''(2) ensure parity compliance during public health emergencies with best practices for delivering evidence-based mental health and substance use disorder treatment, including to ensure virtual, video, internet, telephonic, and other remote services are appropriately covered, including alignment with authorities, flexibilities, and coverage promulgated by the Centers for Medicare & Medicaid Services;

''(3) engage with health insurance issuers to ensure that they comply with the guidelines promulgated and other provisions of section 2726, including through audits, market conduct examinations, secret shopper programs, or other means;

''(4) share information with other States who receive grants under this section;

''(5) submit a report to the Secretary and the Secretary of Labor on information, actions, recommendations, and such other information as such secretaries may require; and

''(6) publicly post a summary of the report submitted under paragraph (6) on the websites of the Department of Health and Human Services and the Department of Labor.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2021 through 2025.''.

SEC. 7. FEDERAL LICENSURE OF PHARMACEUTICAL REPRESENTATIVES WHO PROMOTE CERTAIN OPIOIDS.

Subchapter E of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.

360bbb et seq.) is amended by adding at the end the following:

"SEC. 569E. FEDERAL LICENSURE OF PHARMACEUTICAL REPRESENTATIVES WHO PROMOTE CERTAIN OPIOIDS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall establish a licensure program for pharmaceutical representatives described in subsection (b).

''(b) LICENSURE PROGRAM.—

''(1) REQUIREMENT.—Beginning on July 1, 2021, no individual described in paragraph (2) may engage in the marketing or promoting of opioid drugs unless such individual is licensed under this section.

''(2) INDIVIDUALS REQUIRED TO OBTAIN LICENSURE.—An individual required to obtain a license under this section is any individual who, on behalf of a drug manufacturer, engaged, on more than 15 days in a calendar year, in the marketing or promotion to health care professionals, including educational or sales communications, meetings or paid events, and the provision of goods, gifts, and samples, of any opioid drug (other than methadone) that is listed in schedule II of section 202(c) of the Controlled Substances Act.

''(3) LICENSURE PERIOD.—Each license issued under this section shall be valid for 3 years, and may be renewed for additional 3-year periods.

''(c) REQUIREMENTS.—An individual required to obtain a license under this section shall—

''(1) submit to the Secretary, at such time and in such manner as the Secretary may require—

''(A) such information as the Secretary may require; and

''(B) a registration fee in the amount of $3,000;

''(2) certify that such individual has completed training on ethics, pharmaceutical marketing regulations, the 'CDC Guidelines for Prescribing Opioids for Chronic Pain', published by the Centers for Disease Control and Prevention in 2016 (or any successor document) or the 'FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics', and applicable Federal laws pertaining to drug marketing, labeling, and clinical trials, as the Secretary may require;

''(3) certify that such individual will not engage in any illegal, fraudulent, misleading, or other deceptive marketing of schedule II opioid drugs; and

''(4) file with the Secretary annual reports disclosing the names of providers visited and any drug samples or gifts such individual gives any such provider.

''(d) MANUFACTURER REPORTING REQUIREMENTS.—The manufacturer who employs or contracts with any individual required to obtain a license under this section shall include in reports required under section 1128G of the Social Security Act the name of each such licensed individual that provides payments or other transfers of value required to be reported under such section 1128G that relates to an opioid drug that is listed in schedule II of the Controlled Substances Act.''.

SEC. 8. WITHDRAWAL OF APPROVAL OF CERTAIN OPIOIDS.

(a) IN GENERAL.—Notwithstanding any other provision of law, any ultra-high-dose opioid shall be considered a drug that presents an imminent hazard to the public health within the meaning of section 505(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(e)), and the Secretary of Health and Human Services shall suspend the approval of such drug, in accordance with such section 505(e).

(b) DEFINITION.—In this section, the term ''ultra-high-dose opioid'' means an opioid drug for which the daily dosage provided for in the approved label exceeds the morphine milligram equivalents per day outlined in the report entitled ''CDC Guidelines for Prescribing Opioids for Chronic Pain'', published by the Centers for Disease Control and Prevention in 2016 (or any successor document).

SEC. 9. CONTINUING MEDICAL EDUCATION AND PRESCRIPTION DRUG MONITORING PROGRAM REGISTRATION FOR PRESCRIBERS.

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

(1) by redesignating subsection (k) as subsection (l); and

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

''(k)(1) The Attorney General shall not register, or renew the registration of, a practitioner under subsection (f) who is licensed under State law to prescribe controlled substances in schedule II, III, or IV, unless the practitioner submits to the Attorney General, for each such registration or renewal request, a written certification that—

''(A)(i) the practitioner has, during the 1-year period preceding the registration or renewal request, completed a training program described in paragraph (2); or

''(ii) the practitioner, during the applicable registration period, will not prescribe such controlled substances in amounts in excess of a 72-hour supply (for which no refill is available); and

''(B) the practitioner has registered with the prescription drug monitoring program of the State in which the practitioner practices, if the State has such program.

''(2) A training program described in this paragraph is a training program that—

''(A) follows the best practices for pain management, as described in the 'Guideline for Prescribing Opioids for Chronic Pain' as published by the Centers for Disease Control and Prevention in 2016, or any successor thereto, or the 'FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics' as published by the Food and Drug Administration in 2017, or any successor thereto;

''(B) includes information on—

''(i) recommending non-opioid and non-pharmacological therapy;

''(ii) establishing treatment goals and evaluating patient risks;

''(iii) prescribing the lowest dose and fewest number of pills considered effective;

''(iv) addictive and overdose risks of opioids;

''(v) diagnosing and managing substance use disorders, including linking patients to evidence-based treatment;

''(vi) identifying narcotics-seeking behaviors; and

''(vii) using prescription drug monitoring programs; and

''(C) is approved by the Secretary.''.

SEC. 10. REPORT ON PRESCRIBER EDUCATION COURSES FOR MEDICAL AND DENTAL STUDENTS.

Each school of medicine, school of osteopathic medicine, and school of dentistry participating in a program under title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a et seq.), as a condition for such participation, shall submit an annual report to the Secretary of Education and the Secretary of Health and Human Services on any prescriber education courses focused specifically on pain management and responsible opioid prescribing practices that such school requires students to take, and whether such courses are consistent with the most recently published version of the ''Guideline for Prescribing Opioids for Chronic Pain'' of the Centers for Disease Control and Prevention or the ''FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics'', as published by the Food and Drug Administration in 2017. The Secretary of Education and the Secretary of Health and Human Services shall compile the reports submitted by such schools and submit an annual summary of such reports to Congress.

SEC. 11. REQUIREMENTS UNDER PRESCRIPTION DRUG MONITORING PROGRAMS.

(a) IN GENERAL.—Beginning 1 year after the date of enactment of this Act, each State that receives funding under any of the programs described in subsection (c) shall—

(1) require practitioners, or their designees, in the State to consult the database of the prescription drug monitoring program before writing prescriptions for controlled substances (as such term is defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) in schedule II, III, or IV under section 202 of such Act (21 U.S.C. 812);

(2) require dispensers of controlled substances in schedule II, III, or IV, or their designees, to input data into the database of the prescription drug monitoring program within 24 hours of filling a qualifying prescription, as required by the Attorney General and the Secretary of Health and Human Services, including patient identifier information, the national drug code of the dispensed drug, date of dispensing the drug, quantity and dosage of the drug dispensed, form of payment, Drug Enforcement Administration registration number of the practitioner, Drug Enforcement Administration registration number of the dispenser;

(3) allow practitioners and dispensers to designate other appropriate individuals to act as agents of such practitioners and dispensers for purposes of obtaining and inputing data from the database for purposes of complying with paragraphs (1) and (2), as applicable;

(4) provide informational materials for practitioners and dispensers to identify and refer patients with possible substance use disorders to professional treatment specialists;

(5) establish formal data sharing agreements to foster electronic connectivity with the prescription drug monitoring programs of each State (if such State has such a program) with which the State shares a border, to facilitate the exchange of information through an established technology architecture that ensures common data standards, privacy protection, and secure and streamlined information sharing;

(6) authorize direct access to the State's database of the prescription drug monitoring program to all State law enforcement agencies, State boards responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons authorized to prescribe, administer, or dispense controlled substances; and

(7) in order to enhance accountability in prescribing and dispensing patterns, not fewer than 4 times per year, proactively provide informational reports on aggregate trends and individual outliers, based on information available through the State prescription drug monitoring program to—

(A) the State entities and persons described in paragraph (6); and

(B) the Medicaid agency and the department of public health of the State.

(b) TRANSPARENCY IN PRESCRIBING PRACTICES AND INTERVENTION FOR HIGH PRESCRIBERS.—

(1) STATE REPORTING REQUIREMENT.—Each State that receives funding under any of the programs described in subsection (c) shall, twice per year, submit to the Secretary of Health and Human Services and the Administrator of the Drug Enforcement Administration—

(A) a list of all practitioners and dispensers who, in the applicable reporting period, have prescribed or dispensed schedule II, III, or IV opioids in the State;

(B) the amount of schedule II, III, or IV opioids that were prescribed and dispensed by each individual practitioner and dispenser described in subparagraph (A); and

(C) any additional information that the Secretary and Administrator may require to support surveillance and evaluation of trends in prescribing or dispensing of schedule II, III, or IV opioids, or to identify possible nonmedical use and diversion of such substances.

(2) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, the Secretary of Defense, the Secretary of Veterans Affairs, and the Director of the Indian Health Service, shall submit to Congress, and make public, a report identifying outliers among the medical specialties and geographic areas with the highest rates of opioid prescribing in the Nation, by zip code.

(3) DEVELOPMENT OF ACTION PLAN.—

(A) INITIAL PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Administrator of the Drug Enforcement Administration, the Secretary of Defense, the Secretary of Veterans Affairs, and the Director of the Indian Health Service, shall submit to Congress a plan of action, including warning letters and enforcement mechanisms, for addressing outliers in opioid prescribing practices and ensuring an adequate Federal response to protect the public health.

(B) UPDATED PLAN.—The Secretary of Health and Human Services shall submit to Congress updates to the plan of action described in subparagraph (A), as such Secretary, in consultation with the heads of agencies described in such subparagraph, determines appropriate.

(c) PROGRAMS DESCRIBED.—The programs described in this subsection are—

(1) the Harold Rogers Prescription Drug Monitoring Program established under the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2002 (Public Law 107–77; 115 Stat. 748);

(2) the controlled substance monitoring program under section 399O of the Public Health Service Act (42 U.S.C. 280g–3);

(3) the Prescription Drug Overdose: Prevention for States program of the Centers for Disease Control and Prevention;

(4) the Prescription Drug Overdose: Data-Driven Prevention Initiative of Centers for Disease Control and Prevention;

(5) the Enhanced State Opioid Overdose Surveillance program of the Centers for Disease Control and Prevention;

(6) the opioid grant program under section 1003 of the 21st Century Cures Act (Public Law 114–255); and

(7) the State Opioid Response Grant program described under the heading ''SUBSTANCE ABUSE TREATMENT'' under the heading ''SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION'' of title II of division A of the Further Consolidated Appropriations Act, 2020 (Public Law 116–94).

(d) DEFINITIONS.—In this section, the terms ''dispenser'' and ''practitioner'' have the meanings given such terms in section 102 of the Controlled Substances Act (21 U.S.C. 802).

SEC. 12. INTEROPERABILITY OF CERTIFIED HEALTH INFORMATION TECHNOLOGY.

Section 3001(c)(5) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(5)) is amended by adding at the end the following:

''(F) INTEROPERABILITY.—Beginning on January 1, 2021, the National Coordinator shall not certify electronic health records as health information technology that is in compliance with applicable certification criteria under this paragraph unless such technology is interoperable with the prescription drug monitoring programs of each State that, at the time of the request for such certification, has such a program.''.

SEC. 13. STUDIES RELATED TO OVERDOSE DISCHARGE AND FOLLOW-UP POLICIES.

(a) STUDY.—Not later than January 1, 2021, the Secretary of Health and Human Services shall—

(1) conduct a study on the scope and circumstances of non-fatal opioid overdoses, the policies and procedures that States, health care systems, and first responders have implemented; and

(2) in partnership with stakeholder organizations with subject matter expertise, establish guidelines for hospital procedures following non-fatal opioid overdose and the administration of overdose reversal medication.

(b) STUDY AND DEVELOPMENT OF QUALITY MEASURES UNDER MEDICARE RELATED TO OPIOID ABUSE AND SUBSTANCE USE DISORDER.—Section 1890A(e) of the Social Security Act (42 U.S.C. 1395aaa–1(e)) is amended—

(1) by striking ''MEASURES.—The Administrator'' and inserting ''MEASURES.—

''(1) IN GENERAL.—The Administrator''; and

(2) by adding at the end the following new paragraph:

''(2) STUDY AND DEVELOPMENT OF QUALITY MEASURES RELATED TO OPIOID ABUSE AND SUBSTANCE USE DISORDER.—Beginning not later than 1 year after the date of enactment of this paragraph, the Administrator of the Center for Medicare & Medicaid Services shall study, and through contracts develop, in coordination with appropriate subject matter organizations (such as the entity with a contract under section 1890), for use under this Act, quality measures related to standards of care for treating individuals with non-fatal opioid overdose, discharge procedures, and linkages to appropriate substance use disorder treatment and community support services.''.

SEC. 14. MEDICAID OPIOID DRUG MAPPING TOOL.

(a) IN GENERAL.—The Secretary of Health and Human Services shall create an interactive opioid drug mapping tool, which shall be made publicly available on the internet website of the Centers for Medicare & Medicaid Services, showing prescribing practices of providers that participate in State Medicaid programs and geographic comparisons, at the State, county, and ZIP code levels, of de-identified opioid prescription claims made under State Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(b) COLLECTION OF DATA FROM STATES.—The Secretary of Health and Human Services may request from States such data as the Secretary determines necessary to create the opioid mapping tool described in subsection (a).

SEC. 15. NATIONAL ACADEMIES STUDY.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the National Academies of Science, Engineering, and Medicine (referred to in this section as the ''National Academies'') to carry out a study on the addition of coverage under the Medicare program under title XVIII of the Social Security Act of alternative treatment modalities (such as integrative medicine, including acupuncture and exercise therapy, neural stimulation, biofeedback, radiofrequency ablation, and trigger point injections) furnished to Medicare beneficiaries who suffer from acute or chronic lower back pain. Such study shall, pursuant to the contract under this paragraph, include an analysis of—

(1) scientific research on the short-term and long-term impact of the addition of such coverage on clinical efficacy for pain management of such beneficiaries;

(2) whether the lack of Medicare coverage for alternative treatment modalities impacts the volume of opioids prescribed for beneficiaries; and

(3) the cost to the Medicare program of the addition of such coverage to treat pain and mitigate the progression of chronic pain, as weighed against the cost of opioid use disorder, overdose, readmission, subsequent surgeries, and utilization and expenditures under parts B and D of such title.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, pursuant to the contract under subsection (a), the National Academies shall submit to Congress a report on the study under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary.

By Mr. DURBIN:

S. 4243. A bill to protect children of certain immigrant workers from detention and removal and aging out of lawful status, and for other purposes; to the Committee on the Judiciary.

S. 4243

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD. There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

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 ''Protect Children of Immigrant Workers Act''.

SEC. 2. PROTECTING CHILDREN OF CERTAIN IMMIGRANT WORKERS FROM DETENTION AND REMOVAL AND AGING OUT OF LAWFUL STATUS.

(a) IN GENERAL.—Notwithstanding any other provision of law, subject to subsection (b), with respect to an individual whose parent is the principal beneficiary of an approved employment-based immigrant worker petition filed on a date on which the individual was a child (as defined in section 101(b) of the Immigration and Nationality Act (8 U.S.C. 1101(b))—

(1) the Secretary of Homeland Security shall not detain, refer for removal, initiate removal proceedings against, or remove the individual; and

(2) the individual shall—

(A) without regard to immigrant intent and on application by the individual, be eligible—

(i) to extend nonimmigrant dependent status connected to the nonimmigrant status of such parent until the date on which an application for lawful permanent resident status filed by the individual pursuant to subparagraph (B) is adjudicated; or

(ii) to extend or change status to an alternative nonimmigrant status independent of such parent's visa status until the date on which an application for lawful permanent resident status filed by the individual pursuant to that subparagraph is adjudicated; and

(B) qualify as a derivative beneficiary child for immigrant visa purposes beginning on the date on which such parent's employment-based immigrant worker petition is approved and ending on the date on which the individual's application for lawful permanent resident status is adjudicated, regardless of whether such parent is living or deceased.

(b) APPLICABILITY.—Subsection (a) shall not apply to any individual who the Secretary determines, on an individualized basis, poses a threat to public safety or national security.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 653—EXPRESSING THE SENSE OF THE SENATE THAT A UNITED STATES WITHDRAWAL FROM THE WORLD HEALTH ORGANIZATION UNDERMINES UNITED STATES GLOBAL HEALTH LEADERSHIP AND THE INTERNATIONAL COVID–19 RESPONSE

Mr. CARDIN (for himself, Mr. LEAHY, Mr. BROWN, Ms. CANTWELL, Mr. VAN HOLLEN, Mr. COONS, Mr. CARPER, Mr. DURBIN, Mr. CASEY, Mrs. MURRAY, Mr. HEINRICH, Mr. KAINE, Ms. BALDWIN, Mr. WYDEN, Mr. BENNET, Mrs. FEINSTEIN, Ms. STABENOW, Mr. REED, Mr. UDALL, Ms. KLOBUCHAR, Ms. WARREN, Mr. MURPHY, Ms. SMITH, Mr. KING, Mr. WHITEHOUSE, Mr. BOOKER, Ms. HIRONO, Ms. ROSEN, and Mr. MERKLEY) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 653

Whereas United States contributions to the World Health Organization (WHO) are leveraged with contributions from other countries, the private sector, and foundations to advance longstanding United States global health priorities;

Whereas the WHO was founded in 1948 with United States help and has been at the forefront of major global health achievements in the last 72 years, including the eradication of polio, because of United States financial and diplomatic support;

Whereas the United States has consistently been the largest donor to the WHO in recognition of its vital role in saving lives, improving global disease detection, and coordinating a global public health response;

Whereas the WHO is able to implement health programs in places the United States Government cannot as effectively operate in, including Afghanistan, Syria, Yemen, and the Democratic Republic of the Congo;

Whereas the WHO leads polio surveillance, immunization, and technical support, and is able to reach remote areas in countries where polio still exists;

Whereas the President's Emergency Plan for AIDS Relief works with the WHO to enhance programs and policies in areas, including laboratory capacity, prevention of mother to child transmission of HIV, health system strengthening, prevention of tuberculosis infections, and counseling and testing;

Whereas the United States is home to 83 different WHO collaborating centers, more than 20 of which are at the Centers for Disease Control and the National Institutes of Health;

Whereas the WHO, following the 2014 West African Ebola outbreak, undertook a series of reforms to strengthen its health emergencies program and response in large part due to United States involvement;

Whereas the WHO is leading the global response to the COVID–19 pandemic with its technical, communications, and organizational capacities in 150 countries;

Whereas the WHO is coordinating an unprecedented global clinical trial, known as the ''Solidarity Trial'', to evaluate the safety and effectiveness of 4 drug treatment combinations against COVID–19, involving more than 100 countries, 400 hospitals, and more than 3,500 patients;

Whereas the WHO is leading the global effort to supply health commodities and is coordinating the United Nations Global Supply Chain Task Force, which is working with the private sector, the World Food Programme, and the European Central Bank to establish an emergency supply chain for low-resource countries;

Whereas at least 135 countries rely on the WHO to procure millions of pieces of personal protective equipment and other vital health commodities like tests and testing supplies;

Whereas the WHO is the only organization with the legal mandate and capacity to gather public health data from any country in the world and use it to quickly develop and disseminate technical guidance to help countries prepare public health responses;

Whereas the WHO, through a partnership with member states, major donors, and private sector partners called the ACT Accelerator, is already working to pre-position manufacturing capacity and distribution channels to ensure that all countries have access to future therapies and vaccines faster and at a fair price;

Whereas the Trump Administration froze funding to the WHO pending a ''60 to 90 day review'' on April 14, 2020, but without any disclosure of the review's findings, gave the WHO 30 days to make unspecified reforms on May 19, 2020, and then, 11 days later, announced the United States would withdraw from the WHO;

Whereas, on June 25, 2020, the Senate passed by unanimous consent S. Res. 579, urging United States leadership and participation in global efforts on therapeutics and vaccine development and delivery to address COVID–19; and

Whereas, on July 6, 2020, the Trump Administration officially submitted a formal letter to the United Nations Secretary General to withdraw the United States from the WHO: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) withdrawing the United States from the World Health Organization—

(A) undermines United States global health priorities and threatens lives around the world and in the United States;

(B) risks weakening the global response to the COVID–19 pandemic;

(C) threatens United States humanitarian responses; and

(D) creates a vacuum of leadership at the WHO at a time when it has been our expressed interest to counter China's growing influence within the organization; and

(2) the World Health Assembly agreed by consensus to appoint an interim assessment of the response to COVID–19, and by remaining a member in good standing, the United States will have the most leverage to advocate and put in place the reforms necessary for the World Health Organization to respond to this and future crises.

Mr. CARDIN. Mr. President, we are in unprecedented times. Modem transportation and communication technology make our world more interconnected than it has ever been. These advancements, especially international travel, create risks, as we have seen through the devastating spread of the novel coronavirus all over the globe. But close global connections also strengthen our capacity to work collaboratively to tackle threats facing our communities. The COVID–19 pandemic is one such threat—it is a challenge that we will only be able to overcome together. United Nations Secretary General Antonio Guterres put it best when he said, ''We are only as strong as the weakest health systems.''

President Trump's decision on July 6th to begin formally withdrawing the United States from the World Health Organization, or the WHO, is irrational, reckless, and simply the wrong thing to do. While the WHO is not perfect, its technical capacities and relationship with nearly every country in the world make it the best organization to manage the response to a global pandemic like COVID–19. A few weeks ago, the Senate Foreign Relations Committee heard from a panel of public health experts who all spoke with one voice—leaving the WHO in the middle of a global pandemic will not only compromise the international response to COVID–19, it will put Americans' lives at risk.

Today, I am introducing a resolution with 28 co-sponsors that expresses the sense of the Senate that withdrawing from the WHO undermines U.S. global health leadership and the international COVID–19 response. This resolution recognizes that since the WHO was founded in 1948—with help from the United States—it has relied on U.S. support to lead the world in disease detection and eradication and strengthening health systems. The resolution also highlights the significant benefit the U.S. gains by participating in the WHO, including the ability to improve public health in regions of the world that would be impossible to reach on our own.

Finally, the resolution highlights the lifesaving work of the WHO in responding to the COVID–19 pandemic. This work includes convening an unprecedented global clinical trial—the Solidarity Trial—to help find an effective treatment for COVID–19; coordinating global supply chains of personal protective equipment and other health commodities for more than 135 countries; and pre-positioning manufacturing capacity and distribution channels to ensure that all countries have access to future therapies and vaccines faster and at a fair price. Last month, the Senate unanimously passed a resolution urging U.S. participation in global efforts on therapeutics and vaccine development and delivery to address COVID–19. Leaving the WHO will make it drastically more difficult to accomplish those goals.

The WHO has its flaws, but the United States is best positioned to effect positive changes by maintaining our seat at the table. Historically, we