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FENTANYL: THE NEXT WAVE OF THE OPIOID CRISIS

TUESDAY, MARCH 21, 2017

House of Representatives,

Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2123 Rayburn House Office Building, Hon. Tim Murphy [chairman of the subcommittee] presiding.

Present: Representatives Murphy, Griffith, Barton, Burgess, Brooks, Collins, Walberg, Walters, Costello, Carter, Bilirakis, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Peters, and Pallone (ex officio).

Staff present: Jennifer Barblan, Counsel, Oversight and Investigations; Elena Brennan, Legislative Clerk, Oversight and

Investigations; Adam Buckalew, Professional Staff, Health; Karen Christian, General Counsel; Zachary Dareshouri, Staff Assistant; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Scott Dziengelski, Policy Coordinator, Oversight and Investigations; Brittany Havens, Professional Staff, Oversight and Investigations; Kevin McAloon; Alex Miller, Video Production Aide and Press Assistant; David Schaub, Detailee, Oversight & Investigations; Jennifer Sherman, Press Secretary; Alan Slobodin, Chief Investigative Counsel, Oversight & Investigations; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Staff Assistant; Jon Monger, Minority Counsel; Dino Papanastasiou, Minority GAO Detailee; and C. J. Young, Minority Press Secretary.

Mr. Murphy. Good morning. Welcome to this hearing called "Fentanyl: The Next Wave of the Opioid Crisis."

America is in a full-on opioid crisis. About two decades ago, it started with the over prescribing of opioid drugs and then shifted more to heroin. Today, the subcommittee examines the next wave of the opioid crisis, an even more dangerous threat on our streets -- fentanyl.

Fentanyl is made in the lab and for many years it has been a powerful pain medicine used by patients with cancer or for those with extreme pain.

I might add to this, I remember when I was injured in Iraq a few years ago battlefield medicine meant in recovery they gave me lots of fentanyl patches and I know what it is like to have the reaction to that.

It is 50 times more potent than heroin and 100 times more potent than morphine. Now illicit fentanyl has become a potent additive to heroin, cocaine or even counterfeit prescription drugs.

This is the way the drug dealers increase profits, stretch out their supply and expand the number of addicts by juicing the potency of heroin or other street drugs, sort of what people have done with MSG in foods.

Users often don't even know that fentanyl is in the heroin.

The fentanyl crisis is exceptionally dangerous because of its high potency and the speed with which it reaches the brain. Just two milligrams of fentanyl can kill,
whether swallowed, inhaled or absorbed through skin.

To appreciate how small an amount of two milligrams is, a sweetener packet that you see at your restaurant table is about 1,000 milligrams. Two milligrams of fentanyl can kill you.

Those suffering from an overdose involving fentanyl may require both higher doses and multiple administrations of naloxone to reverse the overdose and to become stabilized. Even the police and first responders are at risk from inadvertently touching or inhaling fentanyl powder at a crime scene or helping an overdose victim.

In March 2015, the Drug Enforcement Administration, or DEA, issued a nationwide alert on fentanyl as a threat to health and public safety.

A year later, the DEA sent another alert, calling the spike in fentanyl seizures an unprecedented threat. Customs and Border Protection data shows an 83-fold increase in the amount of fentanyl seized in three years.

An added challenge is that there are many chemical variations of fentanyl, commonly referred to as analogues. There are about 30 known analogues.

However, only 19 of these analogues are controlled substances under federal law. Since 2013, fentanyl overdoses and deaths have surged with no end in sight. Fentanyl and its analogues have contributed to at least 5,000 overdose deaths in the United States, including the death of music star Prince last year. In my district alone, fentanyl-related deaths have exploded since 2014.

Last year, 86 people in Westmoreland County died from drug overdoses linked at least in part to fentanyl, and even these statistics seriously undercut the fentanyl threat nationally because most states and localities are not testing or tracking fentanyl in drug overdose cases. So we are flying blind.

At this rate, the capacity of law enforcement and the healthcare system will be overwhelmed. China is the primary source of fentanyl and there are thousands of labs making illicit pure fentanyl as well as the source of ingredients or precursors needed to manufacture fentanyl.

Traffickers ship these ingredients to secret labs in Mexico run by drug cartels and then smuggle pounds of fentanyl over the Southwest border through our porous borders, launching it through catapults or drones and into the U.S.

Chinese labs are also a primary source for fentanyl ordered on the open Internet and on the Dark web. Pure fentanyl is

delivered through the mail or air express carriers.

Finally, China is the main source of pill presses that can make thousands of pills an hour to support fentanyl press mill operations. I might add here I am pleased that China is saying that they are taking some action in helping to reduce this and we look forward to working with them because it is so deadly.

The fentanyl problem is spreading and going to get worse because the money and profit is enormous. According to the data from the DEA, a kilogram of heroin can be purchased for roughly $6,000 and sold wholesale for $80,000.

However, a kilogram of pure fentanyl can be purchased for less than $5,000 and is so potent that it can be stretched into 16 to 24 kilograms of product when using cutting agents such as talcum powder or caffeine.

Therefore, while each kilogram of fentanyl can be sold wholesale for $80,000, it can result in a total profit in the neighborhood of $1.6 million. That is about 20 times more profit.

We need a federal strategy dedicated to combating fentanyl as the clear and present danger it presents to our national security and public health.

We welcome our panel of witnesses today. We salute you for

your work, thank you for appearing today and look forward to working with people -- look forward to working together to stop the spread of this epidemic.

Now I recognize my friend from Colorado, Ms. DeGette.

Ms. DeGette. Thank you so much, Mr. Chairman.

Every day somewhere in this country there is a news account about how opiate addiction has wrecked a small town or family. Personal stories about Americans who have become addicted to pain pills and then they get hooked on heroin.

These are heartbreaking stories about Americans dying and leaving loved ones, often their children, to pick up the pieces. The opioid epidemic is unprecedented and it is escalating, and I think we all agree that we need a comprehensive strategy to confront it.

In 2015, more than 33,000 Americans died of an overdose involving a prescription or illicit opioid and more than 2 million people had an opioid use disorder.

Fentanyl is, of course, an even deadlier layer to this crisis. It can be up to 50 times more potent than heroin and a 100 times more potent than morphine. It's lethal at even the tiniest amounts and anyone exposed to it can be -- can have its detriments.

You know, illicit fentanyl is not a new problem. What is

new, though, is its growing prevalence. Since 2010, that number covered by American law enforcement nationwide has risen twentyfold, from 640 samples tested to 13,000 samples tested in 2015, according to information from the DEA.

U.S. law enforcement, as the chairman said, believes China is the primary source of illicit fentanyl and precursor chemicals. Chinese producers ship fentanyl or chemicals to make it directly into the United States.

Precursor chemicals, or finished fentanyl, is shipped to Mexico and Canada where it is trafficked across our borders in pure form or is mixed with other illicit drugs like heroin.

Today, we want to ask the panel some tough questions about law enforcement and diplomatic efforts to stem the tide of fentanyl flowing from China and whether they are sufficient.

We are also going to ask which vectors drug traffickers use to ship this drug into our country, like express consignment carriers and international mail.

I think this is another important step that this subcommittee had been taking to address the opioid epidemic, and for the record I want to continue this bipartisan work.

That said, Mr. Chairman, I also think we need to find a way to address the treatment side of this epidemic and this is, sadly, where I have significant differences with my majority colleagues.

Passage of the Affordable Care Act, as you know, has led to nearly 20 million Americans gaining healthcare coverage. In addition, the ACA has enabled governors to expand the Medicaid services they offer, which was critical in states that were overwhelmed by the opioid epidemic.

Studies estimate that since 2014 1.6 million uninsured Americans gained access to substance abuse treatment across the 31 states like mine that expanded Medicaid coverage.

This is particularly important for hard-hit states like Kentucky, where one study reports that residents saw a 700 percent increase in Medicaid beneficiaries seeking treatment for substance use.

Two weeks ago, the majority rushed through this committee a bill to repeal the ACA that many believe will threaten the progress that Medicaid expansion has made in getting people suffering from addiction into treatment.

In its assessment of that bill last week, the Congressional Budget Office said that millions of Americans -- 24 million of them -- will lose health coverage.

Many of those will be people currently receiving Medicaid assistance which include people receiving treatment for opioid addiction.

In January, healthcare experts from Harvard and NYU wrote

and op-ed for the Hill about how repealing the ACA would reverse important public health gains. They focused primarily on my baby, the 21st Century Cures Act which I did with Fred Upton and all of this whole committee. We approved it unanimously.

But it really -- we can have a whole hearing just about how badly the GOP's ACA repeal bill will hamper the progress that we just passed in 21st Century Cures.

I just want to draw attention to one part of this op-ed, though, where they authors wrote "repealing the ACA and its behavioral health provisions would have stark effects on those with behavioral health illnesses. We estimate that approximately 1,253,000 people with serious mental disorders and about 2.8 million Americans with a substance abuse disorder of whom about 222,000 have an opioid disorder would lose some or all of their insurance coverage."

The end of the day, we don't know what kind of bill is going to reach the president's desk. But if we really want to address the opioid crisis, I suggest that we don't pass this very poorly thought out piece of legislation.

I yield back.

Mr. Murphy. Gentlelady yields back.

I know recognize the chairman of the full committee, Mr. Walden, for five minutes.

Mr. Walden. I thank the gentleman and I thank you for holding this very important hearing.

The opioid crisis, as we know, has touched every corner of our nation. Just like my colleagues, I have met with community leaders, physicians, first responders, law enforcement and families on this issue.

Each have shared their heartbreaking stories on the effects of this crisis in our communities. You see, addiction doesn't understand politics. It doesn't understand income. It doesn't understand race or where someone's from. It is an equal opportunity destroyer. This crisis has hit close to home for all of us.

Last Congress, this committee worked in a bipartisan way to advance sweeping legislation to fight the nation's opioid epidemic. It was an effort that actually began in this subcommittee, which held a series of hearings that examined the growing problems of prescription drug and heroin abuse.

We should be proud of those efforts but as we will discuss today there is a new threat emerging. Last year, there were encouraging reports that showed that the number of prescriptions for opioids in the United States had finally declined. That was good news. For the first time in 20 years that had happened. Yet, we saw the number of opioid-related overdoses and

overdose-related deaths continuing to surge upward and we ask why.

That is why we are having the hearing today. Emerging data strongly suggests the main driver is fentanyl and its chemical variations. Fentanyl essentially represents a third wave in the nation's ongoing opioid crisis. It is why we are here.

Fentanyl is a more challenging threat within the opioid crisis in comparison to threats of prescription opioid and heroin. The fentanyl threat is multifaceted. It's been produced as a legitimate pain medication by drug companies for decades but it is also produced illicitly in black market operations in China.

Illicit fentanyl is hard to detect and, unlike prescription pain killers, it is not primarily diverted from the legitimate market nor is it strictly comparable to the black market of heroin. It can be purchased over the internet openly or on the Dark Web.

Precursor chemicals used to make fentanyl are produced in China and shipped to clandestine labs in Mexico. Drug cartels are smuggling massive amounts of fentanyl with other narcotics from Mexico across the Southwest border.

Drug traffickers in the United States not only are getting deliveries of fentanyl from China through the mail or express carriers but they are also getting direct or indirect shipments from China of pill presses that can make thousands of pills an hour to fuel their operations and distribution networks into our

towns, our communities and the lives of our citizens.

Pure fentanyl is not considered a replacement drug for OxyContin or heroin. It is too potent. Just two the three milligrams can kill an individual, and has.

More often than not, it is added in to heroin, cocaine or counterfeit drugs to boost the potency and increase the likelihood of addiction. What's even scarier is people taking these drugs may not even know that they are taking fentanyl, let alone what it is.

Fentanyl makes the deadly threat of opioid abuse even deadlier. In 2014 and 2015 in my home state of Oregon, a reported 49 people died from fentanyl. The number of deaths from fentanyl appears to be rising and that is just what we know.

As we work to combat this quickly-evolving public health threat, there is an important question to be asked -- how can we fight this threat when we don't even know how quickly it is spreading.

Combating this growing multi-faceted fentanyl threat will require more than drug control strategies aimed at opioid over prescribing and heroin.

Fentanyl is a global problem that requires an urgent response. I commend the efforts of our government, ONDCP, DEA and the State Department particularly for their success in gaining

cooperation with China and the United Nations. We need to continue and support this international engagement to be successful.

Like our work on the opioid epidemic last Congress, combating fentanyl truly requires an all-hands-on-deck effort. We need to think outside the box to find ways to stop the surge of the fentanyl crisis and I look forward to your testimony and working with all of you to solve this problem, and I yield the balance of my time to the gentleman, the chairman of the Health Subcommittee, Mr. Burgess.

Mr. Burgess. Thank you, Mr. Chairman, and thank you, Mr. Chairman, for holding the hearing.

I want to thank the DEA. Mr. Milione, I think you have been in to my office to talk about this issue in the past one on one. It is of concern to me.

You know, I have been on the Health Subcommittee long enough that in 2005 we were having a hearing about why doctors weren't prescribing adequately for pain and now the past two Congresses we have been concerned about the appearance of the opioid epidemic.

Fentanyl is not a new product. It has been around for some time. But on the other hand, the analogues of fentanyl are relatively new and it is the fueling of the illicit trade with

the ability to get things over the internet, which I think has been probably been the crux of this problem.

We do have problems with the overseas market with the way the supply comes in to our country.

So I hope that we can hear some insight this morning on perhaps some additional things that might be done to stop that flow.

Thank you, Mr. Chairman, and I will yield back -- yield back to the gentleman from Oregon, who then yields back, correct?

Mr. Murphy. Thank you. The gentleman's time has expired.

I recognize the ranking member of the committee, Mr. Pallone, for five minutes.

Mr. Pallone. Thank you, Mr. Chairman.

The opioid epidemic in our country continues to grow at an alarming rate. In 2015, more than 33,000 Americans died of an opioid overdose and more than 2 million individuals have an opioid use disorder. According to the Center for Disease Control, 91 Americans die every day from an opioid overdose.

Today we are focusing on fentanyl, a powerful synthetic opioid that is 50 times more potent than heroin and up to a hundred times more potent than morphine.

Because of its potency, fentanyl is a dangerous substitute for heroin and it results in frequent overdoses that can cause

respiratory depression and even death.

The number of overdose deaths is rapidly increasing and the death rate from synthetic opioids other than methadone increased by 72 percent from 2014 to 2015.

This substantial increase in the death rate from synthetic opioids is largely attributable to the increased availability of illicit fentanyl.

I want to thank our witnesses today for their testimony and work on this very important issue. Fentanyl is dangerous not only to users but also to our law enforcement and public health officials on the front lines of this epidemic and I look forward to working together to explore ways that we can better confront the supply of the fentanyl now plaguing our communities.

I also would like to talk today about the treatment side of the opioid epidemic. Just two weeks ago committee Republicans rushed Trumpcare through the committee, a bill which repeals the Affordable Care Act. The ACA has been instrumental in addressing the current opioid crisis and, inexcusably, Trumpcare would only exacerbate the crisis.

Thanks to Medicaid expansion under the ACA, 1.6 million people with substance use disorders now can receive the treatment they need in the 31 states and Washington, D.C. that expanded the program.

But Trumpcare effectively ends Medicaid expansion in 2020. According to the CBO, Trumpcare also cuts $880 billion in federal outlays for Medicaid over the next 10 years, which will severely undermine our efforts to fight the opioid crisis.

These drastic cuts in Medicaid made possible by Republican plans to end Medicaid expansion in the CAPTA program will ration care for millions of Americans including the rationing of substance abuse treatment.

Trumpcare also repeals the central health benefits for Medicaid expansion enrollees at the end of 2019. States would no longer have to offer benefits like substance abuse, mental health services or prescription drugs to millions of Americans who rely on such care.

Repealing the essential benefits packages effectively repeals the mental and substance use disorder coverage provisions of the ACA and would remove approximately $5.5 billion annually from the treatment of low-income people with mental and substance use disorders.

Repeal will take away care from those who are actively seeking treatment and preventive services and we simply cannot afford to eliminate this care in what is oftentimes a life and death situation.

Trumpcare threatens access to lifesaving treatment for more

than 1 million people with opioid disorders.

Our hearing today explores the fentanyl problem. However, I would argue that this issue is a part of a much wider opioid problem that we are battling.

To address this properly, we must make sure Americans with substance abuse disorders can access effective treatment.

And so, Mr. Chairman, I want to work with you to confront fentanyl and the larger opioid problem. However, in my opinion, repealing the ACA and cutting Medicaid by nearly a trillion dollars over the next 10 years will do nothing but undermine our efforts to treat Americans who are suffering from opioid addiction. We will not be able to arrest our way out of this problem.

Without adequate treatment options for those suffering from an opioid addiction, this problem will only worsen and so will the deaths and destruction we have seen play out across the United States.

I don't know if anybody wants my extra minute. If not, I will yield back.

Mr. Murphy. I thank the gentleman. Yields back.

For a minute, I want to offer for the record, if unanimous consent, an article from the Washington Post called "Where Opiates Kill the Most People in 2015." It has interesting maps of where

these occur throughout the country.

For example, synthetic opioid rates in Ohio, West Virginia and Kentucky and pockets in New Hampshire, Massachusetts, Rhode Island and other aspects, which kind of tell us that there is not one opiate epidemic but several, and no silver bullet.

We are going to have to make sure whatever this committee does and finds today from our esteemed witnesses we are going to have to work in a way to give flexibility -- maximum flexibility to states to work this out.

I ask unanimous consent that the members written opening statements be introduced in the record and without objection those documents will be entered in the record.

[The information follows:]

**********COMMITTEE INSERT 1**********

Mr. Murphy. Now I'd like to introduce our panel of federal witnesses for today's hearing. We will start with Mr. Kemp Chester, acting deputy director in the Office of National Drug Control Policy; Mr. Louis Milione, assistant administrator at the Diversion Control Division within the Drug Enforcement Administration, or DEA; Mr. Matthew Allen, assistant director of Homeland Security Investigative Programs at the U.S. Immigration and Customs Enforcement Division within the Department of Homeland Security, or DHS; the Honorable William Brownfield, assistant secretary of state, International Narcotics and Law Enforcement Affairs of the U.S. Department of State; Dr. Debra Houry, director, National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention; and Dr. Wilson Compton, deputy director at the National Institute on Drug Abuse within the National Institutes of Health.

Thank you all for -- I want to thank all our witnesses today for being here and providing testimony. We look forward to a very productive hearing.

Let me charge you with this, though, which I usually don't do. More people are dying of drug overdose deaths than of guns.

We have reached the point where more people are dying of drug overdose deaths than deaths in the entire Vietnam War, almost in a per year basis.

What you are going to tell us today is falling on ears that are open to anything you can offer us. The families in America -- and you have heard the stories, impassioned stories from members here -- stories of the deep concerns of the number of the deaths, the devastation in communities -- what you're saying here is extremely important.

So we look forward to hearing from you on this growing threat of fentanyl and opioid-related deaths.

So as you are aware, this committee is holding an investigative hearing and when doing so it is our practice of taking testimony under oath.

Do any of you have any objection to giving testimony under oath? Seeing no objections, the chair then advises you are under the rules of the House and rules of the committee. You're entitled to be advised by counsel.

Do any of you desire to be advised by counsel during your testimony today? Seeing none, in that case, will you all please rise and raise your right hand and I'll swear you in.

[Witnesses were sworn.]

Thank you. You are all sworn in. You are now under oath and subject to the penalties set forth in Title 18 Section 1001, the United States Code.

I will call upon you each to give a five-minute summary of

your written statement. Just watch the lights there and you'll have a sense of that.

I'll begin with Mr. Chester. You are recognized for five minutes.

STATEMENTS OF KEMP L. CHESTER, ACTING DEPUTY DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY; LOUIS MILIONE, ASSISTANT ADMINISTRATOR, DIVERSION CONTROL DIVISION, DRUG ENFORCEMENT ADMINISTRATION; MATTHEW C. ALLEN, ASSISTANT DIRECTOR, HOMELAND SECURITY INVESTIGATIVE PROGRAMS, HOMELAND SECURITY INVESTIGATIONS, U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, DEPARTMENT OF HOMELAND SECURITY; THE HONORABLE WILLIAM R. BROWNFIELD, ASSISTANT SECRETARY OF STATE, INTERNATIONAL NARCOTICS AND LAW ENFORCEMENT AFFAIRS, U.S. DEPARTMENT OF STATE; DR. DEBRA HOURY, DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, CENTERS FOR DISEASE CONTROL AND PREVENTION; DR. WILSON M. COMPTON, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH

STATEMENT OF KEMP L. CHESTER

Mr. Chester. Chairman Murphy, Ranking Member DeGette and members of the subcommittee, thank you for inviting me and my interagency colleagues to discuss the public health and public safety issues surrounding the opioid epidemic, particularly that of illicit fentanyl and what the federal government is doing to address this problem.

I appreciate the committee's strong support of our work to reduce drug use and its consequences. I currently serve as the

acting director of the Office of National Drug Control Policy, which crafts the president's drug control policy and oversees all federal government counter drug activities and related funding.

This is a critical mission because, as you are aware, more than 52,000 Americans died from a drug overdose in 2015. That's an average of 144 per day with 91 of those deaths involving opioids such as prescription pain medications, heroin and illicit fentanyl.

Overdoses involving opioids have nearly quadrupled since 2000 and between 2013 and 2015 the number of deaths involving synthetic opioids other than methadone, a statistical category that includes fentanyl, has more than tripled, reaching nearly 10,000 in 2015, and this number is likely low because not every overdose death investigation looks for fentanyl.

The majority of the illicit fentanyl in the U.S. is smuggled in after being produced in Mexico or China. Both heroin and clandestinely produced fentanyl can be manufactured, packaged and smuggled by the same drug trafficking organization.

The reemergence of illicit fentanyl represents a complex problem. It is considerably more powerful than heroin, its precursor chemicals are not fully controlled in other countries.

It's being added into the heroin supply or pressed into counterfeit prescription opioid pain pills, meaning users are

often unaware they are taking fentanyl, and because of its potency it can be shipped in small packages and transactions then involve relatively low dollar amounts, making it much harder to detect.

First responders and police officers report that they need to use much more than the standard dose of naloxone to reverse an overdose caused by fentanyl, which strains resources.

We also have a limited capacity to treat those who habitually use illicit opioids. Only one in nine people in the U.S. who need treatment are receiving it and we have seen outbreaks in many states where fentanyl, carfentanil and other fentanyl analogues have played a role in the wave of overdose deaths that devastate communities.

In short, illicit fentanyl is exacerbating an already challenging problem that the federal government is working extremely hard to address.

The reality of this epidemic has led us to adopt new ways of addressing drug use and trafficking. That's why the heart of our effort is the partnership between public health and law enforcement, some of whom are represented here today, to help address the problem in communities across the country.

We are also working with our State Department colleagues to engage foreign partners to prevent illicit drugs from being manufactured and trafficked into the United States.

In terms of public health, we are working to prevent new initiates to drug use by encouraging prescriber and public education, encouraging prescribes to use the CDC's guidelines and their state prescription drug monitoring programs and emphasizing prevention efforts to deter drug use initiation, including ONDCP's Drug-Free Communities Program.

We are also working to expand access to treatment including evidence-based medication assisted treatment for opioid use disorder and help people sustain long-term recovery.

In this regard, we deeply appreciate Congress' support for treatment expansion through the funds authorized under the 21st Century Cures Act.

Another critical innovation is that we are helping to build new partnerships between local law enforcement partners in the public health community to end this crisis and to establish routine cooperation between the federal government and the state, tribal and local levels.

In terms of reducing the availability of these drugs in the United States, the federal government's efforts are centered on stopping illicit drugs before they cross our borders and dismantling the organization that traffic drugs into and through our communities.

Within ONDCP, the National Heroin Coordination Group was

created in October 2015 in partnership with the National Security Council to synchronize federal government efforts to reduce the availability of heroin and illicit fentanyl across the country and address gaps in redundancies in department and agency activities through its interagency-coordinated heroin availability reduction plan, which addresses heroin and fentanyl as a single problem set.

ONDCP also funds the High-Intensity Drug Trafficking Areas program that coordinates anti-trafficking efforts and intelligence across state, local, tribal and federal law enforcement communities, and in 2015 ONDCP developed the Heroin HIDTA Response Strategy, a coordinated effort across 20 states and the District of Columbia in response to the heroin and fentanyl crisis.

And internationally we are working with foreign partners like Mexico, China and Canada to reduce the supply of illicit fentanyl, its precursors and its analogues into and across North America.

While we are working diligently to turn the tide on this epidemic and perhaps are making some progress we continue to work through numerous challenges such as detecting illicit fentanyl at our borders and in our mail and parcel system, working with our international partners to reduce the manufacturing and

trafficking of heroin and fentanyl, and finding and disrupting the internet marketplaces where illicit fentanyl is purchased and delivered.

Mr. Murphy. Could you finish up because we are --

Mr. Chester. Yes, sir.

As the federal government works to reduce the size of the opioid-using population through prevention and treatment and reduce the availability of these drugs in our communities, your support for these efforts is critical to our success.

Thank you, and I look forward to answering your questions.

[The prepared statement of Kemp L. Chester follows:]

**********INSERT 2**********

Mr. Murphy. Thank you, Mr. Chester.

Mr. Milione, you're recognized for five minutes.

STATEMENT OF LOUIS MILIONE

Mr. Milione. Thank you, Committee Chair Murphy, Ranking Member DeGette, distinguished members of the subcommittee.

I want to put these overdose death numbers in some context. So spring is here today and major league baseball will kick off their season next month.

Picture the MLB stadium in any of your respective cities. The more than 52,000 Americans we lost in 2015 to drug overdoses wold overflow any of those MLB stadiums bar one.

I'm sure we all agree that this is an unimaginable tragedy. To the DEA, the fentanyl threat and the broader opioid epidemic are the number-one drug threats facing our country.

With illicit-produced fentanyl you have substances many times more potent than heroin, sold as heroin, mixed with heroin and, increasingly, pressed into pill form before being sold by criminal networks on our streets as prescription pain killers.

There are five pills that represent five counterfeit pain killers. Based on laboratory analysis of the thousands of seized counterfeit pills, one of every five will contain three times the lethal amount of fentanyl -- lethal at 2 milligrams, as was mentioned earlier. To the unsuspecting user, death is lurking in just one of these pills.

Sadly, but not unexpectedly, Mexican cartels are exploiting the opioid use epidemic and aggressively purchasing illicitly-produced fentanyl from China, shipping it to Mexico, mixing it with heroin and other substances and shipping it back into the United States through established distribution networks where it is sold in our communities.

Illicitly-made fentanyl is also being shipped from China into Canada for distribution across our northern border. It's also being shipped directly from China into the United States for domestic distribution cells.

Why are they doing this? Greed and a complete disregard for human life. There is a massive profit potential with fentanyl. One kilogram of pure fentanyl costs approximately in China about $3,500.

If you project that kilogram of fentanyl all the way through the supply chain to the distribution level, that $3,500 kilogram will potentially yield millions of dollars in revenue.

For the DEA and broader U.S. government to deal successfully with this threat we need a balanced holistic approach that attacks supply and reduces demand. Most importantly, we must be proactive.

We need to use any and all available investigative techniques to identify, infiltrate, indict, capture and convict all members

of these criminal organizations both domestic and foreign.

With 221 domestic offices in 21 field divisions and 92 foreign offices in 70 countries, DEA, working with our federal, state, local, international partners is well positioned to engage in this fight.

Throughout DEA's proud history our greatest successes have come from our collaborative efforts with the U.S. interagency and our foreign counterparts. Our approach to this threat is no different.

We have had success and we will continue to have successes against members of these fentanyl manufacturing and distribution networks. But here is the most frustrating part.

Foreign-based fentanyl manufacturers and the domestic Pied Pipers of this poison often operate with impunity because they exploit loopholes in the analogue provisions of the Controlled Substances Act and capitalize on the lengthy resource-intensive reactive process required to temporarily or permanently schedule these dangerous substances.

As we speak, criminal chemists in foreign countries are tweaking the molecular structure of different fentanyl analogues, keeping the same dangerous pharmacologic properties as the controlled substances but helping the manufacturers and distributors avoid criminal exposure because of an altered

molecular structure.

Since July of 2015, DEA has emergency scheduled five illicitly-produced fentanyls. Four are currently in process. We are tracking 19 more.

Scheduling actions are critical important but they are reactive, resource-intensive processes. We will continue to do everything we can on the scheduling front but in the short-term this esteemed body could provide DEA and our law enforcement partners immediate relief by placing the identified fentanyls and the other dangerous synthetic substances into Schedule I.

This would allow us to keep these drugs out of country and bring to justice the egregious domestic and foreign traffickers preying on our youth and flooding our country with these dangerous drugs.

I would like to end with two oppositive but interconnected images -- sunlight and shadows. DEA will always operate in the sunlight. We will always follow the rule of law. We will work to reduce demand with our community outreach and prevention efforts throughout the country.

But we have to also operate in the shadows. We need to infiltrate these secretive dangerous transnational criminal organizations wherever they are here in the United States or in foreign countries.

We need to develop and collect the necessary evidence to bring those that exploit human frailty for profit out from the shadows and into the sunlight of our transparent judicial system for prosecution in the U.S.

The brave men and women of DEA will continue to do the necessarily difficult and dangerous work to address this threat.

Thank you for the opportunity to appear before you and I look forward to answering any of your questions.

[The prepared statement of Louis Milione follows:]

**********COMMITTEE INSERT 3**********

Mr. Murphy. Thank you, Mr. Milione.

Now, Mr. Allen, you're recognized for five minutes.

STATEMENT OF MATTHEW C. ALLEN

Mr. Allen. Chairman Murphy, Ranking Member DeGette and distinguished members, thank you for the opportunity to appear before you today to discuss the heroin and fentanyl crisis in the United States and the efforts of U.S. Immigration and Customs Enforcement to target, investigate, disrupt, and dismantle and bring to justice the criminal elements responsible for manufacturing, smuggling, and distribution of dangerous opioid.

As the largest investigative agency within DHS, ICE Homeland Security Investigations investigates and enforces more than 400 federal criminal statutes.

HSI special agents use their authority to investigate all types of cross-border criminal activity and work in close coordination with U.S. Customs and Border Protection and the Drug Enforcement Administration in a unified effort with both domestic and international law enforcement partners to target transnational criminal organizations that are supplying heroin and fentanyl to the United States.

Today, I would like to highlight our efforts to reduce the supply of heroin and fentanyl to the U.S. and the operational challenges that we encounter.

The United States, as you have heard already, is in the midst

of a fentanyl crisis that is multifaceted and deadly. Fentanyl is a Schedule II synthetic opioid used medically for severe pain relief and it is 50 to 100 times more potent than morphine.

United States law enforcement has identified two primary sources of the U.S. illicit fentanyl threat -- China and Mexico. China is a global supplier of illicit fentanyl and Chinese laboratories openly sell fentanyl.

In China, criminal chemists work around their government's control efforts by modifying chemical structures to create substances referred to as analogues not recognized as illicit in China but having the same deadly effects.

Although there is ongoing collaboration with China, the lack of current Chinese laws that prohibit analogue manufacturing or export is one of the challenges we face in stemming the flow of illicit fentanyl from China.

Mexican drug cartels also obtain illicit fentanyl and precursor materials required to manufacture fentanyl-related substances from China and primarily use fentanyl as an adulterant in heroin that is produced in Mexico.

The cartels have discovered that manufacturing fentanyl is much more cost effective, efficient and draws less law enforcement attention than cultivating opium poppies to produce heroin.

Fentanyl seized at our U.S. Southwest border is typically

5 to 10 percent in purity. Once illicit fentanyl is distributed in local American drug markets, many people who use drugs, whether heroin or prescription pain pills, are unaware of the presence of more potent fentanyl in their narcotic.

As fentanyl used in suspected heroin or counterfeit pills is more potent than the drugs they resemble, it readily leads to overdosing and this is often how law enforcement first learns that fentanyl or an analogue has been introduced into a local drug market.

The addictive nature and demand for opioids paired with the low cost and high potency of fentanyl used in counterfeit opioid production has led TCOs to compete for a portion of the illicit U.S. drug market.

Illicit fentanyl is not only dangerous for people who abuse drugs but also for law enforcement, public health workers and first responders who could unknowingly come into contact with it.

Accidental skin contact or inhalation of the substance during law enforcement activity or during field testing of the substance is one of the biggest dangers and challenges we face in law enforcement.

In response to the dramatic increase in the availability of opioids, the Office of National Drug Control Policy, in close coordination with other federal departments and agencies,

developed a Heroin Availability Reduction Plan to reduce the supply of heroin and illicit fentanyl in the United States.

ICE has been supporting HARP since its inception. We are targeting supply chain networks, coordinating with domestic and international partners and providing field training to highlight officer safety and collaboration efforts.

ICE is also fully engaged with the DEA Special Operations Division and the CBP National Targeting Center to identify shipment routes, targeting parcels that may contain heroin, illicit fentanyl and fentanyl-related substances and manufacturing materials that go into making pills in the United States, fully exploiting financial and other investigative analyses along the way.

ICE is committed to battling the U.S. heroin and illicit fentanyl crisis that demands urgent and immediate action across law enforcement interagency lines in conjunction with experts in the scientific, medical and public health communities.

Thank you for the opportunity to appear before you today and I look forward to your questions.

[The prepared statement of Matthew C. Allen follows:]

**********INSERT 4**********

Mr. Murphy. Thank you very much.

Now, Mr. Brownfield, you are recognized for five minutes. Make sure your microphone is on, please.

STATEMENT OF THE HONORABLE WILLIAM R. BROWNFIELD

Mr. Brownfield. Thank you, Chairman Murphy, Ranking Member DeGette and members of the subcommittee. Thank you for the opportunity to appear before you today.

The broad interagency panel here today demonstrates that this is a health issue, a law enforcement issue and an international issue.

This opioid crisis is perhaps our worst drug crisis in 30 years. It kills tens of thousands of our fellow citizens every year. Illicit fentanyl is responsible for many of those deaths and virtually all of that fentanyl is sourced from abroad through foreign drug trafficking organizations.

To solve the problem, we must cut off international supply. That is where my INL bureau comes into play.

Our strategy is three-part -- work the neighbors, work China, work the United Nations. First, we realize that most illicit opioids reaching the United States enter through Mexico and Canada.

Mexico produces more than 80 percent of the heroin consumed in the U.S. and Mexican heroin trafficking networks introduce fentanyl into the supply chain.

Since the start of Merida Initiative cooperation in 2008,

we have developed a close relationship with Mexican federal law enforcement. We have delivered hundreds of millions of dollars in border inspection and law enforcement equipment, training and capacity building and intelligence exchange.

Mexico invests $20 for every one of ours. Mexico has increased efforts to eradicate opium poppies and we recently agreed to expand those efforts further.

Canada is suffering its own opioid crisis, although most of its heroin comes from Afghanistan. We coordinate closely with Canada to address a shared crisis, ensuring both governments have statutory authority to address the problem and sharing real-time law enforcement intelligence.

And all three governments cooperate through the new North American Drug Dialogue where we share information on narcotics research, exchange best practices and develop actions to protect our citizens.

Second, we have expanded cooperation with China, a major fentanyl source country. In 2015, China moved to regulate 116 new synthetic drugs and on March 1st of this year it added four critical fentanyl analogues to its domestic control including carfentanil, sometimes described as fentanyl on steroids -- 100 times more potent than fentanyl.

We asked China to do more, but I acknowledge these steps by

the Chinese government. They improve our ability to track and control fentanyl and other synthetic drugs entering the United States.

We are also using, targeting and sanctions programs like the narcotics reward and drug kingpin authorities to target fentanyl traffickers.

For nearly 20 years, the U.S. and China have coordinated law enforcement policy through the U.S.-China Joint Liaison Group on Law Enforcement and that dialogue produces valuable cooperation.

Third and finally, we are working through the U.N. system to regulate dangerous opioids and precursors throughout the world. I was in Vienna last week for the annual meeting on the Commission on Narcotic Drugs, the governing body for all U.N. drug policy.

By a vote of 51 to 0, the CND approved our proposal to regulate two essential fentanyl precursors. The entire process took four months rather than the normal two years, and while the regulation will not stop illicit fentanyl production, it will be more difficult for criminals to obtain the chemicals needed to make it and easier for countries to prosecute them.

We also support programs by the U.N.'s drug control organization, UNODC, to eliminate opium poppy cultivation and heroin production in Afghanistan, Mexico, Colombia and Guatemala.

Mr. Chairman, members of the committee, we have an international strategy. We are committed to that strategy. We welcome ideas to improve that strategy.

I have learned two lessons in 25 years engagement in international drug policy. First, it takes decades to get into a drug crisis and will take years of patient persistent effort to get out. Second, no strategy is so perfect it cannot be improved.

Thank you, Mr. Chairman. I look forward to the committee's suggestions.

[The prepared statement of The Honorable William R. Brownfield follows:]

**********INSERT 5**********

Mr. Murphy. Thank you.

Dr. Houry, you are recognized for five minutes.

STATEMENT OF DR. DEBRA HOURY

Dr. Houry. Chairman Murphy, Ranking Member DeGette, I would like to thank you for inviting me here today to discuss this very important issue.

As the director of the National Center for Injury Prevention and Control at the CDC, I would also like to thank the committee for your continued interest in the prevention of opioid misuse and prevention and overdose.

As an emergency physician, I have seen first hand this devastation all over the country. Drug overdose deaths in the United States have nearly tripled in the last 15 years. In 2015, there were approximately 52,000 drug overdose deaths and of those 63 percent involved an opioid.

The large increase in deaths seem to be primarily driven from heroin and synthetic opioids such as fentanyl. fentanyl is an opioid analgesic 80 times more potent than morphine and is almost administered in hospital settings for painful conditions.

Illegally-manufactured fentanyl can be mixed with or sold as heroin and is fast acting. Overdoses can occur in seconds after consumption and an overdose from fentanyl is much more difficult to reverse because it is so powerful.

The rate of drug overdose deaths involving fentanyl more than

doubled from 2013 to '14, and some states have seen the dramatic effect of this drug much more so than others.

For example, Massachusetts experienced a surge of opioid-related deaths from 698 in 2012 to 1,747 in 2015. To examine this increase, the Massachusetts Department of Public Health requested CDC's assistance in an epidemiological investigation, or Epi-Aid.

CDC determined that over 74 percent of the recent drug overdose deaths involve fentanyl and recommended conducting outreach to high risk groups such as people with substance abuse problems recently released from incarceration.

The rise in fentanyl, heroin and prescription drug overdoses are not unrelated. In Ohio, CDC found that approximately 62 percent of fentanyl and heroin overdose deaths were preceded by at least one opioid prescription during the seven years prior to death and one in five people who died from a fentanyl overdose had an opioid prescribed to them at the time of their death.

CDC is committed to three strategies that comprehensively protect the public's health and prevents all opioid misuse and overdose deaths.

The first approach is improving data quality and timeliness to better track trends, identify communities at risk and evaluate prevention strategies.

CDC funds 12 states to improve tracking and reporting of illicit opioid overdoses including fentanyl. Improved surveillance is crucial for states to facilitate faster identification in response to spikes in overdoses, leading to quicker, more tailored interventions.

The second approach is supporting states in their efforts to implement effective solutions and interventions. CDC has funded 44 states and Washington, D.C. for prevention efforts and surveillance activities.

For example, we have funded Ohio to use their prescription drug monitoring program to identify high-risk patients and they have achieved full data integration with Kroger Pharmacies as part of their integration with electronic health records.

Our third approach is to equip health care providers with the data and tools needed to improve the safety of their patients. To aid primary care providers and evidence-based prescribing practices, CDC developed and published the CDC guideline for prescribing opioids for chronic pain.

In addition to the critical partnership with states, CDC knows this epidemic requires partnerships across sectors and we've been working side by side with law enforcement. We are working with the Drug Enforcement Agency to implement prevention strategies and have initiated a personnel exchange.

The heroin response strategy, which is funded by ONDCP and deployed in eight high-intensity drug trafficking areas, sets out to link public health and public safety. CDC is working to coordinate public health workers on the ground. Successfully addressing this problem requires focused efforts in prevention. All three components -- law enforcement, treatment and prevention -- must work together to reverse this dangerous threat. We each have a critical role to play. Without effectively preventing more Americans from developing opioid use disorder in the first place we will never get ahead of the problem. Without prevention, more Americans will require treatment, often for the rest of their lives, and more will overdose.

Thank you again for the opportunity to be here with you today and for your continued support of CDC's work in protecting the public's health. I look forward to your questions.

[The prepared statement of Dr. Debra Houry follows:]

**********INSERT 6**********

Mr. Murphy. Thank you, Doctor.

Now, Dr. Compton, you're recognized for five minutes.

STATEMENT OF DR. WILSON M. COMPTON

Dr. Compton. Chairman Murphy, Ranking Member DeGette and members of the subcommittee. Thank you for inviting me to provide an overview of how science can help us address the rise in fentanyl use in overdose deaths.

My name is Dr. Wilson Compton and I'm the deputy director of the National Institute on drug abuse. As a physician and researcher, I've seen first hand the devastating impact of the opioid crisis on families and communities and have conducted numerous studies to better understand trends in opioid use and ways to respond.

What is fentanyl and its relationship to the opioid crisis? Fentanyl's high potency and fat solubility allow it to rapidly enter the brain, leading to a fast onset of effects which increases the risk for addiction and overdose.

The emergence of fentanyl and other even higher potency synthetic opioids creates enormous challenges for controlling supply since very small amounts can cause large-scale damage to users as well as to law enforcement and first responders who may come into contact with the drugs.

Fentanyl is one part of the ongoing opioid overdose epidemic which also includes prescription opioids and heroin. While

recent federal and state efforts have begun to help curb over prescribing of the prescription opioids, overdoses continue to rise mainly due to the rise in heroin in fentanyl-related deaths.

NIDA's efforts in this area are part of the broader initiatives of the Office of National Drug Control Policy and the Department of Health and Human Services.

The population of people using fentanyl largely overlaps with those using heroin and so the strategies being implemented to address the ongoing opioid crisis are expected to help address fentanyl addiction and overdoses.

NIDA, along with FDA, co-chairs the Opioid Subcommittee of the Department of Health and Human Services Behavioral Health Coordinating Council and in this role we help to coordinate interagency efforts.

So how is research helping to address the opioid crisis? NIDA has supported the development of the three medications that have been FDA approved to treat opioid addiction. Methadone, buprenorphine and naltrexone all have strong evidence of effectiveness.

Despite this effectiveness, only a fraction of people with opioid use disorders are being treated with these medications due to limited treatment capacity, stigma, lack of provider training and cost.

Therefore, NIDA research is helping to develop strategies to promote wider adoption of these medications in variety of settings. For example, initiating buprenorphine treatment in emergency departments has been shown to help ensure that people who overdose are effectively engaged in ongoing treatment for their underlying opioid use disorder.

Other studies have found that providing interim buprenorphine or methadone while awaiting admission to a treatment program reduces opioid use and increases the likelihood of engaging in treatment.

How can research specifically inform our response to fentanyl? Through NIDA's national drug early warning system, we are supporting research to better understand fentanyl's use patterns and trends in hot spots such as Ohio and New Hampshire.

In the first phase of the New Hampshire study, for example, researchers reported that about one-third of fentanyl users knowingly use the drug and may seek out a certain dealer or product when they hear about overdoses because they think it must be highly potent.

What about overdose treatment? Although naloxone can rapidly reverse an opioid overdose, the current standard dose of naloxone is likely not adequate to reverse some overdoses from high-potency opioids like fentanyl.

In response, we are supporting research to develop new longer lasting naloxone formulations and new administration protocols.

NIDA also supports research on prevention and treatment. For instance, in partnership with the CDC, SAMHSA and the Appalachian Regional Commission, NIDA is testing interventions to address opioid misuse in rural America.

In addition, we are planning a research initiative to study treatment expansion models resulting from the additional resources provided to states via the 21st Century Cures Act.

Research is also underway to develop a vaccine for fentanyl to keep fentanyl from entering the brain, thereby protecting against addiction and overdose.

In summary, over 33,000 deaths for opioid overdoses occurred in 2015 with nearly 10,000 involving synthetic opioids like fentanyl. Science-based solutions are available. The challenge is often in their implementation.

NIDA will continue to work closely with the other federal agencies, both those that are here today and many others, community organizations and private industry to address these complex challenges.

Thank you. I look forward to your questions.

[The statement of Dr. Wilson M. Compton follows:]

**********INSERT 7**********

Mr. Murphy. Thank you, Doctor.

We will now begin with questions. I will recognize myself for five minutes.

Mr. Chester, does the ONDCP believe that fentanyl is another wave of the opioid epidemic?

Mr. Chester. Yes, sir. It really is two things. I think it is an outgrowth of the -- of the heroin crisis, and then once fentanyl has found its way into the supply chain it represents a unique aspect of that particular --

Mr. Murphy. So do we have a strategic plan? Does the federal government have a strategic plan to address that unique issue?

Mr. Chester. We do. As I mentioned, the Heroin Availability Reduction Plan included both heroin and fentanyl as part of its problem set and that particular plan guides and synchronizes federal government activities against the opioid problem set, specifically heroin and fentanyl. Yes, sir.

Mr. Murphy. Mr. Milione, do you believe that with this unprecedented threat of fentanyl that we have a federal plan solidly in place as broad as it needs to be?

Mr. Milione. I always think there is more to do, based on the level of the threat. Certainly, at DEA it is a priority. We have programs in place to deal with it. But as Ambassador

Brownfield said, there is always room for improvement based on the need of the threat.

Mr. Murphy. Mr. Allen, based on the data that our law enforcement places at international mail facilities at nine different airports in 2015 and 2017, I find it amazing that not one package of fentanyl was detected out of 8,473 that were examined.

Is there more difficulty in coming up with a targeting profile for fentanyl shipments than we know about and what can be done to prove this?

Mr. Allen. Detection of fentanyl in -- you know, at the land border and in consignment packages and mail is a challenge that we continue to deal with. I think we have better success in certain channels than we do in others. Because Customs and Border Protection gets advanced information from the express consignment companies their ability to target packages that are inbound to the United States is much better than our ability to target mail that is coming to the United States because the universal postal union that we operate under does not mandate that international shippers including China and others provide advanced information about packages and mail that is coming to the United States.

Mr. Murphy. So requiring that would help? Would requiring that information help with the postal service?

Mr. Allen. Yes, it would.

Mr. Murphy. Can I also ask where is -- who can answer this question? Where is it coming over the border with Mexico? I understand it is places in California and Arizona, am I correct? Do we know specifically?

Mr. Allen. The two areas where we've seen it most prevalently is in southern California and southern Arizona. The vast majority has been detected.

Mr. Murphy. And how do they bring it across the border?

Mr. Allen. In personally-owned vehicles or on bodies coming -- people that are coming as pedestrians across the land border detected at ports of entry.

Mr. Murphy. People -- so people walk across or people who come through -- legally through ports of entry and it is either way? Illegal or legal, they're both coming through?

Mr. Allen. Legal. Where we are not detecting it is between the ports of entry. We are seeing it come in at designated points of entry and it is being detected and seized and arrests are being made by Customs and Border Protection at ports of entry.

Mr. Murphy. But in other parts we are not seeing it? They're coming across the border in other places and they're not picked up there?

Mr. Allen. On the land border we are not seeing it come

between the ports of entry. The other method of it coming into the United States is through express consignment packages and mail, which generally is detected in the interior at express consignment hubs where all consignment packages are cleared by CBP or at international mail facilities that are designated around the United States.

Mr. Murphy. Thank you.

Dr. Houry, the most recent available data of fentanyl-related overdose deaths come from 2015. Am I correct or do you have more recent data for 2016?

Dr. Houry. So we have data through 2015 but we've also released a quarterly report for 2016 through the National Center for Health Statistics and that is death data.

I think what is really helpful is with the funding that we received this past year we've stood up a surveillance system in 12 states that looks at nonfatal data also. That has been in place for six months.

That allows us to have some DROMIC data from emergency departments to capture more quickly emerging trends.

Mr. Murphy. With all that, is it -- do you think it is still under reported significantly?

Dr. Houry. I do think it is significantly under reported because many medical examiners and coroners aren't testing for

fentanyl analogues. Up to 20 percent of times, you know, the type of drug is not reported. We are working with AFSO and with the National Association of Medical Examiners to improve death certificate reporting.

Mr. Murphy. Dr. Compton, in just a few seconds -- it is a scientific challenge. Can you explain how it is that fentanyl is more dangerous than other opioids medically?

Dr. Compton. Well, the key is through both its strength as well as its fat solubility. So not only is it inherently more potent but it can more rapidly enter the brain where it exerts its respiratory depression, which is what kills people.

Mr. Murphy. And all right. We will get to more of these but I will go to Ms. DeGette now for five minutes. Thank you.

Ms. DeGette. Thank you very much, Mr. Chairman.

Mr. Milione, as I mentioned in my opening statement, I think we all agree the amount of fentanyl recovered by American law enforcement has risen from 640 samples tested to 13,000 samples tested in 2015. Would you agree with that statistic?

Mr. Milione. I would, not having them in front of me. But that sounds right.

Ms. DeGette. Yeah. I mean, it is really raised -- going up in crisis proportions, right?

Mr. Milione. That's correct.

Ms. DeGette. And have arrests for counterfeit pills or sources increased as well?

Mr. Milione. I would have to get back to you as far as if there has been an increase. We have been studying -- we have been very aggressively investigating these networks.

Ms. DeGette. But I think you would agree that the amount of fentanyl recovered has been growing exponentially, right?

Mr. Milione. It has.

Ms. DeGette. Now, Dr. Compton, I want to ask you, because other opioids sometimes -- often lead to fentanyl use some have suggested that to stem the demand for fentanyl we also need to treat opioid addiction because addiction drives the users to seek those other drugs that contain fentanyl. Would you agree?

Dr. Compton. Yes. I think the fentanyl issue is most closely related to heroin addiction. So it is the very same people using heroin that seem to have the most trouble with fentanyl.

Ms. DeGette. And treatment, as we've learned in many, many hearings in this subcommittee, is an important component in the addiction fight. Is that right?

Dr. Compton. Absolutely. We think expanding treatment access is a key component of our -- of our attempts to address this.

Ms. DeGette. Now, based on -- I assume you have had experience with opioids and with heroin. You just can't stop this by arresting people. Would that be fair to say? You have got to also have treatment.

Dr. Compton. I think it is either -- to point out that it is the combined public health and public safety approaches that look most promising.

So we look at models that include criminal justice systems as well as public health as showing reductions in crime as well as important health outcomes.

Ms. DeGette. Okay. But health outcomes are a key part of that, right?

Dr. Compton. Of course.

Ms. DeGette. And so this what I am concerned about. When you're trying to treat opioid addiction, as we have also learned in our many hearings in this subcommittee it is a comprehensive treatment that is very extensive. Wouldn't you agree with that?

Dr. Compton. Yes. We have certainly learned that the treatment needs to last quite a long time. It takes people a long time to turn their lives around and recovery is not an instantaneous process.

Ms. DeGette. And these drugs, they sometimes change the chemistry of the brain so that you have to have to

medication-assisted treatment and other types of tools to be able to treat this. Is that right?

Dr. Compton. Yes. NIDA research has certainly demonstrated that.

Ms. DeGette. And so in some of these states that have been hit hard with the opioid and fentanyl epidemic, the Medicaid expansion that they have been able to get has been able to help them really target populations for addiction treatment and prevention. Would that be fair to say?

Dr. Compton. Certainly treatment expansion is a shared goal for all of us and making sure that the research we support is embedded within the health care system is essential.

Ms. DeGette. Now, in the past few years after the passage of the Affordable Care Act Medicaid was now able to pay up to 50 percent of medication treatment in some of these hardest-hit states. Is that right?

Dr. Compton. Well, I would really want to refer the specific questions about how Medicaid is funded to the state officials that implement those programs or the CMSes.

Ms. DeGette. So you are not familiar about how some states in the last years have been able to increase their treatment?

Dr. Compton. I'm certainly familiar with the state's efforts to expand treatment in the last few years.

Ms. DeGette. Well, let us talk about Ohio, for example. In Ohio, Republican Governor John Kasich recently said, "Thank God we expanded Medicaid because that Medicaid money is helping to rehab people," and in fact a February 6th, 2017 Pew Report noted that Ohio added 700,000 new Medicaid recipients under its expanded program and roughly a third were diagnosed with a substance abuse disorder.

According to the CBO, the Republican ACA repeal's proposal would cut $880 billion in federal outlays for Medicaid over the next 10 years. Would you disagree with any of those figures?

Dr. Compton. Well, certainly, we are interested in research that can look at changes in the health care system. We are partnering with SAMHSA to study the implementation of the 21st Century Cures Act.

Ms. DeGette. Right. But would you -- would you disagree, for example, that Ohio added 700 [sic] new Medicaid recipients under its expanded program and a third were diagnosed with substance abuse disorders?

Dr. Compton. Those figures sound reasonable.

Ms. DeGette. Okay. So what I'm worried about is probably pretty clear. If you reduce the Medicaid expansion that in states like Ohio, Kentucky, West Virginia, other states that have been hard hit by fentanyl and opioid and heroin that that is also going

to reduce the treatment programs we are able to give them.

Thank you, Mr. Chairman.

Mr. Murphy. You're right. We can't arrest our way out of this. We have to treat it. And just a follow-up to what you're saying, do we even have enough providers? Does anybody know? Are we -- we know that have the counties in America don't have psychiatrists, psychologists, social workers. Do we have enough trained drug treatment providers in America?

Dr. Compton. We do not have enough to fully meet the needs and they are not evenly spread across the country. So that is why we are engaging in the rural initiative to address the particularly severe shortages in rural areas.

Mr. Murphy. Thank you very much.

Dr. Houry. And I would just add to that treatment is important but preventing people from needing addiction services in the first place will also save the health care system a lot of money. So making sure we are using safe prescribing practices is a key component.

Mr. Murphy. And we'll get to that as well.

Ms. Walters of California is recognized for five minutes.

Ms. Walters. Thank you, Mr. Chairman.

We have seen the opioid and heroin epidemic ravage every part of our country. Even affluent areas like my home of Orange

County, California, are struggling with over 200 deaths per year.

Now we are witnessing a far deadlier iteration, fentanyl-laced drugs. This incredibly powerful pain killer reserved for the most severe and acute pain are being added to heroin, cocaine and counterfeit drugs.

As a mother of four young adults, it breaks my heart every time I see or hear of another life lost. Just last year, a 19-year-old from Orange County overdosed after taking fentanyl-laced cocaine.

This epidemic again hit home when a DEA investigation resulted in four arrests for an alleged fentanyl importation and distribution conspiracy in Long Beach.

The DEA reported that the men had over 30,000 acetyl fentanyl tablets and 13 kilograms of the narcotic.

Mr. Milione, I want to commend your agency for this investigation and keeping this deadly drug off the streets of Orange County.

Mr. Milione, the making and distributing of pills containing fentanyl has been disguised by molding the pills in a wide variety of counterfeit brands and colors. What are the most prevalent pill types being discovered?

Mr. Milione. Thank you for the question. It's a pretty broad range but oxycodone -- they are going to mimic whatever is

popular on the street depending on the market, depending on the area.

So if there is a real market for oxycodone 30s, they'll replicate those. If it is more a powdered substance that they want in a capsule because they'd rather snort the substance, that market will influence how they package it.

Ms. Walters. What types of pill making machinery are most commonly associated with these counterfeit drug operations?

Mr. Milione. There is a broad range. I mean, anywhere from an inexpensive pill machine to ones that cost $10,000, $15,000, $20,000 that can produce 250,000 pills an hour.

Some of them are handheld that can be very easily used. So it is a broad spectrum there.

Ms. Walters. Okay. And what are the most likely sources of these counterfeit drugs?

Mr. Milione. China is the primary source for the fentanyl. But then, as I said before, going into Mexico and then the networks are shipping the merchandise up into the United States and what we are seeing more and more that actually the pills -- the counterfeit pills are being made in the United States at different domestic transportation cells around the country.

Ms. Walters. Okay. Thank you. And Dr. Houry, we understand that the typical victim of a fentanyl overdose can be

extremely hard to define since it does not follow economic structure or community locales.

What can you tell us about current trends and tendencies?

Dr. Houry. So you are right, we are seeing this epidemic really increase in all demographics. It's most hardest hit in those 20 to 44 and really that -- or 25 to 44 and we are seeing it more in men.

What I think is important, though, is people -- like in Rhode Island we saw that a third of the decedents had had a prescription within the past 90 days for an opioid and a third of those had had a high dose of morphine milliequivalent prescription.

So what we had said in the guideline to really be cautious was that people are getting exposed to opioids and then going on to fuel their addiction through heroin and fentanyl.

Ms. Walters. Okay. Thank you.

And Mr. Chester, in recent months fentanyl was first identified as a major problem in the Northeast, parts of the Midwest and certain states like Florida and Maryland. What do you see as trends or directions of its spread?

Mr. Chester. We have begun to see some indications that it has moved west. Obviously, Sacramento, California was the first one. That was about a year ago that we had begun to see it move a little bit farther west.

I think fentanyl found its way into the Northeast simply because it was easier to mix into the powdered white heroin that was popular in the northeast United States.

And so in the western part of the United States we are beginning to see more of the pill form that Mr. Milione was discussing as well.

But fentanyl, even though it began being geographically concentrated in the Northeast, we've seen indicators of areas throughout the United States.

Ms. Walters. Okay. Thank you. And I yield back the balance of my time.

Mr. Murphy. Ms. Castor is recognized for five minutes.

Ms. Castor. Well, thank you, Mr. Chairman, for calling this hearing and thank you to all of our expert witnesses for shining a light on this.

It does feel like we are in the Twilight Zone though because as we are talking about the seriousness of the opioid epidemic we are faced in two days with a vote on a health bill that will recede in this country's responsibility in health services to families who are addicted, who need substance abuse treatment, mental health treatment.

Mr. Chester, you said that only one in nine are receiving treatment who need it. Mr. Milione, you say we have to reduce

demand as part of a balanced strategy.

And yet, this GOP health care bill that is coming to the floor will take a hatchet to coverage for millions of Americans plus it will end Medicaid health services as we know it that provide in Florida, in most states, the most important mental health and substance abuse health services.

So this is very important. But, boy, this bill that is coming up for a vote would really take us backwards when we are talking about opioids.

In fact, my -- one of my local sheriffs in Pinellas County, which is St. Petersburg and Clearwater, says we cannot and we never will solve this problem at the law enforcement level.

This needs to be treated as an addiction problem -- a mental health problem. We may have had great success in beating back the pill mills but all that meant is we are going to see a switch to different drugs and different dealers.

And I wanted to highlight what's happening in West Virginia because it is startling and there is a good investigative reporter that is shining a light on it.

Mr. Milione, according to a December 2016 article in the Charleston Gazette Mail, opioid wholesalers ship mass quantities of opioid medicines that appear to be foreign excess of what certain communities in West Virginia should receive based on sound

medical needs.

The article says, "In six years, drug wholesalers showered the state with 780 million hydrocodone and oxycodone pills while 1,728 West Virginians fatally overdosed on those two painkillers. The unfettered shipments amount to 433 pain pills for every man, woman and child in West Virginia."

This reporting strongly suggests that West Virginia appears to have been receiving quantities of hydrocodone and oxycodone pills that would clearly be more than what would be medically necessary.

Mr. Milione, are you familiar with some of the reporting which suggests West Virginia may have been grossly oversupplied with dangerous prescription opiates?

Mr. Milione. I am.

Ms. Castor. I mean, this is really shocking. It would appear that addiction to pain pills can, according to all of the reporting and what you all have testified here today that once you have oxy and hydrocodone that takes over someone's life that that will quickly lead to the user seeking more powerful opiates such as heroine or counterfeit pills, both of which may be adulterated with fentanyl.

Dr. Houry, in your testimony you say reversing epidemic -- the epidemic requires changing the way opioids are prescribed.

Is it therefore reasonable to assume that addiction to prescription pain medicines have a connection ultimately to the fentanyl problem and the larger opioid epidemic?

Dr. Houry. Yes. Many of the people who have overdosed on fentanyl have had a opioid prescription at the time of their death. So I believe all of these fentanyl, heroin and prescription opioid overdose deaths are linked.

Ms. Castor. And Mr. Milione, MSNBC also ran a story about the substantial influx of opioids into West Virginia. It reported on a small town called Kermit, which I understand only has 392 people.

They reported that Kermit received 9 million hydrocodone pills in two years. If this reporting is true, it is hard to believe that we have sufficient systems in place to spot dangerous trends.

Is the DEA familiar with the reports regarding what happened in this small town with the oversupply of addictive pills and what can you tell us about it?

Mr. Milione. I am familiar with that report but we are all -- we are familiar that that is happened in many, many locations across the country. So we have an obligation, obviously, across the whole supply chain from the manufacturers to the distributors.

Ms. Castor. What is happening with the wholesalers?

Mr. Milione. Well, the wholesalers have to uphold their regulatory obligations and we have taken action recently against the big -- two of the big three, McKesson and Cardinal.

Our hope is that their compliance programs, like any good corporate citizens, would work to prevent diversion and they would uphold those obligations. But it is not just the wholesalers. We have to go all the way down the supply chain in order to kind of try to maintain this closed system of distribution.

So it is certainly complex and it is a challenge. But we are well aware of all the issues across the country.

Ms. Castor. Thank you. My time has run out.

Mr. Murphy. Thank you.

Dr. Burgess, you're recognized for five minutes.

Mr. Burgess. Thank you, Mr. Chairman.

Mr. Milione, let me stay with you if I can and I don't know if we can get this map of the opiate deaths in 2015 up on the screen. But the map is almost counterintuitive to me. We talk about -- that is not the one. It is the total opiate deaths in 2015, just for the purposes of illustration. Thank you.

Almost counterintuitive -- six of the states with the lowest numbers -- go back one slide, please -- six of the states with the lowest numbers, of those six, four are border states -- Texas, California, North Dakota and Montana -- which would be

counterintuitive if we talk about things that are coming in across the border.

But also if you look at the map, boy, it seems like there is a bullseye on the Midwest, and what are you doing to sort of interrupt those supply chains that seem to have targeted a portion of the country?

Mr. Milione. A great question. So you're right, it is transiting in and it is going to -- it is not staying at the border where it crosses. It is going to locations around the country.

The Northeast is getting hit. The Midwest is, unfortunately, increasingly getting hit. But now the West is also getting hit.

So what are we doing? Applying law enforcement techniques. We are working with our federal partners, infiltrating the supply chain but also looking at the distributors and trying to disrupt them with the judicial process.

Mr. Burgess. Ambassador Brownfield, let me ask you a question and anytime we have a Texan on the panel that is a good thing. So I thank you for being here today.

And just for the record, you are career at the State Department. Is that correct?

Mr. Brownfield. I am, Congressman.

Mr. Burgess. Well, and thank you for your service to the

State Department.

Now, of course, the secretary is in China or has been in China recently. Your testimony today -- your written testimony that you provided and your -- and your verbal testimony kind of indicated that perhaps things were looking up. Things were -- there were positive developments, and I guess I am just not feeling that there are positive developments.

And in fact, Mr. Milione, please don't arrest me but I went online and looked at how to order fentanyl online just while we are sitting here and there are a lot of opportunities and I suspect those opportunities many of them come from Asia or come through China.

Mr. Brownfield, do you -- Ambassador Brownfield, do you think we are doing enough to interrupt those?

Mr. Brownfield. Congressman, I will say we are starting very close to point zero in terms of our cooperation with China. We have moved in a positive direction.

We are dealing with a country that has somewhere between 170,000 and 400,000 companies that produce pharmaceuticals somewhere in the People's Republic of China.

As recently as two or three years ago there was largely no control over their production whatsoever. Since then, 116 synthetic drugs are now controlled by the Chinese government and

within the last month and a half -- literally, within the last month four new ones, including important fentanyl analogies, are now controlled by the Chinese government.

We have a dialogue. We are talking to one another. Three years ago, their answer was -- by the way, is not unusual -- around the world was we do not have a fentanyl problem and therefore we are not particularly interested in cooperating with you because it is not being abused in China.

We have gotten beyond that. Are we where we want to be? No, of course not. What you have just proven is we have not yet solved the problem. But are we in fact ahead of where we were two or three years ago? On that, I say yes.

Mr. Burgess. Well, and that -- I thank you for that effort. I agree with you that is a positive development. But given the distributional aspects on our United States map, is it possible -- and, really, it is for anyone on the panel -- is it possible to identify from which laboratories or manufacturing houses overseas, which are causing us the greatest problems in these areas that we are seeing on our United States map. Does anyone have an answer for that?

Mr. Milione. Congressman, it is a great question, and to build on what Ambassador Brownfield was saying, we have had, on the law enforcement side in China in our Beijing country office

tremendous success getting leads from the Chinese of U.S.-based recipients of their fentanyl. That's a huge step forward and allows us now to kind of uncover that network in the United States.

Yes, we have had successes uncovering what those labs are in China and we've been working cooperatively with our law enforcement counterparts over there and we are very pleased with the direction that it is going.

Mr. Burgess. Well, and just in the limited time I have remaining, Dr. Houry and Dr. Compton, I mean, both of you talked about fentanyl use patterns and I'm a big believer in prescription drug monitoring programs.

Look, I was a physician. It's important to have drugs like fentanyl available. We are grateful for their utility in clinical settings. Clearly, they have to be used appropriately.

But do you have a sense of what I was talking to the DEA and the State Department about -- do you have a sense of where the use patterns are occurring?

Is -- are you able then to target limited resources so that perhaps an ER can have one of these early intervention programs?

If you're in a hot spot I think that is a good idea. If you're in -- out in Lubbock, Texas that might not be as important.

Dr. Houry. In Ohio we were able to do that. We did an Epi-Aid there and found eight counties that had highest rates.

We were able to then, you know, help guide Ohio to where to focus their efforts. And then in Massachusetts we also saw that there was a high rate of overdose deaths in those that were recently incarcerated -- about 50 times what we saw in other populations.

So we were able to use the data for that. With prescription drug monitoring programs you can very much see people at risk for opioid use disorder and use that to help link to further --

Mr. Burgess. Are you?

Dr. Houry. What we are doing right now is the program has been in place for two years and we are in 44 states and getting data that is quicker and better able to be used by states and letting states really focus on evidence-based interventions.

Mr. Burgess. I am way over time but, honestly, we authorized NASPR back in 2005. It shouldn't be just recently. This should have been an ongoing exercise over the last decade, in my opinion.

Thank you, Mr. Chairman. I will yield back.

Mr. Murphy. The gentleman yields back.

Before I recognize the next one, I want to put together a couple pieces here we just had. So the gentlelady from Florida and Dr. Burgess from Texas talked about these issues.

Kermit, West Virginia -- I think that is where you mentioned this tremendous prescription rate -- massive amount. I pulled up another chart here of disability rates in the United States

and don't you know, Mingo County and those areas in West Virginia are among the highest in the nation, where Dr. Burgess just pointed out the deaths that are occurring there.

It makes we wonder as you're talking about collecting more data, Dr. Houry, how much more data do you have to have? You're seeing these targeted areas where the amount of prescriptions is way, way out of control.

You can see on that map. This is way out of control and yet -- and these deaths are occurring.

So are there any kind of teams, like, going into these places and identifying who's writing these prescriptions and then the deaths that come from this?

Dr. Houry. Absolutely. We've been sending teams into Ohio, to Massachusetts, to Rhode Island. We've given specific information to the states on how to combat --

Mr. Murphy. West Virginia?

Dr. Houry. West Virginia we've been funding the program. I did the site visit myself out there to West Virginia.

We've been working with each state to look at the prescription drug monitoring programs and if you look at the guideline 18 states have now adopted or have implemented aspects of the guideline to help with safer prescribing in their states and we are starting to see significant improvements and you see

things like Kentucky through our CDC funding.

Now on our prescription drug monitoring program it has an alert for if there is high morphine-related equivalence to, again, make sure that people are getting safer prescriptions.

Mr. Murphy. Thank you.

Ms. Schakowsky, you're recognized for five minutes.

Ms. Schakowsky. Thank you, Mr. Chairman, and I want to thank all of our witnesses. This has been a very important issue because it is an important fight for our communities.

Obviously, the law enforcement piece and figuring out how we can stop the entry into our country of the components of fentanyl -- very important.

But I want to say, again, and it is been said many times before, this is also a very serious health issue. And to my Republican colleagues, as we face this vote that is coming up on Thursday we have to recognize the importance of the Medicaid program.

It's the second biggest payer for drug abuse treatment in the United States. It funded, roughly, 25 percent of public and private spending on drug abuse treatment in 2014. We talk about West Virginia.

We are talking about a lot of low-income people and Medicaid is really the source of help for them.

For my home state of Illinois, Medicaid has been absolutely vital to address substance abuse and providing access to treatment.

Medicaid expansion has provided coverage to 650,000 low-income adults in Illinois, nearly one-third of whom have mental health or substance abuse disorders.

That's just the typical percentage all over the country. Without Medicaid, these individuals would be more likely to end up in emergency rooms or jails, which would drive up costs for state and local budgets.

It's also clear that in Illinois we need to be further expanding access to substance abuse treatment and I'm sure that is the case in many other states around the country.

From 2014 to 2015, Illinois saw 120 percent increase in the number of deaths from drug overdoses. And so, you know, yet the Republican Trumpcare proposal would decimate the Medicare program that serves one in four people in Illinois -- one in four people in Illinois.

The Republican bill would end Medicaid expansion and pose a drastic per capita cap on funding. I don't want to go more -- on more about that because it is been certainly addressed.

Dr. Compton, wouldn't you agree that solving the fentanyl and opioid addiction problem requires that we also ensure that

people have access to appropriate substance abuse treatment?

Dr. Compton. Certainly given that the underlying issue is an opioid use disorder, treatment is a key component of solving this problem.

Ms. Schakowsky. Thank you.

And Dr. Houry, in your testimony you stated that "a rise in fentanyl, heroin and prescription drugs involve overseas are not unrelated." I'm sorry -- overdoses, not overseas. I'm going to say that again. "The rise in fentanyl, heroin and prescription drug-involved overdoses are not unrelated." Would you agree that in order to solve the fentanyl crisis we must also address the larger opioid prescription drug epidemic?

Dr. Houry. Yes. I think a very comprehensive approach is needed and I think prevention is a key aspect of that.

Ms. Schakowsky. I wanted to also ask Dr. Compton how harmful would it be for a patient with an opioid disorder to have to discontinue his or her substance abuse treatment?

Dr. Compton. One of the keyest predictors of relapse and of recidivism is stopping treatment. So when people stop treatment, particularly abruptly, they're extraordinarily high risk of relapse to their underlying addiction problems as well as criminal behavior and other serious problems.

Ms. Schakowsky. Thank you.

I'm very concerned. I'm also on the Budget Committee. We know that there has been proposed an 18 percent cut in HHS, $5.8 billion cut in the National Institutes of Health, which I -- my understanding is that you're actually doing some research on -- I don't know if the right word is vaccine but some sort of prevention, something that would -- against opioid addiction. Is that true?

Dr. Compton. Well, we even have research specifically targeting fentanyl where the development of a vaccine might lead to an approach that could keep the -- keep the fentanyl from getting into the brain.

The goal is to keep it in the circulatory system so you get antibodies developed that attach to the fentanyl and keep it out of the brain where it exerts its dangerous effects.

Ms. Schakowsky. Thank you.

Again, I want to thank all of the people who are here today testifying how you're trying to stop it before it starts and understand all the sources. But I also am interested in the health services.

Thank you. I yield back.

Mr. Murphy. Gentlelady yields back.

I now recognize the chairman of the committee, Mr. Walden.

Mr. Walden. Thank you very much, Mr. Chairman. I want to

thank the witnesses again for your learned testimony and your answers to our questions.

The fentanyl threat, Mr. Chester, has been described to us as the third wave of the opioid epidemic. It seems to me that individual states -- I've looked at some maps -- are seeing different effects, different aspects of the overall epidemic. Some are facing fentanyl head on right now.

Looks like in other areas it hasn't hit or at least not as with the deadly effect. Others are fighting against prescription drug or heroin overdoses.

So I guess my question is are we better off to look at this as sort of a state by state basis. I realize there are national implications but it seems like there are some real hot spots in the states.

And so when we think about a strategy here to combat it should it be multi-headed and look at this opioid epidemic in that way or and look at kind of all-of-the-above or sort of a one-size-fits-all? What, from your experience, would work best?

Mr. Chester. Yes, Congressman. So we look at it as a complex national security law enforcement and public health issue at the national level and then at the state level there are unique environmental factors that cause different manifestations of the opioid problem and as you correctly point out there is -- there

is fentanyl in some states more than it is others, there are prescription opioids in others and in others there is heroin. And in fact we've seen evidence in some places that heroin deaths are preponderant and in other cases fentanyl has surpassed heroin as being the preponderant cause of death.

So in the implementation of our plans we do two things. Number one, we try and respond to unique aspects of that state's environment but also develop a framework to share lessons learned from one state to another.

So things that certain states have found to be successful in dealing with their particular aspect of the problem can be shared with other states who may not be facing that particular problem but may see it in the future.

Mr. Walden. All right. Thank you.

And Ambassador Brownfield, first of all, I want to commend the State Department and the good work that you all have done and commend the DEA for your work in helping getting the recommendation of the March 16th effort by the U.N. Commission on Narcotic Drugs in favor of controlling two primary fentanyl precursors.

And I want to thank the Chinese, too. I've met with the ambassador. We've sent them a letter thanking them for their work to shut down some of the facilities.

What do you hope will be the impact from the U.N. recommendation on the fentanyl problem in the U.S.? What can we expect out of that?

Mr. Brownfield. First, at the risk of shameless pandering to you, Congressman, may I thank you for your letter to the ambassador. It makes my job enormously easier when they hear directly from you.

What do we respect from -- expect from the CND decision to control the two precursors? First, we have to wait another, roughly, 170 or 168 days before it is fully implemented.

This is a period of time during which the, roughly, 185 member states of the U.N. who are also part of the -- of the CND are -- have endorsed or ratified the treaties -- have the right to seek an exception.

I do not expect anyone to seek an exception to the ruling because the vote was unanimous. It was 51 to 0.

When it comes into effect, the countries that produce these two precursors, the two most prevalent precursors in the production of fentanyl in the entire world will be required to control, register, license and verify production of these precursors there. They will --

Mr. Walden. And, again, which two countries are those?

Mr. Brownfield. I mean, the two precursors. The most

important country is China which, in fact, did support -- not only vote for but did support and assist us to some extent in lobbying for the passage.

So what will happen at that point in time is whenever a company, any company in the world, is going to export either of these two precursors, the government of the country where it is produced will be required to notify the national authorities of the country to which it is being exported and it will have to provide the basic data and information -- how much, when, who is the receiving party, route by which it will be shipped.

That then allows the national authority -- in this case it might be HSI or ICE or DEA -- to determine what is coming in and doing the due diligence to verify this is a legitimate and legal shipment.

This is why is said in my -- in my oral statement this is a way to shut down the diversion of legal and licitly produced fentanyl.

Mr. Walden. You know, the state of Oregon and elsewhere tried this with methamphetamine to get at the precursor ingredients and it made a big difference when you put pseudoephedrine behind the counter and required a prescription.

Boy, that just changed the whole dynamic in terms of the individual cooking operations that were polluting homes and

killing people.

And so I commend you and the State Department and the governments that were involved for taking this step. We look forward to being partners with you, going forward.

And I yield back the balance of my time.

Mr. Murphy. Mr. Tonko, you are recognized for five minutes.

Mr. Tonko. Sorry about that. Problem with the mic.

Thank you, Mr Chair. I am quite satisfied we are holding this hearing today because it is literally a life or death issue for my constituents.

In my hometown of Amsterdam, New York, a small community of about 18,000 people, we had four overdose deaths and another dozen treated overdoses in the month of December alone.

If that rate of carnage were maintained for an entire year, one in every 375 individuals in my hometown would perish. These overdoses were all attributed to fentanyl -- one in 375.

When you drive down the interstate in my district, instead of billboards advertising for McDonald's or Taco Bell, you see billboards advising you to call 911 in case of an opioid overdose.

Last year, I had the opportunity to visit a clinic where I witnessed people taking their first steps to recovery aided by a law I helped to pass last year that raised the arbitrary limits on the number of patients a doctor can treat for opioid use

disorder.

Bearing witness to these success stories from the recovery community fuels my drive to push for policies that will expand the recovery opportunity for everyone.

That is why I found it astounding that in all of the witnesses' testimony today the word Medicaid was mentioned just twice and both times in the context of prescription drug monitoring programs.

We can talk supply reduction all we want. But you simply cannot talk about a federal response to the opioid epidemic without talking about Medicaid, which is the largest payer for behavioral health care services in our country.

In New York, Medicaid pays for 38 percent of all medication-assisted treatment for opioid use disorder. In New Jersey, it is 22 percent. Pennsylvania, 29. Indiana, 17. I could go down the list but you get the point.

And as my colleagues have ably pointed out, there is a huge elephant in the room here. The Trumpcare bill this House is being asked to vote on later this week would be the single most devastating piece of legislation to individuals struggling with addiction in our nation's history.

Trumpcare would eviscerate treatment for individuals who are struggling with opioid addiction by ending the Medicaid

expansion, repealing guarantees of mental health and substance use benefits and gutting Medicaid to the tune of $880 billion over the next 10 years alone.

You don't have to take my word for it. The American Society of Addiction Medicine, a professional society representing over 4,300 professionals in the field of addiction medicine wrote to Congress saying we are concerned that rolling back the Medicaid expansion, certainly sun setting the EHB requirements for Medicaid expansion plans and capping federal support for Medicaid beneficiaries will reduce coverage for access to addiction treatment services, changes that will be particularly painful in the midst of the ongoing opioid epidemic.

Rolling back the Medicaid expansion and fundamentally changing Medicaid's financing structure to cap spending on health care services will certainly reduce access to evidence-based addiction treatment and reverse much or all progress made on the opioid crisis last year.

The mental health liaison group, an umbrella organizations for groups involved in mental health and substance abuse service wrote, and I quote, "The AHCA would leave without coverage the 1.3 million childless nonpregnant adults with serious mental illness who were able for the first time to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8

million childless nonpregnant adults with substance abuse disorders who gained coverage under expansion for the first time."

Current Ohio governor, Governor Kasich, "Thank God we expanded Medicaid because that Medicaid money is helping to rehab people."

Former Arizona Governor Jan Brewer, no one's idea of a bleeding heart liberal, wrote, and I quote, "It just really affects our most vulnerable, our elderly, our disabled, our childless adults, our chronically mentally ill, our drug addicted. It will simply devastate their lives and the lives that surround them because they're dealing with an issue which is very expensive to take care of as family with no money."

I could go on but you get the point. I would, Mr. Chair, like to order into the record -- place -- enter into the record this letter from 415 addiction groups nationwide opposing Trumpcare for the devastating impact that Trumpcare would have on treatment for the opioid epidemic.

Mr. Murphy. Without objection.

[The information follows:]

**********COMMITTEE INSERT 8**********

Mr. Tonko. Thank you, Mr. Chair.

From my vantage point, there is no one outside of a three-block radius of this Capitol Building that thinks that Trumpcare is anything better than a raging dumpster fire.

Certainly, no one thinks this back room bill will improve the lives of those struggling with the disease of addiction.

And with that, Mr. Chair, I yield back.

Mr. Murphy. Gentleman yields back. I do want to note for the gentleman that the article referenced before -- I don't know if you've seen it -- from the Washington Post.

There's an important statement that says, the important takeaway is that there is not one opioid epidemic but several.

To policy makers this may mean that solving the problem will similarly require more nuanced vascular solutions than a blanket war on drugs. A strategy to reduce pill overdose in Utah may not have any effect on fentanyl deaths in Massachusetts.

I'm sure we'll go on and -- I want to make sure we work together to make sure states have that kind of flexibility to do what they do. So I will continue to work with you on that. Thank you.

I will now recognize Mr. Carter of Georgia, who is himself a pharmacist. Thank you.

Mr. Carter. Thank you, Mr. Chairman. Thank you all for

being here on this -- what is obviously a very serious subject. I want to start by talking about the legal, if you will, marketing of fentanyl.

We talked about it some during this hearing. One of the -- one of the questions I have, I know -- I can't remember who it was that mentioned that you're working with the wholesalers, with Cardinal and McKesson in trying to make sure that they're doing their part and accurately pointed out that you need to follow it all the way through the supply chain.

I can tell you as a practising pharmacist for over 30 years that is very important. We need to make sure that happens.

Have you been in contact with any of the manufacturers -- Janssen making Duragesic or Mylan makes a generic -- about how much they are able to manufacture and put on the market?

Mr. Milione. What we are not seeing is a large-scale widespread diversion of legal fentanyl.

Mr. Carter. Right.

Mr. Milione. It's diverted for personal use mostly. What we are dealing with is clandestinely produced fentanyls. We do have engagement with the manufacturers, obviously, for issues that come up and we are happy to work with them.

Mr. Carter. That's good, and, you know, that is important for a couple of reasons and I would be remiss if I did not point

out that one of the problems we had at the dispensing level is not being able to get enough of the product so that the people who truly needed it -- cancer patients and those who were truly in need of it -- we would run short on them because they'd put monthly limits on us or something of that sort and we weren't able to get it and that was really a tragedy as well. So I hope we keep that in mind as we go along.

One of the things that I was very involved with as a member of the Georgia state legislature was our yearly update of our dangerous drugs and one of the problems we always had was trying to identify the analogues, and I know that has to be a challenge.

Dr. Houry, that is got to be a challenge here, and one of my other colleagues mentioned about the precursors to it and how we control that. One of the -- one of the abused substances that I was always chasing was synthetic marijuana and, you know, and identify it and add it into the -- each year into the dangerous drug list and then the next year they'd come out with something else.

I even went as far as to try to identify the molecular structure and say anything with this and still it is just so difficult. Can you -- can you address that, sir?

Mr. Milione. Sure. I mean, that is -- the synthetic threat, outside the fentanyl threat, which is significant, is

massive. We have identified about 400 different substances.

It's kind of a misnomer to call it synthetic marijuana. It's a synthetic cannabinoid and then you have the cathinones and then a whole other series of these synthetics.

This is a major problem for us, and the same criminal chemists that are tweaking the molecular structures of fentanyl are doing the same when we schedule those cannabinoids.

Very dangerous -- one hit can send someone into a coma or have some kind of violent reaction. It's a big problem for first responders but it is a devastating problem because it is sold legally --

Mr. Carter. Absolutely, and that is one of the problems we had. We had deaths in my district. We had five deaths in Glyn County because of that. They were buying it at the convenience store.

Mr. Milione. We cannot keep up -- we cannot keep up pace with the emergency scheduling on the cannabinoid cathinone.

Mr. Carter. Absolutely. We are just chasing our shadows there.

Mr. Milione. Right.

Mr. Carter. And a couple other things, real quickly.

First of all, from what I'm being told by some of the drug agents, particular in Georgia, part of the problem too is just

with marijuana coming over. Some of it is laced with fentanyl. Now, that is a big problem.

Now, full disclosure -- I am a big, big opponent to the legalization of marijuana. I think it is just a gateway drug. But nevertheless, that seemed to be a problem, too.

Now, before I run out of time, I want to get to a subject that is very important to me and that is mail order drugs and mail order prescriptions coming through the mail, being delivered to patients' houses. That's where we find out so much.

And listen, Mr. Chairman, one of the biggest culprits -- the VA. I am telling you, in Georgia, three out of the five facilities that deliver drugs through the mail are the VA clinics and that is a concern and something we need to address.

We have -- we have opioids coming through the mail, being delivered, left on the -- on the front porch of someone's home. Not even having it signed for, just leaving a box there.

How much of a problem have you found with what the drugs that are coming through our -- through our mail system?

Mr. Allen. Well, I don't want to imagine what they -- on the VA issue we have a number of open investigations and we are trying to work cooperatively with the compliance departments at the VA nationally, at their headquarters also.

But those are definitely areas of significant concern and

I think, you know, that is distinguished from the trafficking of counterfeit drugs that are often moved through the mail.

When Representative Burgess talked about going online, there is just a plethora of online pharmacies that are, you know, appearing to sell legitimate pills when in fact they are counterfeit.

Mr. Carter. Absolutely.

Mr. Allen. Those are moved through the mail system on a daily basis.

Mr. Carter. And I see I'm out of time. But I do want to say that that is a problem we need to be looking at, Mr. Chairman. This committee and this Congress needs to be looking at mail order prescriptions and what's going through our mail now, and I yield back.

Mr. Murphy. So let me ask the gentleman, who's a pharmacist, along those lines then. As a pharmacist who will see that perhaps you would be picking up patterns of prescribing it in the community as a pharmacist and you would notice perhaps a massive amount coming through but you would not see that on a mail order system at all? You would be completely blind to that? Am I correct?

Mr. Carter. You -- on a mail order system. In other words, pharmacies that are mailing through, if they're legitimate, they should be keeping records of what's going out, yes.

Mr. Murphy. Well, I used the example before -- the gentlelady from Florida was offering West Virginia, which is ground zero for this.

Mr. Carter. Absolutely.

Mr. Murphy. That pharmacy may not necessarily see that people are getting it mailed in from out of the area.

Mr. Carter. Absolutely, especially if it is more than one. Now, you know, the PBM -- excuse me, the PDMPs -- sorry -- that helps tremendously, especially if we can do it over state lines. That is a tremendous help. We've just recently started that in Georgia.

But Florida is one of the states that is still not doing it and that is a problem because it is a big problem down there.

Mr. Murphy. Thank you. Appreciate that.

Mr. Carter. Thank you, Mr. Chair.

Mr. Murphy. Recognize the vice chairman of the committee, Mr. Griffith, for five minutes.

Mr. Griffith. Thank you very much, Mr. Chairman, and I want to thank all of the witnesses for being here today. This is a very serious subject. But I've got to refute some things that I have heard today or at least one in particular.

I think we are comparing apples and oranges when we try to bring in fentanyl and opioid abuse into the debate over whether

you want Obamacare, Medicaid expansion or the American Health Care Act, and in fact what I've heard repeatedly is is that somehow Medicaid expansion has helped to solve this problem.

But the map of deaths of opioid use that we saw earlier that Dr. Burgess put up -- and I've got a paper copy here -- shows us that is not the case and I think it is apples and oranges.

I don't think Obamacare caused opioid abuse. I don't think that Obamacare is going to solve it on its own. We are trying to find those answers here today.

I don't think the American Health Care Act is going to be able to solve it in and of itself on its own. But when you look at the states where the deaths are -- you know, if you're just going to play games with numbers, the expansion states seem to have more deaths than the nonexpansion states.

Now, do I think that is fair? No, I don't. I think that is horse hockey. But I think that what my colleagues on the other side of the aisle have said about us causing problems by voting for the American Health Care Act is irrelevant to our discussion today.

So with that being said, Dr. Compton, you mentioned the Appalachian Regional Commission -- that you're all working on a project with them. What exactly are you doing? That's my turf, in part.

I represent southwest Virginia, the Appalachian regions of southwest Virginia, which of course border hot spot areas for opioid abuse in Kentucky and West Virginia and it spills over into my district as well.

Dr. Compton. Well, I certainly remember a terrific meeting in Wise, Virginia. It's a lovely town. They convened a group from all across the Appalachian region to look at this issue several months ago.

Our initiative with the Appalachian Regional Commission is a grant program to look at demonstration products to improve the public health infrastructure and determine how good a job that'll do to address the opioid crisis in rural parts of the country, and the Appalachian Regional Commission will be co-funding this along with SAMHSA, the CDC and, of course, NIDA taking the lead on it.

Mr. Griffith. Well, we appreciate it because it is a significant problem and one of the issues there that we have to look at is is that whether or not the folks started off because of the -- it is a high area for disabilities as well. People have done for years a lot of hard manual work and that they get a prescription and then they get hooked.

Dr. Houry, you indicated in Ohio at least that 62 percent of the people who died from opioid, from heroin or fentanyl had

-- in the last seven years had a prescription drug for an opioid. Can you talk more about that?

Dr. Houry. Sure. We've been seeing this in many states. Like in Rhode Island, a third of the people who had overdosed on fentanyl had had an opioid prescription within three months and a third of those had had a high dose opioid prescription, showing that, you know, people that are on prescription opioids get addicted to opioids and can then go on to overdose from heroin or fentanyl.

Mr. Griffith. And sometimes their prescription runs out but they're hooked and is there some way we can connect the doctors recognizing that maybe their patient has gotten hooked to get them the help?

Because if the prescription just ends and nobody's alerting anybody, aren't those a lot of the folks who are going out and buying it then illegally on the streets somewhere?

Dr. Houry. Well, and I think that is why we've got our CDC prescribing guideline where we did talk in there about if you have a patient that you suspect opioid use disorder on of the importance of linking them to treatment.

And I think one of the things that I've been really proud about the work CDC is doing is although we are funding the states to do what's most important for the states, each month we do

technical assistance calls that help then with their data and provide scientific expertise and where to really focus resources and what are the best evidence-based treatments and then have a convening of all the states to share these best practices that way. As we are seeing different things emerge in different states we can share those.

I think, you know, data does drive action and I heard us talk about should this be a national or a state approach. New Hampshire was number 20 one year for overdoses. The following year it was number five.

So I think we need to give states the flexibility to deal with what's going on in their state but we need to have that overall approach.

Mr. Griffith. Thank you very much.

Mr. Milione -- if I said that right, and I apologize if I messed it up -- but I would be remiss -- while I think that marijuana is a dangerous drug I think your testimony here today indicated that fentanyl was your number-one concern and it is -- and it is not your jurisdiction so it is a rhetorical question.

I ask you just to take back why don't we let there be more research on marijuana and its ability to help patients whether it be epilepsy or, in this case, pain? Because while I think it is a dangerous drug, I don't think it is as dangerous as fentanyl

and other opioids.

With that, Mr. Chairman, I yield back.

Mr. Milione. If I could -- if I could say in response to that, we support any approved research along those lines. So we will continue to work with the researchers on those things and we support that.

Mr. Griffith. Well, if I might, Mr. Chairman, it is just the problem is as a Schedule I drug it makes it tougher than it would be if it were Schedule II like fentanyl and other opioids.

Mr. Murphy. Gentleman yields back.

Now, Mr. Pallone for five minutes.

Mr. Pallone. Thank you, Mr. Chairman.

The Affordable Care Act, through the expansion of Medicaid, extended health insurance coverage to hundreds of thousands of Americans in urgent need of treatment for opioid use disorders and I'm concerned that if the money is cut from Medicaid, which is what the CBO says would happen with the Republican bill, patients could lose access to care and this could make the fentanyl problem even worse.

So Dr. Compton, in your testimony you state that, and I quote, "opioid addiction is a chronic condition and many patients will need ongoing treatment for many years."

What could happen to a patient if their treatment for an

opioid addiction was interrupted, for example, because the patient no longer had health care coverage for substance use disorders?

Dr. Compton. Well, we do know that when treatment is interrupted or stopped, whether that is intentional or unintentional, the risk of relapse is extraordinary.

Mr. Pallone. Well, thank you.

Now, some health experts estimate that nearly 1.3 million people are receiving treatment for mental health and substance abuse disorders thanks to Medicaid's expansion. Our efforts to curb the opiate epidemic, I believe, could be severely impacted if those now receiving treatment lose their health insurance.

Should the ACA be repealed, we clearly would expect the opioid crisis, and by extension the fentanyl crisis, to worsen.

So Dr. Compton, again, if people who are currently being treated for an opioid use disorder were to lose coverage, would we expect the numbers of overdoses from opioids including opioid containing fentanyl many increase?

Dr. Compton. Well, I hesitate to make a prediction when there is so many factors that can play a role here in terms of how states will respond, how the Medicaid system in general will be organized.

Our goal, of course, at NIH and NIDA is to make sure that

the research we support is implemented no matter what the health care system is.

Mr. Pallone. Okay. I just use this state of West Virginia as an example because it was very hard hit by or is very hard hit by the opioid epidemic.

A February 6th article by the Pew Charitable Trust reports that West Virginia in fact has the highest opiate overdose death rate in the nation.

Let me ask Dr. Houry -- I don't know if I'm pronouncing it right there -- are you aware that West Virginia has one of the highest death rates from opiate overdoses in the U.S.?

Dr. Houry. Yes.

Mr. Pallone. And Dr. Compton, that same Pew article reports that the Medicaid expansion has added 173,000 adults to West Virginia's Medicaid program. West Virginia's Medicaid enrollment is now at 573,000 people, which is about a third of the entire state's population, according to the Pew article.

Dr. Compton, Pew also reported that in 2015 the first year that West Virginia expanded Medicaid the number of people in treatment for substance abuse jumped from 16,000 to 27,000.

The increased use of Medicaid services for substance abuse would suggest that thousands of West Virginians went without needed treatment service prior to Medicaid's expansion. Would

that be a fair assumption, Dr. Compton?

Dr. Compton. Well, certainly, when we think about states like West Virginia I would point out that the rural aspects make it very complicated to deliver services.

So I am very proud that we are able to implement this new research program in rural areas.

Mr. Pallone. And it would appear to me that Medicaid is essential in West Virginia's fight against opioid addiction, which would include the growing problem of fentanyl. I guess my last question, again, Dr. Compton, is if West Virginia were to lose these services would we expect that the opioid and fentanyl problems to worsen, assuming that they were -- you know, lost Medicaid coverage -- those people?

Dr. Compton. Well, I can't speak to the implications of the coverage issues but, certainly, for individuals who are being treated, if you stop their treatment abruptly that could be very deleterious.

Mr. Pallone. I mean, the problem that I see is that the Republican bill with regard to the expansion eliminates the essential services guarantee and what we have found in the past is a lot of times when you don't have that kind of guarantee the first thing to go is behavioral services, drug treatment, mental health services, things that are expensive and that many states

didn't provide until we said in the Medicaid expansion that they would have to. And I just think that between the cutbacks that would occur, because states would be getting less money, they're going to get less money, they don't necessarily have to cover people depending upon their income, you know, as the -- as they reduce the Medicaid expansion population, and then even with the traditional Medicaid or any kind of population if there is no guarantee of essential services then, you know, the first thing that often is cut back is treatment for drugs.

So that is my fear and that is why I think that this is devastating if we are trying to deal with fentanyl and some of these other opiate problems that we have.

So thank you all. Thank you, Mr. Chairman.

Mr. Murphy. Thank you. The gentleman yields back.

I recognize Mrs. Brooks for five minutes.

Mrs. Brooks. Thank you, Mr. Chairman, and thanks to everybody on the panel for your incredibly important work.

I must say that fentanyl is not a new problem. I was U.S. Attorney in Southern District of Indiana from '01 to '07. I learned about fentanyl then.

But, yet, we didn't talk about it much the way we focused on methamphetamine and the dangers, for instance, to children, to the environment.

What we are not talking about in the country is the danger. We talk about the overdoses and now seeing the incredible increase in overdoses.

But can we talk a little bit about truly how just dangerous fentanyl is as a product? And I realize that this gets a little dicey because we use it in medical procedures. But I think, having just been with law enforcement and firefighters this past weekend, there are dangers, are there not, Mr. Allen, and that is part of why you're doing training?

And I want to ask you, Mr. Milione, can you talk to us about the dangers of fentanyl and why haven't we, for a long time now, talked about the incredible danger?

Because I don't think addicts and I don't think their families really have understood how incredibly dangerous it is.

Mr. Allen. I would say that in the law enforcement community we have been. I would say since the recent surge in fentanyl one of the key things that we have gotten out to the law enforcement community, largely following the lead of DEA, is making awareness to our personnel, to public safety personnel generally, what they could be encountering.

For us operationally it has changed how we do some of our work. One of the investigative techniques that we have done historically is to purchase drugs, whether it is online or

domestically and online.

We stopped doing that because of the officer safety concerns that we have that could be inherent to an undercover agent buying drugs or a state and local officer buying drugs and not necessarily knowing what they're purchasing.

There's also a challenge for us from the perspective of field testing. You know, gone are the days, glorified in a lot of television shows, of agents, you know, pulling out a pocket knife and probing a package of suspected drugs and putting that into a test kit.

We, particularly at DHS and within DHS Customs and Border Protection, have taken the lead on trying to examine and explore and field non-intrusive testing that would allow us to go to a place where agents don't have to physically open a package in order to determine what the substance is inside.

Mrs. Brooks. Mr. Milione, why is there a surge in fentanyl? What is your DEA -- and I know you've been at this for a long time -- but what would you say is the cause behind the surge that we have been seeing?

Mr. Milione. It's free market principles applied to the convergence of the opioid epidemic with massive profits that can be made, and cartels and criminal groups that are exploiting that, they see the opportunity.

They aggressively market the small amount of fentanyl. They can -- they don't have to deal with the massive bulk of heroin and they can get so much more profit out of that. So that is one of the things.

Mrs. Brooks. But they don't care that it is killing their customers because there are more that just -- pipeline?

Mr. Milione. In a perverse -- in a -- I mean, and it is very callous but it is the cost of doing business and I think some of the medical professionals on the panel would say unfortunately there is a perverse, sometimes, reaction when people overdose from high-potency fentanyl. It sometimes attracts more attention to that product.

Mrs. Brooks. Any idea what the stats are of how many cases we've been charging in the last year or two causing death? Federal cases where we are actually prosecuting drug traffickers for causing death?

Mr. Milione. I would have to get back to you with specific statistics. But we are doing more and more of those around the country -- death resulting cases, working with the U.S. Attorneys' offices, engaging with the U.S. Attorneys, trying to get them to lean forward and work cooperatively on that. It is definitely what we are focused on.

Mrs. Brooks. And I guess going to Dr. Houry's comment, is

part of the challenge, maybe for a U.S. Attorney, is that coroners are not keeping track of and going into that much detail on the cause of death, which could be a problem, I could see, for a U.S. Attorney, but should we be -- should we be asking or requiring coroners to do a better job on that aspect?

Dr. Houry. I think it is a resource issue for coroners and medical examiners. When you look at the opioid epidemic and the number of deaths that they are now doing cases on, oftentimes they don't have the resources in their community to do that testing for fentanyl or they don't have the labs. They have to send it out, which is additional funding that they need.

Mrs. Brooks. Besides the labs, what kind of resources would they need to do the testing aside a heroin death or a fentanyl death?

Dr. Houry. So they would need the lab to distinguish the type of analogue. I think also it is helpful to have the medical examiner through the family history and so forth to determine if this was an unintentional overdose, was this a legal fentanyl where you can see the injection or other paraphernalia associated with it. But I would say it is really the testing for the laboratory and the training as well.

Mrs. Brooks. Thank you. I yield back.

Mr. Murphy. Mr. Walberg, you're recognized for five

minutes.

Mr. Walberg. Thank you, Mr. Chairman, and also thank you to the panel. It is clear from your testimony and the questions that you live in a world that is difficult, frustrating, challenging, ugly. But you're doing a great job for us and we appreciate that.

My home state of Michigan shares over 700 miles of land and water border with Canada as part of the longest border in the world.

Mr. Milione, does DEA have precise data on how much fentanyl is coming in directly from Canada?

Mr. Milione. We can -- we have the data as to what's been seized but that is -- there is a certain flaw in that. We don't know exactly what is coming in but we know what we have seized and we can get those statistics to you.

It is imperfect, though, because there are networks that are finding any porous entry to be able to get it in. So --

Mr. Walberg. Having flown over the entry from Detroit River into Lake Erie and seeing the creative and amazing ways that people will find to cross that water border and seeing the efforts by Customs and Border Patrol as well as ICE and others to interdict that, I would agree with you. It is probably very difficult.

But significant amount coming across?

Mr. Milione. Significant in the sense that that is one of our -- the main threat streams -- China to Canada, Canada across our northern border.

Mr. Walberg. Mr. Allen, do you have numbers on how much fentanyl ICE has interdicted from Canada and are there hot spots along the northern border?

Mr. Allen. What we -- what the DHS components, both ICE and CBP, have seized coming from Canada is primarily coming in through consignment and mail, not necessarily along the physical land border with Canada.

Mr. Walberg. Consignment and mail?

Mr. Allen. And mail.

Mr. Walberg. Okay. Mr. Allen, in your written testimony you mention that ISIS met with Canadian officials to share trends and targeting strategies in fentanyl-related investigations.

Can you talk a little bit more about this effort and does your agency intend to expand the coordination with Canada?

Mr. Allen. Well, we work along with the Department of State and DEA in that effort. We are meeting with Canadian counterparts, Mexican counterparts and Chinese counterparts, as you have heard today, and I do think that expanding the exchange of information with both source and transit countries is going to be part of how we improve what we do and recognizing that some

of the fentanyl that makes its way to the United States either directly from China or via other places is also in the same stream that makes its way to Canada and Mexico as well.

Mr. Walberg. I mean, it is great to have a border neighbor that generally we can work pretty well with.

Mr. Allen. I would add, you know, one of the things that distinguishes the relationship between the U.S. and Canada and China and Mexico is that the Canadians have come to us and talked about them having a very similar and significant problem that we are.

Mr. Walberg. I have supported legislation in the last two Congresses introduced by my colleague, Pat Tiberi, called the STOP Act, which, as you know, aims to stop the shipment of synthetic drugs like fentanyl and carfentanil into the U.S.

The bill would require shipments from foreign countries through our postal system to provide electronic advanced data like where it is coming from, who it is going to and what is in it before crossing our borders into the U.S.

Mr. Allen, how would this information help better target illegal drug shipments and keep these dangerous elements out of our communities?

Mr. Allen. That would assist primarily Customs and Border Protection, which takes the lead on interdiction, by giving them

advanced information that they could use at places like the National Targeting Center to be more effective and more efficient in targeting mail that is coming to the United States.

As we have heard earlier, one of the things that constrains the ability of the -- what information the postal -- U.S. Postal Service has in advance is the Universal Postal Union and my understanding of the STOP Act is that it would require us to update the UPU through negotiations led by the State Department to provide more and more timely information that would assist CBP in targeting.

Mr. Walberg. Are there additional steps Congress should consider along with that taking to assist your efforts to identify and stop these shipments?

Mr. Allen. None that come to mind.

Mr. Walberg. Anyone? Thank you, Mr. Chairman. I yield back.

Mr. Murphy. Now I will recognize another member of the full committee, Mr. Bilirakis, for five minutes.

Mr. Bilirakis. Thank you so much, Mr. Chairman. I appreciate it. Thanks for allowing me to ask the questions and I really appreciate the panel being here. This is such a very important issue. It affects all our districts.

Mr. Chester, a lot of people are aware of opioid abuse like

OxyContin or heroin but not fentanyl. Is that the case?

And then what are the educational outreach programs currently underway and what resources are available for communities who want to get the message out? I think that is important. If you could answer that question I would appreciate it.

Mr. Chester. Yes, Congressman. As I stated earlier, kind of the components of how we are dealing with this comprehensively is to prevent an issue as to drug use, provide treatment for those who are addicted to these drugs and then stop the flow of the drugs coming in to the United States.

In terms of prevention, one of the primary mechanisms that we use in ONDCP is the Drug-Free Communities program. The Drug-Free Communities program, which is funded by ONDCP and is managed by the Substance Abuse and Mental Health Services Administration, is in thousands of communities around the country as a prevention program that is focused on individual needs of individual communities.

Local communities require local solutions and it is a coalition of 12 community members that are focused on the needs of that particular community not only to raise awareness of drug issues but prevent primary drug use or initiation of primary drug use focused on the demographic of about 13 to 17 years old, which

is the target demographic for that program. Very effective program.

Mr. Bilirakis. It has been effective? Okay. Very good.

Mr. Milione and Mr. Allen, as you mentioned earlier, China announced its intention to ban the manufacture and sale of four additional types of fentanyl.

Can you discuss our working relationship with China to prevent entry and sale and are there mechanisms to hold China accountable to its commitment to ban fentanyl?

Mr. Milione. Our relationship on the law enforcement working level has been tremendous. Our administrator, Acting Administrator Chuck Rosenberg, was recently in China, met with our counterparts.

As a result of those meetings and shortly thereafter and working with the State Department they agreed to schedule these four -- one of them carfentanil, which is 10,000 times more potent than morphine.

This is -- these are significant steps. The other -- the other positive thing has been when they initiated investigations in China there has been real bilateral sharing.

They provided us leads of domestic-based distributors that are -- that are ordering fentanyl and that is really helped flush out these networks and now these investigations are ongoing.

So we've been very pleased with the cooperation. We hope it continues and, certainly, it can expand.

Mr. Bilirakis. Very good.

Mr. Allen. And I would only echo that. The Chinese government has provided DHS with seizure -- information about seizures made in China on their way to the United States and we have been able to use that information to, as Mr. Milione said, identify other individuals and organizations that have received shipments from the same points of origin in China that has allowed us to begin investigation.

Mr. Bilirakis. Thank you.

Mr. Brownfield. Finally, Congressman, if I could add one more point from the State Department's side.

Mr. Bilirakis. Please go ahead. Please. Please.

Mr. Brownfield. Beginning a little over a year ago, we reached a bilateral understanding with the Chinese government that they would control the delivery of products from China to the U.S., even if they were not controlled in China if they were controlled in the U.S., in exchange for which we made the same commitment to them.

Now, it is not enforceable in any sort of international organization. But it is an agreement that we reached between ourselves as two governments.

Mr. Bilirakis. Thank you.

Dr. Houry, in your testimony you mentioned that CDC is committed to giving providers and health systems the tools they need to improve how opioids are used and prescribed.

Can you discuss these tools and how communities can take advantage of these tools?

Dr. Houry. Absolutely. We have really had a multi-pronged approach. One is just through education. We have been working with -- directly with medical schools and nursing schools on preclinical training on effective pain management and safe prescribing practices.

We have also developed seven continuing education webinars that are available for free for providers on our website around safe prescribing of opioids, and with the guideline itself -- I am a practising physician. I know you have to have something that you can use.

So we have a checklist that is been downloaded more than 25,000 times by providers to use and we also now have a mobile app on our phone around the guideline that has things on motivational interviewing and how do you talk with a patient about these difficult decisions on whether or not to give an opioid, a calculator to help you calculate what's the appropriate and safe dose of an opioid to give.

And we are also -- we have piloted a community education program and awareness around the risks of opioids in 10 cities that were hardest hit.

Mr. Bilirakis. Very good. I would like to talk to you about possibly coming to my area in Florida, the Tampa Bay area, if you haven't already.

Dr. Houry. I would welcome that.

Mr. Bilirakis. Thank you very much. I yield back, Mr. Chairman.

Mr. Murphy. Gentleman yields back.

Now, just some closing comments. Ms. DeGette, five minutes.

Ms. DeGette. Thank you, Mr. Chairman.

I just wanted to respond to what our colleague, Mr. Griffith, said about the ACA. Certainly, nobody thinks that the shocking increase in opioid and heroin use is in any way related to the ACA and we recognize that some of those areas where we do have the Medicaid expansion are the areas which are the red on the map and that is quite disturbing.

Our point, though, is that if we hope to treat these folks who are getting addicted to opioids that it is important that they have access to medical treatment and that is why we are concerned if the Medicaid expansion is retracted because in those states the Medicaid expansion has helped many people who have -- who need

to have addiction treatment, which is extensive.

And to that end, I have a letter dated March 20th, 2017 from the Oregon AFSCME which talks about the Medicaid expansion in Oregon and how many people would lose their Medicaid expansion and their treatment for opioid addiction if the Republican alternative passed this week.

And I would like to ask unanimous consent to put a copy of that record -- that letter into the record, Mr. Chairman.

Mr. Murphy. Without objection.

[The information follows:]

**********COMMITTEE INSERT 9**********

Ms. DeGette. Thank you. I yield back.

Mr. Murphy. Gentlelady yields back.

Just a couple of questions that I have. Mr. Chester, do you have any idea how many federal agencies are there that deal with substance abuse across all spectrums and all departments?

Mr. Chester. I do not have that answer off the top of my head but I would -- I would like to follow up with you, if I can, on that.

Mr. Murphy. Good. And I know when we asked GAO to do the scenario of mental illness they said at least 112 but it is probably more. They just couldn't figure this out. I don't know how many there are.

I know one of the things this committee did in our mental health bill was tasked the assistant secretary of mental health and substance abuse to coordinate these 112 federal agencies on efforts in the area of mental illness. Goodness knows how many there are in substance abuse.

And it is a question that I want you all to let us know -- I need some answer to -- as well as getting back to us that what would you suggest that this administration do in working with Congress to combat this deadly, deadly problem.

I mean, we will have meetings -- we will have intense hearings here on things like Ebola, which affects a couple American lives,

or on flu, which is thousands of deaths every year.

But we are far past that with fentanyl and opioids and we see towns devastated. And so we do need your suggestions. We want to work together. And I say to my colleague, too, you and I have a shared passion in this area.

It is absolutely unquestionable and this is one we have to be working together. As I said before, there is no silver bullet. States have to handle this a different way.

What was affecting things in West Virginia with perhaps some prescription practices that Ms. Castor pointed out and disability rates and unemployment rates may be very different from Massachusetts or Utah or anywhere else and I want to make sure states have full flexibility.

So I look forward to saying, let's stay committed to this. We'll get answers to this together.

And I also would ask, Mr. Chester, there is a letter we sent February 23rd, a bipartisan letter with several questions. You may be aware of that.

Any idea when we can expect some answers to that?

Mr. Chester. Yes, Congressman. It is in final -- the letter is complete. It is in final interagency clearance. We hoped to get it to you this morning but we will get it to you as soon as possible.

Mr. Murphy. Thank you. Appreciate that.

Mr. Chester. Thank you for the letter.

Mr. Murphy. Yes. Now, let me just say that in conclusion I want to thank all the witnesses and members that participated in today's hearing and remind members you have 10 business days to submit questions for the record so the witnesses have time to respond to those.

And with that, I again thank the witnesses. This is a very important hearing on a critically important issue for our nation. We look forward to working with you again until we have this issue addressed.

And with that, this hearing is adjourned.

[Whereupon, at 12:36 p.m., the hearing was adjourned.]