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MARKUP OF:

H.R. 4978, NURTURING AND SUPPORTING HEALTHY BABIES ACT;

H.R. 4641, TO PROVIDE FOR THE ESTABLISHMENT OF AN INTER-AGENCY TASK FORCE TO REVIEW, MODIFY, AND UPDATE BEST PRACTICES FOR PAIN MANAGEMENT AND PRESCRIBING PAIN MEDICATION, AND FOR OTHER PURPOSES;

H.R. 3680, CO-PRESCRIBING TO REDUCE OVERDOSES ACT OF 2015;

H.R. 3691, IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN ACT;

H.R. 1818, VETERAN EMERGENCY MEDICAL TECHNICIAN SUPPORT ACT OF 2015;

H.R. \_\_\_\_\_, OPIOID USE DISORDER TREATMENT EXPANSION AND MODERNIZATION ACT;

H.R. 3250, DXM ABUSE PREVENTION ACT OF 2015;

H.R. 4969, JOHN THOMAS DECKER ACT OF 2016;

H.R. 4586, LALI'S LAW;

H.R. 4599, REDUCING UNUSED MEDICATIONS ACT OF 2016;

H.R. 4976, OPIOID REVIEW MODERNIZATION ACT OF 2016; AND

H.R. \_\_\_\_\_, EXAMINING OPIOID TREATMENT INFRASTRUCTURE ACT OF 2016

Wednesday, April 20, 2016

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 1:34 p.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Barton, Whitfield, Shimkus, Murphy, Burgess, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Schakowsky, Castor, Sarbanes, Schrader, Kennedy, and Pallone (ex officio).

Staff Present: Gary Andres, Staff Director; Will Batson, Legislative Clerk, E&P, E&E; Mike Bloomquist, Deputy Staff Director; Leighton Brown, Press Assistant; Rebecca Card, Assistant Press Secretary; Karen Christian, General Counsel; Paul Edattel, Chief Counsel, Health; Peter Kielty, Deputy General Counsel; Carly McWilliams, Professional Staff, Health; Tim Pataki, Member Services Director; James Paluskiewicz, Professional Staff, Health; Graham Pittman, Legislative Clerk, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Santini, Policy Coordinator, O&I; Jennifer Sherman, Press Secretary; Adrianna Simonelli, Legislative Associate, Health; Sam Spector, Counsel, O&I; Heidi Stirrup, Policy Coordinator, Health, John Stone, Counsel, Health; Sophie Trainor, Policy Advisor, Health; Dylan Vorbach, Legislative Clerk, CMT; Gregory Watson, Legislative

Clerk, C&T; Jen Berenholz, Minority Chief Clerk; Elizabeth Ertel, Minority Deputy Clerk; Kyle Fischer, Minority Health Fellow; Waverly Gordon, Minority Professional Staff Member; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Chief Oversight Counsel; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Kimberlee Trzeciak, Minority Health Policy Advisor.

Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today the subcommittee will consider 12 bills: to improve treatment for opioid abuse, report on infants suffering from neonatal abstinence syndrome, update best practices for pain management and prescribing pain medicine, allow for co-prescribing of opioid reversal drugs, expand access to medication-assisted treatment, ban the sale of DXM to anyone under 18 without a prescription, study the dangers of opioid abuse in treating sports-related injuries, develop standing orders for naloxone prescription, clarify when prescriptions can be partially filled, encourage abuse deterrent technologies for opioids, and request a GAO report to Congress on substance abuse treatment availability and infrastructure needs throughout the U.S.

As many of you know, one of this subcommittee's top priorities has been helping and protecting children and families. These bills that are the subject of today's markup represent our ongoing effort to work together to strengthen public health and address problems in our Nation's healthcare system.

In my home State of Pennsylvania, one out of every four households is affected by addiction. More than 2,400 Pennsylvanians died from overdoses last year, making it the leading cause of accidental death in our Commonwealth.

According to the Centers for Disease Control and Prevention, the

CDC, about 120 Americans on average die from a drug overdose every day. Overall, drug overdose deaths now outnumber deaths from firearms. More than 4 million Americans abuse prescription drugs or painkillers, another 517,000 reported past year heroin use, a 150 percent increase since 2007.

These facts are shocking, but they reflect the reality right in our neighborhoods. It is happening to Democrats and Republicans, to people of every race and religion. It happens to our friends, family members, and neighbors. We all know someone and we share their pain.

Today we have legislation before us that will begin to address the addiction crisis we face. In 2015 the Energy and Commerce Committee's Oversight and Investigations Subcommittee held five hearings on the drug abuse crisis. In October, as chairman of the Health Subcommittee, I chaired a two-part hearing at which we heard from experts like the administration's drug czar, Michael Botticelli, and Dr. Kenneth Katz of the Lehigh Valley Health Network. We discussed several proposals that would improve Federal public health policies and help addicts get treatment.

Each of these bills deals with a different aspect of the epidemic because we need a comprehensive plan -- not just adequate funding, but targeted funding, not just emergency response, but education and prevention.

These bills would make a number of changes to existing law. They would responsibly expand the number of practitioners who can provide medication-assisted treatment to patients, develop best practices and

a national awareness campaign, ban certain drugs to youth without a prescription, help pregnant women who are addicted, request a report from GAO on the state of our substance abuse treatment availability and infrastructure needs.

Congress will take action on behalf of the families and communities across Pennsylvania and the rest of the country being shattered by this public health crisis.

I want to thank the sponsors of each of these bills for their diligent work thus far. These bills address a complex epidemic, and I know that after the subcommittee consideration today the work will continue. Support each of these bills and urge their adoption by this subcommittee.

And I yield back the balance of my time. And now recognize the ranking member, the gentleman from Texas, Mr. Green, 5 minutes for his opening statement.

Mr. Green. Thank you, Mr. Chairman.

It has been more than a decade since Congress passed legislation to address the addiction and drug use. Today we are marking up 12 bills to enact a multipronged, broad response to the opioid and addiction epidemic. Our response to this crisis requires an all-hands-on-deck effort, and I am pleased to support these thoughtful bills. Together they will provide enhanced and expanded prevention, treatment and recovery programs for patients and families suffering from addiction.

Prescription drugs abuse is a growing national epidemic. Addiction overdoses and deaths involving nonmedical prescription drug

use, especially pain relievers, have risen dramatically over the last decade. According to the Centers for Disease Control, more people died from drug overdose in 2014 than in any year on record.

The majority of drug overdose deaths involve an opioid. Since 1999 the rate of overdose deaths involving opioids, including prescription drug relievers and heroin, nearly quadrupled. From 2000 to 2014 half a million people died from drug overdoses. Seventy-eight Americans die every day from opioid abuse.

There is not a person in this room who doesn't have a personal connection, constituent, or heartbreaking story of someone affected by this epidemic. It is happening in every single community. It is happening in Texas and across the country. We must face the opioid epidemic head on, and today's subcommittee votes on bipartisan solutions marks an important step forward.

The bills we are considering today rightly treat addiction like the public health crisis it is. The Nurturing and Supporting Healthy Babies Act will enhance our understanding of neonatal abstinence syndrome to remove barriers for treatment and prevention of NAS, which has hurt too many infants and their families.

We are considering legislation to establish an interagency task force to devise and disseminate best practices for chronic and acute pain management. The Co-Prescribing to Reduce Overdoses Act will establish a grant program for co-prescribing overdose reversal drugs to high risk patients, expanding access to lifesaving treatments.

The Improving Treatment for Pregnant and Postpartum Women Act

will continue residential treatment programs for women and support family-based services for women with substance abuse disorder, including opioid addiction.

The Veteran Emergency Medical Technician Support Act will streamline the licenser requirements for veterans who have successfully completed military emergency medical technician training and want to serve as civilian EMTs.

The Opioid Use Disorder Treatment Expansion and Modernization Act will expand access to medication-assisted treatment so that more patients can access the full scope of evidence-based services while minimizing the potential for drug diversion.

The DXM Abuse Prevention Act will ban the sale of over-the-counter drugs containing DXM to individuals under 18 unless they have a prescription.

The James Thomas Decker Act directs the CDC to study and report information and resources available to young athletes and their families regarding the dangers of painkillers and how to seek addiction treatment.

Lali's Law will allow States to develop standing orders for naxolone prescriptions and educate health career professionals regarding the dispensing of overdose reversal medication without person-specific prescriptions.

The Reducing Unused Medications Act will clarify when a prescription for a drug listed on Schedule 2 of the Controlled Substance Act may be partially filled.

The Opioid Review Modernization Act will codify the FDA action plan on opioids. This will mean better labeling decisions, new recommendations for prescriber education programs, and encouraging the development of new drugs with abuse-deterrent properties.

The Examining Opioid Treatment Infrastructure Act requires a review on substance abuse treatment facility and infrastructure needs throughout the United States, which we know is insufficient to meet our Nation's needs.

I want to thank all the bills' sponsors and Ranking Member Pallone, Chairman Upton, and Chairman Pitts for their commitment and leadership on this issue. While I urge swift passage of these bills, our work is not done. We need to provide real funding for this effort to ensure agencies have the resources to implement their provisions and thus real Americans can get the help they desperately need.

Thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the chairman of the full committee, Mr. Upton, 5 minutes for his opening statement.

The Chairman. Well, thank you, Mr. Chairman.

Before I start, I just want to take a moment to thank every member on both sides of the aisle. I want to say that I think I have spoken to every member here about this issue and their concern as they reflect their representation from their State and the sincerity of why we really do need to take bipartisan action. I thank them for that, and I am pleased to say that we in fact are doing the Lord's work by moving these

bills today.

You know, every 12 minutes somebody dies of a drug overdose in the U.S. That means someone has already passed away just since we started this subcommittee hearing a few minutes ago. So it is pretty frightening, and we have to face the epidemic head on, and that is why this subcommittee markup is such an important step forward.

Addiction to opioids often progresses to heroin abuse, and the disturbing trend of growing addiction emergency room visits and death are tearing apart families and communities not only in Michigan, but certainly across the country. Opiate-related overdoses have become the number one cause of injury related to death in Michigan as well as nationwide. And it has hit most of my counties pretty hard. We have lost some pretty good kids. In recent years we lost a young 18-year-old, Amy Bousfield, a graduate of Portage Central High School, and Marisa King, a 21-year-old who began using heroin despite having lost two friends to the drug, including Amy.

The epidemic does not discriminate. We know that. So we have to band together and take what we have learned to begin to make some changes that move us forward.

The numbers are staggering. CDC in Prevention reports that nationally nearly 260 million opioid prescriptions were written in 2012. That is one for every single U.S. adult, with 20 million to spare. And according to the director of the National Institute on Drug Abuse, Americans consume 80 percent of the world's prescriptions of opioids. Yet we only represent, as we know, less than 5 percent of

the population.

So what makes this so different? Over the past year we have held lots of hearings, in both Health and Oversight, with dozens of witnesses, and we have met with the experts, stakeholders, individuals, and recovering family members for sure. Opioid addiction is a chronic disease of the brain and can be treated. Unfortunately, only about 10 percent of the 23 million folks suffering from alcohol and drug addiction get any form of treatment. And of the 10 percent who do receive it, less than 20 percent receive evidence-based treatment.

In the past too often Federal policy towards opioid addiction has underemphasized the public health. No, we don't want to simply arrest our way out of the problem, that is not the answer. So we are here today to try and do something about it, marking up nearly a dozen bipartisan bills that touch on the spectrum of issues driving the opioid crisis and general drug abuse.

Two of the bills help expand access to naloxone, a lifesaving overdose reversal drug. We have also got a bill that is going to expand access for pregnant and postpartum opioid-addicted women and their children. Another is going to make it easier for our vets returning from a tour of duty to translate the skills that they honed on the battlefield to working and volunteering on our EMT squads across the country, and I heard from some of those folks just this morning.

Members on and off this committee have brought forward a number of good bipartisan ideas that we are going to advance in this subcommittee. While there is no one solution to the growing epidemic,

the bills before us today represent good steps in addressing the problem that is affecting every community, every one, in countless families across the country.

So this subcommittee is going to do important work today and the full committee is going to act as early as next week to keep the ball moving forward, and we look forward to having these bills on the House floor literally the first week that we are back in May.

I yield back.

Mr. Pitts. The chair thanks the gentleman.

And I now recognize the gentleman from New Jersey, Mr. Pallone, for 5 minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

Today we are meeting to mark up a number of different pieces of legislation related to the opioid abuse epidemic facing our Nation. We have all come to know just how widespread and devastating this epidemic is. Opioid addiction is an indiscriminate killer. Americans young and old, rich and poor, of all races and genders, and from all regions of the country are losing the fight against addiction.

Back home, about 256,000 New Jersey residents are addicted to heroin or prescription opioids. That is nearly the same as the entire population of Newark, the largest city in New Jersey. And New Jersey is not alone in this crisis. We know that nationwide prescription opioid abuse has skyrocketed. Between 1999 and 2010 the death rate from prescription opioids more than quadrupled. In fact, every day 78 families lose a loved one lost too soon due to an opioid-related

overdose death.

It is important that we approach this issue as a public health crisis and work to get people the care they desperately need. I am particularly concerned about the current gaps in access to treatment. There are serious barriers to treatment that must be addressed, such as a shortage of substance abuse providers, a lack of counseling and support services, and the pervasive stigma related to receiving treatment. I believe that if we do not address these issues in a comprehensive manner, we will continue to see overdose deaths and related outbreaks of HIV and hepatitis C increase.

The bills being considered today address a range of issues related to the opioid epidemic. I strongly support these bipartisan legislative efforts to expand access to substance abuse treatment services, increased access to overdose reversal medication, improve provider education, and increase public awareness of the problems of substance abuse.

However, while these are important steps forward, I want to make clear that I don't think these efforts are enough. There is an urgent need to dedicate increased Federal funding to help our communities combat this crisis, and I am disappointed that Congress has failed to provide resources proportionate to the severity of this crisis.

Congressional Republicans continue to reject calls for increased resources, including President Obama's request for a new 2-year, \$1.1 billion mandatory investment to expand access to treatment for opioid addiction and close the treatment gap. Given my colleague's

unwillingness to spend any significant Federal resources, we have tried today to identify statutory and regulatory changes that promote expanded access to treatment and recovery services.

The policy that provides the best opportunity to expand access to treatment services without new Federal funding is legislation to lift the cap on the number of patients that providers can treat with bupre -- I always pronounce it wrong -- with buprenorphine.

Buprenorphine is a highly effective evidence-based treatment for opioid addiction. However, currently doctors are only permitted to prescribe buprenorphine to up to 100 patients, resulting in patients who are on waitlists and cannot access treatment immediately. As with many medical conditions, timely access to treatment for opioid use disorders is absolutely crucial and delays can be dangerous opportunities for relapse, overdose, and even death.

The statutory and regulatory regime governing buprenorphine is outdated, anachronistic, and is hampering our response to our national crisis. We are asking doctors on the front lines battling this crisis to do so with one hand tied behind their backs. We have a responsibility to the individuals, families, and communities that are being shattered by opioid addiction to do everything within our power to combat the current crisis.

While H.R. 4981 makes an important step towards fulfilling that goal by raising the buprenorphine cap to 250 patients and providing prescribing authority to nurse practitioners and physician assistants, I think we can and should go further, and I strongly urge my colleagues

to support a higher cap than the one included in this legislation, and I will be introducing an amendment during the markup to accomplish this.

I am sure most of us here can recall the heartbreaking story of a friend, family member, or constituent struggling with substance abuse. We owe it to these individuals and their families to do everything we can to pass meaningful legislation, provide adequate resources, and put a stop to the epidemic. Although I wish the legislation we are considering today provided more resources to address this problem, I am pleased that we are meeting today to consider these important bipartisan efforts, and I look forward to further action.

So thank you, Mr. Chairman. I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman.

The chair reminds members that pursuant to the committee rules, all members' opening statements will be made part of the record.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Pitts. Are there further opening statements?

The gentleman from Kentucky, the vice chairman, is recognized for 3 minutes.

No opening statement.

Are there any other opening statements?

Dr. Murphy is recognized for 3 minutes.

Mr. Murphy. Thank you, Mr. Chairman.

We all know we are in the throes of an opioid crisis. And to help address this, I know we are going to move several important bills here.

I had prepared a list of 10 different amendments based upon the bipartisan work of the Oversight and Investigations Subcommittee over the last 2 years. I will not be offering all the amendments today because I have assurances from committee leadership we will be working to address these concerns between subcommittee and full committee.

But I did want to mention them quickly here, including:

Keeping the buprenorphine prescribing cap at a level where treatment can be provided with the aim of recovery;

Enhancing the requirements that patients receiving buprenorphine receive evidence-based addiction counseling;

Amending the 42 CFR Part 2 so that highly diverted drugs like buprenorphine are included in a prescription drug monitoring program like NASPER;

Allowing patients to voluntarily share their substance abuse treatment records with primary care and fiscal health providers;

Studying how pain metrics on patient satisfaction surveys that

are tied to payments for hospitals are actually contributing to increased rates for overprescribing pain medication;

Expanding our understanding of how the institution of mental disease exclusion has decreased access to inpatient and residential treatment for substance abuse disorders, thus limiting evidence-based treatment options for individuals trying to recover from addiction;

Ensuring that we are working upstream to prevent an overdose and a priority to help addicts recovery and retrain from using dangerous drugs instead of simply expanding access to naloxone.

I have a tremendous amount of admiration for the members of this committee who are working on these issues and I want to continue to work on this, but on such things as dealing with medication-assisted therapy the evidence that we have seen in the Oversight and Investigations Subcommittee clearly told us that it has to be accompanied with wraparound services and counseling since that is how clinical intervention is defined by SAMSA and that just having medication-assisted treatment alone and assurances that someone will seek treatment isn't enough.

Our statistics in Pennsylvania, Mr. Chairman, you cited them, they are bleak. It is getting worse. And while we see improvements in mortality rates for cancer, auto accidents, so many other areas, we see continued mortality rates climb with regard to drug abuse. We can't continue this.

Let's keep this in mind: Many addicts are master manipulators, of physicians, of families, and friends. Their addiction is more

powerful than their care for their own life or love of family, and many will lie to the doctor and steal from their family and take food from their children to feed their addiction. If it was easy as putting the solution in front of an addict and saying, "Could you please sign this and say you will get treatment?" they would all be cured.

So I just want to make sure the committee is very careful as we wade into this area. We as a committee cannot become enablers and allow ourselves to be lulled into the belief that because we are doing something we are doing the right thing. For decades Congress has failed to address the issue of drug abuse, treating it as a crime, and rewarding doctors who overprescribe opioids.

I am grateful this committee is addressing this head on, and I look forward to continue to work with the committee leadership between now and the full markup so we can have a meaningful bill presented before the House.

And I yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from Illinois, Ms. Schakowsky, 3 minutes for an opening statement.

Ms. Schakowsky. Thank you, Mr. Chairman.

There is no question that we are in the midst of an opioid abuse epidemic, and there is not a member here whose district has not been touched by it. That is why I am so glad we are here today to work on how we can better combat the growing problem. The bipartisanship is really great.

One of the most important things we can do is expand access to medication-assisted treatment. Currently we have thousands of people across this country on waiting lists to access medication-assisted treatment because of the current caps we have on prescribing and the limited number of providers who can prescribe. And at the same time, we have people dying of opioid overdoses every day.

So I strongly support increasing the number of patients a doctor can prescribe buprenorphine to, and I also strongly support allowing physician assistants and nurse practitioners to provide buprenorphine and I am pleased that the legislation we are considering today allows for both.

Currently nurse practitioners and physician assistants can prescribe opioids, which we know are at the heart of the epidemic and are so often abused, yet we do not allow nurse practitioners and physician assistants to prescribe the medication used to treat opioid addiction. The Opioid Use Disorder Treatment Expansion and Modernization Act will correct this problem. I am proud to support it.

I also strongly support H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act, and I am pleased we are expanding this program to increase funding for outpatient services. Pregnant and postpartum women who are seeking addiction treatment have unique circumstances and the treatment they receive needs to be cognizant of that. They often are unable to enter into an inpatient rehab program because they have children at home. So we need to be sure that they

have treatment options that work for them and their families.

And finally, while I support the bills we are considering today, I also believe we need to have a serious conversation about increasing funding for addiction treatment. There is no question that we have an access problem when it comes to treatment and every single day addicts who want help are unable to get it because there simply aren't enough treatment centers.

I look forward to working with my colleagues on this committee to continue to find ways to combat the growing epidemic of opioid abuse and to include more direct treatment.

Thank you.

Mr. Pitts. The chair thanks the gentlelady.

Does anyone seek recognition on the majority side?

Does anyone seek recognition on the minority side?

If not, the chair now calls up H.R. 4978, and asks the clerk to report.

The Clerk. H.R. 4978, to require the Government Accountability Office to submit to Congress a report --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with and the bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 1-1 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

Are there any other amendments to the bill?

I will recognize myself to speak briefly on the bill.

The Nurturing and Supporting Healthy Babies Act was induced by the gentleman from West Virginia, Congressman Evan Jenkins, to help us fully evaluate the rate of neonatal abstinence syndrome, NAS, within Medicaid. Neonatal abstinence syndrome is a serious condition that affects infants whose mothers have taken a large amount of opioids during pregnancy.

I am hopeful that this bill will allow us to fully evaluate the current gaps in services for babies suffering from neonatal abstinence syndrome. This legislation builds off of the good work our committee has undertaken on the NAS, H.R. 1462, the Protecting Our Infants Act, which has been signed into law. That legislation studies how we can prevent and treat prenatal opioid abuse and NAS more broadly.

So I urge my colleagues to vote yes on this legislation.

The question now occurs on forwarding H.R. 4978 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

The next bill is H.R. 4641, and the chair calls up H.R. 4641 and asks the clerk to report.

The Clerk. H.R. 4641, to provide for the establishment of an

interagency task force --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with. The bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 1-2 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

Mrs. Brooks. Mr. Chairman, I move to strike the last word.

Mr. Pitts. Who is seeking recognition?

The gentlelady from Indiana is recognized for 5 minutes.

Mrs. Brooks. Mr. Chairman, it is clear from the scope of the bills that are about to be discussed that the spike in opioid and heroin abuse directly impacts every district across the country, and we know that the current opioid and heroin epidemics making headlines nationwide. And I have heard as recently as last week from Hoosiers about the personal and tragic impacts this epidemic is having on families. In Indiana alone from 1999 through 2009, health officials saw a 500 percent increase in the rate of drug overdose deaths.

This epidemic didn't happen overnight and it is not going to be resolved overnight. It is impossible to point to one specific reason for why it has spiraled out of control to a point where in Indiana and across the country overdose deaths now are surpassing motor vehicle-related deaths.

But the one thing we do know and that we have learned is that about 80 percent of all heroin addicts started down that road with an opioid prescription. Providers across the country and in my home State in Indiana are working to stem this tide and I applaud them for that. Through conscious efforts to crack down on overprescribing in one of my counties, Grant County, Marion General Hospital successfully dropped the number of pain prescriptions written over the past year by 100,000 pills, in 1 year. This is one example of the efforts of

those on the front lines of this epidemic undertaking to fight back against it.

Prescribing physicians, pharmacists, first responders, law enforcement, and most importantly, family members of addicts are working in our communities every day, and we must ensure they have the best guidance, support, and resources to be successful.

In drafting prescriber guidelines for pain medication, the CDC has taken a significant step to support prescribers. They understand that the overprescription of opioids is a serious problem and that clear guidelines for prescribers need to be implemented to help address our Nation's growing heroin and opioid abuse crisis.

H.R. 4641, which I introduced with our colleague, Representative Kennedy, would examine these guidelines and ensure that opioid prescribing practices are reviewed, modified, and updated where needed by an interagency task force and expert stakeholders from the prescriber, patient addiction, and recovery community to reflect best practices going forward.

I am grateful that our leaders, Chairmen Upton and Pitts, Ranking Members Pallone and Green, recognize the seriousness of this epidemic, and I look forward to consideration in the House of this and all of the other solutions that we have to help providers and patients stem the tide of the opioid abuse.

With that, I yield back.

Mr. Pitts. The chair thanks the gentlelady.

Are there amendments to the bill?

The chair recognizes Mr. Kennedy to offer an amendment.

Mr. Kennedy. Thank you, Mr. Chairman. I have a bipartisan amendment at the desk.

Mr. Pitts. Which one? Clerk, read the amendment?

The Clerk. Amendment to H.R. 4641 offered by Mr. Kennedy.

[The amendment of Mr. Kennedy follows:]

\*\*\*\*\* INSERT 1-3 \*\*\*\*\*

Mr. Kennedy. Thank you.

Mr. Pitts. The gentleman is recognized.

Mr. Kennedy. Thank you, Mr. Chairman.

One thing that has been very clear in this committee and in this entire body is that combating opioid abuse disorders transcends a partisan divide. I have been fortunate to work very closely with Congresswoman Susan Brooks on this issue over the past few years. As former prosecutors, we both have seen the way that addiction leads too many in our justice system rather than into the treatment that they so desperately need.

But we also knew that, in talking to our constituents, that a few families and communities have been spared the heartbreak of addiction and that any effort to combat it will require all of us, from advocates, to treatment specialists, to law enforcement, to families. And that is why we have introduced this bill.

By convening a task force that includes experts in numerous agencies, background specialties, we can replicate the best practices across the country, avoid repeating our shortcomings, and develop a strategy to increase access to treatment for all Americans battling substance abuse disorders. So I urge my colleagues to support this legislation.

The amendment that I have offered along with Representative Brooks is a simple bipartisan amendment that would expand the list of task force members to include the Substance Abuse and Mental Health Administration and Indian Health Services.

It is my understanding that staff continue to discuss other possible additions to the list of task force members and that conversations will continue as this legislation moves to the full committee. I urge my colleagues to support this amendment and to ensure the task force is as robust as possible and includes the views that we all need in order to get to the right answers on a very difficult topic.

And I yield back.

Mr. Pitts. The chair thanks the gentleman. We will support this amendment.

Does anyone else seek recognition on the amendment?

If not, the question now occurs on forwarding H.R. 4641, as amended --

Mr. Griffith. Mr. Chairman.

Mr. Pitts. No, we are not ready yet, we have got more.

Mr. Griffith. Yeah.

Mr. Pitts. The chair recognizes the gentleman, Mr. Griffith, to offer an amendment.

Mr. Griffith. Thank you very much, Mr. Chairman. I actually want to strike the last word for the purposes of a colloquy with Representative Brooks and yourself or Chairman Upton.

Mr. Pitts. The gentleman is recognized.

Mr. Griffith. Thank you, Mr. Chairman.

I had thought about introducing an amendment today, but decided that it would probably be better to hold off and see if we could work

something out before the full committee.

The amendment is a simple one. Its intent is to reassert the authority of the legislative branch as a coequal branch of government. If we are creating a task force, advisory board, or commission that is ultimately reporting back to Congress, I think congressional appointees should be represented in the discussion so that it doesn't come as a complete surprise when the group comes out with their report.

We did that with some congressional appointments as a part of the advisory board within the 21st Century Cures. And I came from the Virginia Legislature, where I served for many years, and we did that as a commonplace there. It worked very well. It was bipartisan.

And so what I would propose is that we have a 3-2 split in the House and a 2-1 split in the Senate -- other configurations may work -- between the majority party and the minority party. Appointments can be delegated by the leadership to the chairman and ranking member of the committee of jurisdiction if that is their wish. This is kind of the idea.

And over time it is a slow process and steady project that I think we should work on to make sure that we have a voice in a lot of the behind the scenes things that are going on so we are not waiting a year and a half, a report comes out, and all of sudden we go, "Well, that is crazy." We have some congressional appointees that will be talking with us, we will be talking with them. And working in a partnership as a part of the task force or having appointees on the task force I think we can do great things.

I will yield to Representative Brooks or Chairman Pitts or Chairman Upton, whoever might want to speak on this matter, in hopes that we can work together to include legislative appointments to the task force before we get to the full committee workup.

Mr. Pitts. The chair recognizes Mrs. Brooks.

Mrs. Brooks. Thank you, Mr. Chairman.

I do have a question -- learned about this yesterday -- to the gentleman from Virginia. And originally when it was brought to me, I was under the impression that it was a Member of Congress, but you are actually interested in an appointee, someone with actual expertise in the area of prescribing that Congress would appoint, not that it would specifically be a Member of Congress. Would that be correct?

Mr. Griffith. That is correct. However, if there was a specialized area. As I look at the broad picture, if we wanted to make it a Member of Congress, I am not against that. But generally speaking, Members of Congress from across the United States have lots of things to do, and I am not trying to add to that, but have experts in the field who are representatives of each of the legislative branches, Congress and the Senate, so that we have some input while the process is going on instead of being left in the dark and then all of a sudden proposals come out. That is the concept, but it can work either way.

Mrs. Brooks. Thank you.

I look forward to working with the gentleman from Virginia on this concept moving forward. I think it definitely has merit. And seeing that it was included in 21st Century Cures, I think it could have merit

with this bill as well.

Mr. Griffith. Thank you very much.

Mr. Pitts. That concludes the colloquy. We are still on the Kennedy amendment. Does anyone else wish to speak on the Kennedy amendment?

If not, we will vote now on the Kennedy amendment.

The question now occurs on amending 4641 with the Kennedy amendment.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the amendment is adopted.

Are there other amendments to 4641?

If not, the question now occurs on forwarding H.R. 4641, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

The chair now calls up H.R. 3680, Co-Prescribing to Reduce Overdoses Act, and ask the clerk to report.

The Clerk. H.R. 3680, to provide the Secretary of Health and Human Services to carry out a grant program for co-prescribing opioid overdose reversal drugs.

Mr. Pitts. Without object, the first reading of the bill is

dispensed will. The bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 1-4 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

The chair recognizes the gentleman, Mr. Sarbanes from Maryland, to offer an amendment.

Mr. Sarbanes. Thank you, Mr. Chairman. I have an amendment at the desk, a technical amendment.

Mr. Pitts. The clerk will report.

The Clerk. Amendment to H.R. 4680 offered by Mr. Sarbanes.

[The amendment of Mr. Sarbanes follows:]

\*\*\*\*\* INSERT 1-5 \*\*\*\*\*

Mr. Pitts. The gentleman is recognized for 5 minutes.

Mr. Sarbanes. Thank you Mr. Chairman.

I want to thank Ranking Members Pallone and Green, as well as yourself, Mr. Chairman, and Chairman Upton, for working diligently with me and my staff so we could bring this bill to the markup today. And I also appreciate the support of Representative Bucshon from the other side of the aisle.

I am pleased to offer this amendment that will essentially make some technical changes to the bill that were previously agreed to by both the majority and minority and reflect some technical assistance that we received from HHS during this process.

This bipartisan bill, the Co-Prescribing to Reduce Overdoses Act, would create a demonstration project to encourage prescribing opioid overdose reversal drugs like naloxone to patients at an elevated risk of overdose, as well as to a close relative of such a patient.

Mr. Chairman, as you and members of the committee know, this has reached epidemic proportions, the opioid addiction crisis. More than 100 Americans die every single day. It is a preventable drug overdose. And overdose fatality is now the leading cause of accidental death in the country.

In 2014 in Maryland, 578 people died due to heroin compared with 464 the year before. In Baltimore, my hometown, 303 people died from drug and alcohol overdoses in 2014, 192 of them as a result of heroin. This was a 19 percent increase from 2013. This is more than the number of people who died of homicide in the city.

And in Anne Arundel County, which I also represent, 360 opioid overdoses, fatal and nonfatal, of which 49 were fatal; 16,000 people in 2013 died due to prescription opioids overdose and an additional 8,000 died due to heroin overdose. And the problem is getting worse, as we know.

This is an epidemic, but it is an epidemic that we can begin to stem with bills such as this and many of the others that are being proposed today.

Naloxone is a drug that safely and effectively reverses both opioid- and heroin-induced overdoses if administered in time. It has been used by nonmedical personnel -- we have heard plenty of testimony about this -- with only minimal training for over 15 years and has been proven to lower overdose mortality by almost 50 percent.

More people need access to this lifesaving medication. And while efforts to distribute naloxone to first responders and community organizations are critical and important, we also have to take a more proactive approach.

One part of that approach addressed in this bill is the idea of co-prescribing naloxone to patients or to their caregivers who are taking opioids and are at high risk of overdose. This is supported by the American Society of Addiction Medicine, the American Medical Association, and the Veterans Health Administration.

The bill before us today would create a demonstration project for federally qualified health centers, opioid treatment centers, and other providers to encourage co-prescribing naloxone. Funds could be

used for training, to purchase opioid overdose reversal drugs, to offset copays, to conduct community outreach and raise awareness, to connect patients who have experienced a drug overdose with appropriate treatment, and to track individuals participating in the program. All grant recipients would be required to evaluate the outcomes of the program.

I am extremely pleased to see this bipartisan bill move forward today because I know that this will save lives and help begin to stem the tide of this terrible epidemic bill. This bill has been endorsed by the AMA, the American Society of Addiction Medicine, and the Harm Reduction Coalition. There are two Republican cosponsors, Representative Bucshon, who I mentioned, from Indiana, who serves on this committee, and Representative Randy Hultgren from Illinois. We would certainly welcome additional support, and I urge my colleagues to support this amendment to the bill and the underlying bill.

I yield back.

Mr. Pitts. The chair thanks the gentleman. Again, we support this bipartisan amendment.

Is there anyone else seeking recognition on the Sarbanes amendment?

If not, the question now occurs on adopting the Sarbanes amendment to 3680.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed

to.

Are there any other bipartisan amendments to the bill?

Mr. Engel. Mr. Chairman.

Mr. Pitts. I am sorry, where? Who is seeking recognition?

Mr. Engel. Over here.

Mr. Pitts. Mr. Engel.

Mr. Engel. Thank you.

Mr. Chairman, I just want to very briefly move to strike the last word. I had an amendment to the previous bill which contained the text of H.R. 3119, the Palliative Care and Hospice Education Training Act, which I introduced last year with Congressman Tom Reed of New York.

And I just want to say that palliative care is interdisciplinary patient- and family-centered health care that focuses on providing relief from the pain, symptoms, and stress of a serious illness. Its goal is to alleviate suffering and improve quality of life for patients and their families. One of the main goals of my bill is to expand training opportunities for healthcare providers in palliative care and specifically pain management. And I am raising this issue today because I feel that better provider training in pain management needs to be part of our response to the opioid crisis.

To truly tackle high rates of opioid abuse and addiction we must make sure opioids are being prescribed responsibly, and according to the Substance Abuse and Mental Health Services Administration, there was a fourfold jump in the prescribing of opioids for pain treatment between 2000 and 2010, and, sadly, during this same period rates of

opioid abuse and addiction similarly skyrocketed.

The prescription opioid death rate in the U.S. has more than quadrupled since the late 1990s. In 2013 prescription opioids played a role in more than 16,000 overdose deaths and nearly 2 million Americans grappled with opioid abuse or dependence. And as we work to combat this epidemic it will not enough to respond to addiction. We must simultaneously work to prevent it by affording the healthcare workforce robust training on pain management, including how to prescribe opioids safely.

Let me also say that Congresswoman Brooks and Congressman Kennedy's bill gets to the heart of this need by making sure we have guiding principles in place to inform providers' decisions as they treat patients suffering from chronic and acute pain. So what I have done is take the added step of ensuring that we have the education centers, curricula, and teachers needed to improve provider training in pain management.

Let me say in conclusion, we cannot hope to overcome this crisis without providing our healthcare workforce with the education and information necessary to prescribe opioids carefully and that is exactly what my amendment would do.

I am not putting in an amendment. I just wanted to raise that. And I thank the chairman and the subcommittee for its indulgence.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman for his remarks.

Are there other bipartisan amendments?

The chair recognizes Mr. Griffith to offer an amendment.

Mr. Griffith. Thank you, Mr. Chair. I believe there is an amendment at the desk.

Mr. Pitts. The clerk will report.

The Clerk. Amendment to H.R. 3680 offered by Mr. Griffith.

[The amendment of Mr. Griffith follows:]

\*\*\*\*\* INSERT 1-6 \*\*\*\*\*

Mr. Pitts. The chair recognizes Mr. Griffith for 5 minutes in support of his amendment.

Mr. Griffith. Thank you very much, Mr. Chairman.

Last year I wrote a letter with 22 of colleagues calling on HHS to develop best practices for the use of naloxone. This bill, with my amendments, codifies the request for best practices.

My amendment takes bipartisan language developed by Senators Kaine and Capito calling on HHS to develop these best practices for prescribing naloxone to patients who are at an elevated risk of overdose for opioids or heroin. This would include those who may or may not be in treatment for opioid addiction.

We incorporated technical assistance in the amendment from HHS to ensure these best practices do not cause liability concerns for our medical providers.

Finally, there is no new expenditure associated with the development of these best practices as HHS would develop those using existing authorizations.

It is my hope that we will add this amendment to a very good bill.

Mr. Pitts. The chair thanks the gentleman.

Does anyone else seek recognition on the Griffith amendment?

Mr. Sarbanes.

Mr. Sarbanes. I just want to thank the gentleman for the amendment. It is a sound and a constructive addition to the bill and I support it.

With that, I yield back.

Mr. Pitts. The chair thanks the gentleman.

Dr. Murphy seeks recognition?

Mr. Murphy. Thank you. I move to strike the last word.

I have a quick question, if I can, for Mr. Griffith on this amendment, if I could. I know that one of the concerns I hear from the DEA and from other providers is that with naloxone out there, obviously it saves lives. And it has been great for first responders to have this with them.

A couple of things that I have heard have raised concerns. One, in competing actual drug overdoses, in some cases once a person is revived from naloxone they refuse to go to the hospital, and so those numbers are never registered in terms of drug overdose rates. I don't know if this specifically addresses that, but it is something I think we ought to be looking at.

The second thing we hear is from people who are highly addicted, they actually now will push themselves further in taking a dangerous drug with this distorted belief in their mind that this near-death experience is okay because I can take this, someone will have some naloxone around, and so I can take a bigger risk with that. I just want to make sure in our educational process of dealing with this we are aware, we are monitoring those numbers to also look at the effect that this may have.

And I yield to the gentleman if you have any comments on addressing those.

Mr. Griffith. I think both are points that ought to be reviewed.

I think we should certainly get it out there in the field and see what happens over time. I mean, you are right, there are going to be some folks who do that, but the vast majority of folks who are overdosing aren't thinking of it in those terms. I can't tell you it wouldn't happen, but I do think it is something we should monitor. I think it is a very good point.

Mr. Murphy. I appreciate it, especially given the idea that once an addict is there, that is all they are concerned about, is their addiction. And I appreciate it. I look forward to further conversations.

Mr. Chairman, I yield back.

Mr. Sarbanes. Will the gentleman yield?

Mr. Murphy. I will yield to you, yes.

Mr. Sarbanes. It is a fair concern and it is something that I have looked into as we put the bill together.

On your first point, I actually had the opportunity recently to be with some healthcare professionals in one of my counties who indicated that in the situations where somebody is being revived through naloxone after overdosing, what they are finding is that the family are immediately contacting health professionals to report that, because it causes such alarm inside the family.

And they are talking about as part of best practices you might include providing information, an emergency hotline, and so forth with the naloxone so that people could immediately call and report that. Because at that point in time that is the opportunity, the research

shows, to have a person who is motivated with their family to move into a treatment program. And we understand that just reviving somebody from an overdose, that is not the end of the process, it is really the beginning of the process.

On your second question, there are a fair amount of studies that suggest that your concern, while valid, I think is one that we recognize, there is a response to that. Naloxone actually causes acute withdrawal, which is very painful for individuals who are dependent on opioids, and it negates the purpose of taking the opioids. And there is a whole set of studies that have concluded that the availability of naloxone does not, in fact, encourage people to use more drugs or to use them in riskier ways. And those are some studies that we can certainly provide going forward.

Mr. Murphy. I appreciate the gentlemen's comments. Perhaps one of the things we can do is see if there are some practice guidelines that can be written along with this to make sure we are monitoring those. And I appreciate the gentleman's concern.

Mr. Sarbanes. I think it is a good idea.

Mr. Bucshon. Will the gentleman yield for a second?

Mr. Murphy. Yes.

Mr. Bucshon. I would like to just say, as someone who has given Narcan or naloxone to patients in the hospital, that it is very important that they do go to a hospital after they have been given naloxone. Number one, sometimes one dose is not enough and they rebound. Number two, there are side effects of naloxone. I don't have

them listed in front of me, but you should look that up. There can be problems with, like you said, with quick withdrawal. People can become combative, tachycardic, a fast heart rate, and other things.

I do think the concern about patients that don't go to the hospital, that we need to make it very clear as part of our training process of first responders or others giving naloxone, that it is very important that those patients go to a medical facility after they have been given it. And I would argue, even if it is given by a family member, family members need to understand that there are risks of not going to the hospital.

I yield.

Mr. Sarbanes. I appreciate the discussion just in the last 20 seconds because I think it points up the value of having a demonstration, a program like this, because we begin to explore some of the issues that we just talked about here.

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

Mr. Pitts. The chair thanks the gentleman.

Does anyone else seek recognition on the Griffith amendment?

If not, the question now occurs on adopting the Griffith amendment.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

Does anyone else seek recognition on the amended bill?

The question now occurs on forwarding H.R. 3680, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

The chair now calls up H.R. 3691 and ask the clerk to report.

The Clerk. H.R. 3691, to amend the Public Health Service Act to reauthorize the residential treatment programs --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with. And the bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 1-7 \*\*\*\*\*

Mr. Lujan. Mr. Chairman.

Mr. Pitts. Who is seeking recognition?

The chair recognizes the gentleman, Mr. Lujan.

Mr. Lujan. Mr. Chairman, motion to strike the last word.

Mr. Pitts. The chair recognizes the gentleman.

Mr. Lujan. Mr. Chairman and Ranking Member, our communities are hurting and our families face a substance abuse crisis that is tearing them apart. Illicit drugs like heroin and methamphetamine and prescription drug abuse have led to an epidemic of drug overdose.

In two counties in my district in New Mexico the overdose rate is more than four times the national average. Too many people suffering and too many people are being forgotten.

But it isn't just New Mexico. The crisis touches everyone, whether they live in rural communities, the suburbs, or the inner city. Millions of Americans, be it a brother, a sister, a parent, or a close friend, know that the struggle of substance abuse is real.

People need access to healthcare providers and doctors. Our citizens need access to medicine and care. But in too many communities in New Mexico and across the country simply accessing lifesaving resources and services can often be an impossible challenge.

That is why I introduced the Improving Treatment for Pregnant and Postpartum Women Act, which will strengthen efforts to ensure that some of our most vulnerable, pregnant and postpartum women and children, get the care they need, And I encourage and appreciate the committee's support. I thank my many colleagues who have joined me in supporting

this effort, Congressman Tonko, Congressman Clarke, Congresswoman Matsui, and Congressman Cardenas.

I believe that my bill and the many other bills we are considering today are an important step forward. And while no single solution will solve this crisis, one thing is clear: We must provide robust resources and support to those who want to get better. But right now there just aren't enough resources to go around.

For that reason, I am already working with my colleagues to introduce new legislation that reflects President Obama's call for new and expanded funding of \$1 billion to combat the heroin and opioid abuse crisis that is plaguing our country. I believe that the President's proposal represents a significant downpayment to address this crisis.

I hope we can make this legislation bipartisan. I look forward to working with my colleagues and hearing their ideas and those of the staff, because as we can see here, this effort requires a bipartisan coalition and innovative approaches that test new ideas. But it is time to recognize that in order to address this epidemic we must have increased support.

I look forward to continuing to work with my colleagues on this committee to provide assistance and relief to families and people in need across this country.

And with that, Mr. Chairman, I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman.

Anyone else seeing to speak on the legislation?

Let me speak briefly on behalf of the bill. I am pleased with

the progress of H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act. The bill provides pregnant and postpartum women and their infants with family-based treatment to address a substance abuse diagnosis. And while my colleague and I still have some CutGo issues to resolve, I believe this bill is a step in the right direction to provide expectant mothers and infants with necessary care in the case of substance abuse. So I urge support of the bill.

Are there any bipartisan amendments to the bill?

Are there any other amendments to the bill?

If not, the question now occurs on forwarding H.R. 3691 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

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[2:31 p.m.]

Mr. Pitts. All right, the next bill. The chair calls up H.R. 1818 and asks the clerk to report.

The Clerk. H.R. 1818, to amend the Public Health Service Act to provide grants to States to streamline State requirements --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-1 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

Are there other amendments to the bill?

Let me speak briefly in favor of the bill.

No amendments?

Mrs. Capps. No.

Mr. Pitts. Yeah. No amendments.

I want to speak briefly in favor of H.R. 1818, the Veteran Emergency Medical Technician Support Act. H.R. 1818 will allow military medical-trained personnel to meet certain civilian emergency medical training licensure requirements.

First responders play a key role in addressing the opioid crisis, and I believe this bill will allow more emergency medical technicians to serve our communities across the country. This bill has previously passed the House twice with large bipartisan support, and I urge my colleagues to vote yes on this legislation.

Is there anyone else seeking -- Mrs. Capps is recognized to speak on the bill.

Mrs. Capps. Thank you, Mr. Chairman. I move to strike the last word and also highlight the importance of H.R. 1818. I appreciate the chairman speaking in its favor. This is the Veteran Emergency Medical Technician Support Act. I have worked with Representative Kinzinger the past two Congresses on this issue. I am pleased to see it up for discussion again today.

You know, our men and women in the military receive some of the best technical training in emergency medicine anywhere, and this is

while they are serving their country. But when they leave the military to return home, they are so often required to start back at square one to receive certification for civilian jobs.

Similarly, military medics with civilian credentials when they join the military often must let their civilian certifications lapse while defending our country.

Either way, this keeps our veterans out of the civilian workforce and deprives our communities of valuable medical personnel.

Vets EMT is a small but very straightforward bipartisan bill to help States streamline their certification processes to take military medic training into account for civilian licensure. Similar legislation has passed the House, as you said, in previous Congresses. I am hopeful we can continue to work together in a bipartisan way to get this bill into law. I believe we owe these talented professionals the opportunity to join our healthcare workforce and improve the care with their service in our community.

And I yield back.

Mr. Pitts. The chair thanks the gentlelady.

Anyone else seeking recognition on H.R. 1818?

If not, the question now occurs on forwarding H.R. 1818 to the full committee.

All those in favor, say aye.

Those opposed, no.

They ayes appear to have it, the ayes have it, and the bill is agreed to.

The chair now calls up H.R. 3250 and asks the clerk to report.

The Clerk. H.R. 3250, to amend the Federal Food, Drug and Cosmetic Act to prevent the abuse of dextromethorphan --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with. The bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-2 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

Are there any other amendments to the bill?

Does anyone seek recognition speaking on H.R. 3250?

If not, the question now occurs on forwarding H.R. 3250 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

All right. The chair now calls up H.R. 4969 and asks the clerk to report.

The Clerk. H.R. 4969, to amend the Public Health Service Act to direct the Centers for Disease Control and Prevention to provide for --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-3 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill? Are there any other amendments to the bill? If not, I would like to speak briefly in favor of the bill.

This is the John Thomas Decker Act, H.R. 4969. The bill directs the Secretary to provide for informational materials to educate and prevent opioid addiction in teenagers and adolescents who are injured playing youth sports and then prescribed an opioid.

One study found that adolescents and teenagers who played high-injury competitive sports and were prescribed an opioid had a 50 percent higher chance of nonmedical use of prescription opioids than their peers who did not participate in these types of sports.

I urge my colleagues to support the amendment and the underlying legislation.

All right. We are offering one bipartisan amendment, and I would like to ask the clerk to report the amendment.

The Clerk. Amendment to H.R. 4969 offered by Mr. Pitts.

[The amendment of Mr. Pitts follows:]

\*\*\*\*\* INSERT 2-4 \*\*\*\*\*

Mr. Pitts. All right. This amendment merely makes technical changes to the bill.

Does anyone seek to be recognized on the amendment? If not, the question now occurs on the Pitts amendment.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

Are there any other amendments to the bill?

If not, the question now occurs on forwarding the bill, H.R. 4969, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

All right. The chair now calls up H.R. 4586 and asks the clerk to report.

The Clerk. H.R. 4586, to amend the Public Health Service Act to authorize grants to States for developing standing orders and educating healthcare professionals regarding --

Mr. Pitts. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-5 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

I have a bipartisan amendment that I will offer. The clerk will report.

The Clerk. Amendment to H.R. 4586 offered by Mr. Pitts.

[The amendment of Mr. Pitts follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Pitts. All right. This is the Lali's Law, H.R. 4586. The bill creates a competitive grant program that helps States increase access to naloxone, a lifesaving opioid overdose reversal drug.

Increasing access to naloxone through standing orders at pharmacies will get this critically important drug into the hands of more individuals at risk for overdose from opioids and their loved ones. So I urge my colleagues to support the amendment and the underlying legislation.

Yield back. Does anyone else seek recognition on this bipartisan amendment?

If not, the question is on the bipartisan Pitts amendment.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the amendment is agreed to.

Is there anyone seeking recognition on the amended bill?

If not, the question now occurs on forwarding H.R. 4586, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

The chair now calls up H.R. 4599 and asks the clerk to report.

The Clerk. H.R. 4599, to amend the Controlled Substances Act to permit certain partial fillings of prescriptions.

Mr. Pitts. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-6 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?

The chair recognizes the gentleman, Mr. Kennedy, to offer an amendment.

Mr. Kennedy. Thank you, Mr. Chairman. I have an amendment at the desk.

Mr. Pitts. The clerk will report.

The Clerk. Amendment in the nature of a substitute to H.R. 4599 offered by Mr. Kennedy.

[The amendment of Mr. Kennedy follows:]

\*\*\*\*\* INSERT 2-7 \*\*\*\*\*

Mr. Pitts. The chair recognizes Mr. Kennedy 5 minutes to support his amendment.

Mr. Kennedy. Mr. Chairman, thank you.

This is a bipartisan amendment in the nature of a substitute that essentially makes just some technical changes to the underlying legislation. I believe there is broad bipartisan support for the legislation. And I want to acknowledge my colleague from Massachusetts, Katherine Clark, who is one of the authors of this piece of legislation.

Mr. Chairman, earlier this month a young woman from my home State of Massachusetts named Kelsey Errico died of a heroin overdose after a long fight with substance abuse disorder. Hoping to spare families from her same heartbreak, Kelsey's mother Kathleen decided to use her death as an opportunity to raise awareness about the devastating disease she faced. In Kelsey's death notice her mother wrote, quote, "The disease of addiction is merciless. It is up to us to open our minds and hearts to those who are still sick and suffering. Kelsey does not want us to cry for her. She wants us to fight for her."

Kelsey's story has become far too common in our Commonwealth. It has become far too common in Oregon, in Indiana, in West Virginia, and every other State represented on this dais today.

In just 3 weeks last month, the county where I once served as a prosecutor experienced 20 overdose deaths, 2 of which were in the presence of children. And a recent study of opioid-related hospital visits in Massachusetts found that they had risen by nearly 200 percent

between 2007 and 2014, from 31,000 to 57,000. More than just numbers, those are lives lost and families forever altered.

That is why our delegation has been working closely on this issue over the past few years and why I am honored to offer the amendment in the nature of a substitute of the Reducing Unused Medication Act sponsored by my colleague, again, Congresswoman Katherine Clark.

Almost exactly 2 years ago, our delegation helped raised awareness across our State for National Prescription Drug Take-Back Day, leading to nearly 23,000 pounds of unused medication collected in Massachusetts and 390 tons collected across the country. Thousands of patients who no longer needed those pills dropped them off and removed the risk of abuse and misuse by family members and friends battling addiction who might have found them.

Passing this bipartisan, bicameral bill, we can give providers and patients the ability to reduce the amount of unused opioids that remain in medicine cabinets. Inside doctor's offices and exam rooms, those patients should have the authority to manage their prescription and limit the amount of drugs that may end up forgotten in their homes for years.

When 70 percent of all adults who misuse opioids obtain them through loved ones, this legislation is one way for us to combat drug diversion and one step to bolster our prevention efforts. It is as yet another way we can honor Kelsey's memory and continue to fight for her and the millions of other Americans battling this disease. I urge my colleagues to support this amendment in the nature of a substitute.

And I yield back.

Mr. Pitts. The chair thanks the gentleman. This is a bipartisan amendment which we support.

Are there any other members seeking recognition on this amendment?

The question now occurs on the Kennedy amendment to H.R. 4599.

All those in favor of the Kennedy amendment, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

Are there any other amendments to the bill?

Anyone seek recognition on the amended bill?

If not, the question now occurs on forwarding H.R. 4599, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

All right. The next bill, H.R. 4976, the Opioid Review Modernization Act. The chair calls up H.R. 4976 and asks the clerk to report.

The Clerk. H.R. 4976, to require the Commissioner of Food and Drugs to seek recommendations from an advisory committee of the Food and Drug Administration --

Mr. Pitts. Without objection, the first reading of the bill is

dispensed with, and the bill will be open for amendment at any point.

So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-8 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?  
Are there any amendments to the bill?

The chair recognizes Mr. Lance to speak on the bill.

Mr. Lance. Thank you, Mr. Chairman. I move to strike the last word.

I am working on this legislation with our colleague from the Hudson Valley, Sean Patrick Maloney. The bill will help address the rampant opioid and drug abuse epidemic by reforming and improving the medical drug approval and labeling process at the Food and Drug Administration. The bill will ensure that the FDA rigorously reviews the benefits and risks of opioid pain medications and the benefits and risks are communicated to prescribers and patients. Finally, the bill encourages the development and approval of opioids with abuse-deterrent properties.

The FDA has a critical role in combatting the Nation's abuse crisis while also ensuring that patients with pain have access to the therapies they need. This is just one piece of the puzzle, obviously, but I believe it is an important measure that will help us address the overall crisis. And I urge support of this measure, and I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman. Anyone else seek recognition?

If not, the question now occurs on forwarding H.R. 4976 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

The chair now calls up calls up the Examining Opioid Treatment Infrastructure Act of 2016 and asks the clerk to report.

The Clerk. Discussion draft, to direct the Comptroller General of the United States to evaluate and report on the inpatient and outpatient treatment capacities, availability, and needs of the United States.

Mr. Pitts. Without objection, the first reading of the bill is dispensed with. The bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-9 \*\*\*\*\*

Mr. Pitts. Are there any bipartisan amendments to the bill?  
Are there other amendments to the bill?

The chair recognizes the gentleman, Mr. Pallone, to speak on the bill.

Mr. Pallone. Thank you, Mr. Chairman.

As we know, the opioid epidemic is nothing short of a public health crisis. In 2014, prescription pain killers were involved in 18,000 overdose deaths and heroin was involved in an additional 10,000. Roughly 2 million Americans live with a prescription opioid addiction, while 467,000 Americans are addicted to heroin.

Unfortunately, I don't think that we have reached the apex of this crisis. Last year, deaths from prescription drug overdoses increased by 9 percent, while deaths from heroin overdoses increased by 26 percent.

But these numbers paint only a partial picture of the heavy toll of this epidemic on our society. Throughout this country, countless families and communities have been shattered by opioid abuse, misuse, and addiction, and I think it is time that we truly pursue best practices to reverse this problem and improve our ability to identify and treat people with substance abuse disorders.

In 2013, for example, only 1 in 10 Americans with a substance abuse disorder received any form of treatment, and that is completely unacceptable, and we should be asking why so few Americans are accessing the treatment they need.

Unfortunately, research also indicates that the majority of

people in need of treatment for substance abuse disorders do not receive anything that approximates evidence-based care. As we have heard from a number of experts who have testified before this committee, a majority of individuals who receive treatment for substance use disorders are receiving care that is ineffective, outdated, and not evidence-based. Each day we are losing lives because of our inability to provide the treatment capacity necessary to deal with the epidemic.

And that is why I am supporting this bill, which directs GAO to evaluate and report on the inpatient and outpatient treatment capacity, availability, and needs of the United States. It directs the agency to examine treatment capacity for substance use disorders across the continuum of care, as well as to examine the availability of treatment options based on reliable scientific evidence of efficacy.

A comprehensive survey of our treatment infrastructure will help us to understand where there are gaps and what we can do to address them. And so I urge my colleagues to support this legislation so we can receive the results of the study for further committee action.

I yield back.

Mr. Pitts. The chair thanks the gentleman.

Anyone else seeking recognition on the bill?

If not, the question now occurs on forwarding the Examining Opioid Treatment Infrastructure Act of 2016 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed

to.

All right. Finally, the chair calls up the Opioid Use Disorder Treatment Expansion and Modernization Act and asks the clerk to report.

The Clerk. Discussion draft, to amend the Controlled Substances Act to improve access to opioid use disorder treatment.

Mr. Pitts. Without objection, the first reading of the bill is dispensed with. The bill will be open for amendment at any point. So ordered.

[The bill follows:]

\*\*\*\*\* INSERT 2-10 \*\*\*\*\*

Mr. Bucshon. Mr. Chairman.

Mr. Pitts. Who is seeking recognition?

The chair recognizes Dr. Bucshon.

Mr. Bucshon. I move to strike the last word.

Mr. Pitts. For 5 minutes.

Mr. Bucshon. First, I would like to ask unanimous consent to introduce for the record a letter from the American Society of Addiction Medicine urging swift passage of this bill.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Bucshon. I would also like to introduce a letter of support from the Harm Reduction Coalition.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Bucshon. And then thank the American Medical Association and American Association of Nurse Practitioners, the American Academy of Physician Assistants, and the American Nurse Association for their support.

The opioid epidemic has left no area of this Nation untouched. Just yesterday, a local newspaper in my district reported that in one small city 31 of our fellow citizens lost their lives due to opioid-related overdose last year. The evidence is clear that this epidemic is growing and it will continue to grow unless immediate action is taken. As a doctor, a father, and a public policymaker, I want to do my part to help our communities overcome this challenge.

That is why I am proud to offer H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, today with my colleague from New York, Mr. Tonko. Together, we have worked day in and day out over the past few months to find common ground and move forward on this important issue. Our final bill represents months of stakeholder engagement and bipartisan work to improve the treatment of opioid addiction and limit drug diversion.

Our legislation increases access to opioid addiction treatment where it is needed most by lifting prescribing caps in a responsible and measured manner. It empowers physicians through education, training, and quality-of-care measures, allowing them to make informed decisions in the prescribing process for opioid use disorder treatment. It also encourages a multipronged approach to opioid use disorder treatment by providing physicians and patients education and a wider

range of treatment options. It also deters bad actors, both on the prescribing side and the patient side, by implementing physician-crafted diversion control plans to rein in the abuse and overprescription epidemic.

Again, I want to thank Mr. Tonko and all those who have worked with us throughout this process. And I look forward to H.R. 4981's passage here, in full committee, and on the House floor.

I yield.

Mr. Pitts. The chair thanks the gentleman.

Are there any other amendments?

Mr. Bucshon. Mr. Chairman, I have an amendment at the desk.

Mr. Pitts. Okay. Do you want to speak first.

Mrs. Capps. This is in general.

Mr. Pitts. In general. Okay. Let's go to the amendments, and then we will speak.

Dr. Bucshon, the clerk will report.

The Clerk. Amendment to the discussion draft offered by Mr. Bucshon.

[The amendment of Mr. Bucshon follows:]

\*\*\*\*\* INSERT 2-11 \*\*\*\*\*

Mr. Pitts. All right. The chair recognizes Mr. Bucshon in support of his amendment.

Mr. Bucshon. Thank you, Mr. Chairman. My amendment just makes technical changes to clarify the intent of existing provisions within my bill. I urge its adoption, and I yield back.

Mr. Pitts. All right. The gentleman offers the amendment. We support this amendment.

Does anyone desire to speak on the amendment, on this amendment.

Mrs. Capps. Just on the bill.

Mr. Pitts. Okay. We will wait for the bill.

Okay, on the Bucshon amendment, all those in favor of the Bucshon amendment to the Opioid Use Disorder Treatment Expansion and Modernization Act will say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the amendment is agreed to.

And to offer an amendment, Dr. Murphy.

Mr. Murphy. Thank you, Mr. Chairman.

Mr. Chairman, I am going to offer an amendment and withdraw it, but basically it changes the level from 250 to 200. And I know that there is no bigger advocate of trying to do the right thing for dealing with opioid abuse than Dr. Bucshon and I have nothing but admiration for him.

I wanted to point out a couple of concerns that have come up in hearings under this Subcommittee of Health, but also under Energy and

Commerce's Oversight and Investigations Committee.

One is an exchange I had with Dr. Richard Frank, who is the assistant secretary for planning and evaluation, back in October of 2015. What I was asking about in looking at dealing with a possibility of raising the number of patients a provider could be prescribing for, and I asked about such questions as, how much time does a doctor spend with each patient? What kind of counseling do they get? Are they in therapy? Are they following through on this? Are they really engaged in treatment? And basically the answer was they did not know.

We had also heard stories where sometimes the actual counseling was someone sitting in the waiting room and calling that group therapy while the patients were waiting to have their time with the doctor.

And as to the question of how much time such persons actually spend with the doctor while they are getting their prescription written, heard some stories from some clinics where it is a minute and a half or 2 minutes and not exactly what we should be doing.

So to that end, certainly Mr. Frank said he shared our concerns and said Secretary Burwell shared their concerns too and that we need to have a careful approach in addressing these evidence-based treatments.

On October 7, I should also say, several Members of Congress sent a letter to Secretary Burwell asking her a number of questions about how we track the data when someone is providing these prescriptions. This is October 7. I would like to offer this for the record, if I could. We have not received a response yet, but I know that Secretary

Burwell tries to be pretty responsive and hope that we could still be involved in some discussion on this.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Murphy. I would also like to offer an article here that appeared out of an NIH public access, but it was originally from the Journal of the American Medical Association in 2012. The article was titled "Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences."

Now, this one did not specifically deal with the issue of increasing the numbers of patients in medication-assisted treatment, but it did raise some very important questions, such as when there is an incentive for a prescriber, particularly from patient satisfaction surveys, there is a concern that has been associated with higher prescribing amounts of opiates.

For example, they are saying that given that compensation favors interventional procedures and high patient volume rather than time-consuming discussion, many physicians may behave in a way even they think is questionable, write their requested opiate prescription, and move on.

It also said nonfulfillment correlates to patient dissatisfaction, which can translate to lower treatment satisfaction scores. It also said a portion of physicians' compensation may depend on the quality of services provided, part of which may be based on patient satisfaction targets. Patients can report dissatisfaction based on real or perceived problems, including whether a clinician did or did not prescribe a desired medication.

At some institutions the first question on the patient satisfaction survey queries the extent of agreement with the statement,

quote, "I was satisfied with the way the doctor treated my pain," unquote. And it goes on to say that there are powerful disincentives for physicians to provide medically correct care and could contribute to some of the erosion of the trust needed in a healthy patient-physician relationship.

I raise these issues that I hope as this bill moves forward between the subcommittee and committee that we make sure we are working with HHS to make sure we have some much-needed questions raised and answers to them of the impact of increasing these numbers, what kind of time is spent between the physician and patient, are they really getting treatment? We know that buprenorphine is the third-most diverted drug and people oftentimes get their prescription, they buy other drugs and take it. We don't know if patients are getting drug tested to see if they are taking other opiates and bypassing the system.

I know that there are many physicians out there who are doing a tremendous job with a great deal of care and compassion and heart trying to do the right thing and they can handle these numbers well. I also know that given the questions we raised last year, just last fall with HHS, and we have not received answers to these yet, I am still concerned that we don't have answers, and raising this number could have some unintended consequences.

So with that, Mr. Chairman I would like to offer these articles, one from Time magazine of April this year and one from the Journal of the American Medical Association, along with the Secretary, if you will accept them --

Mr. Pitts. Without objection, they are entered into the record.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Murphy. Thank you. And I look forward to working with you, Mr. Chairman, the chairman of the full committee, and Dr. Bucshon on this.

And, Dr. Bucshon, I don't know if you have any comments, but I will leave it at that.

Mr. Bucshon. I don't. Thank you. And I look forward to working with you.

Mr. Murphy. Thank you.

Mr. Pitts. And you withdraw the amendment.

Mr. Murphy. Withdraw the amount.

Mr. Pitts. The chair thanks the gentleman.

Are there other amendments?

Mr. Pallone, you have an amendment. Yeah. She wants to speak on the -- now?

Mrs. Capps. Yes.

Mr. Pitts. All right. The chair recognizes Mrs. Capps 5 minutes to strike the last word.

Mrs. Capps. Thank you, Mr. Chairman. And I move to strike the last word.

The Opioid Use Disorder Treatment Expansion and Modernization Act represents months of work across the aisle and across the Capitol to find effective solutions to help people with opioid addiction access the best treatments available. And I want to thank the authors of this legislation, Mr. Bucshon and Mr. Tonko.

We know that to combat the opioid crisis we need to support all

avenues of prevention, treatment, and care, including access to medication-assisted treatment. Today, Federal law needlessly prohibits nurse practitioners and physician assistants who are otherwise permitted by their States to prescribe Schedule 3, 4, or 5 drugs from doing so to address opioid abuse. This is despite the fact that these professionals and their prescribing abilities are traditionally regulated at the State level.

The bill before us would fix this discrepancy and allow these valuable healthcare providers to join the fight against opioid abuse, in line with their current prescribing allowances determined by their own States. We will be making progress by expanding the number of healthcare providers able to help folks who need this kind of treatment.

The need for medication-assisted treatment is greater than the number that can be treated by certified physician providers, and that is a fact. Americans are suffering because they cannot find a healthcare provider to treat them with buprenorphine. That is a fact as well. We have a solution in the Opioid Use Disorder Treatment Expansion and Modernization Act.

So I urge my colleagues to support access to treatment and to knock down artificial barriers to care once and for all.

And I am happy to yield back.

Mr. Upton. Would the gentlelady yield?

Mr. Pitts. The chair thanks --

Mrs. Capps. I would yield.

Mr. Upton. Then I won't need to seek my own time.

I think the gentlelady for her comments.

I want to thank both Dr. Bucshon and Mr. Tonko. They have worked together. This is truly a bipartisan bill.

I know that on the desk there are a number of amendments that both raise and lower the caps, and I have had discussions with Dr. Murphy last night and suggested to him that I think we have struck the right balance, knowing that we have got amendments that go up and down. And I look forward to continuing to listen before we get to full committee to see if we did get the right level or not. But I would like to think that the amendments that either raise or lower the caps might be either not offered or withdrawn after we discuss them.

And we will continue to listen between now and when we get to full committee next week, but I would like to think that this is the right balance and that we could proceed without further amendment to this.

And I yield back. I thank the gentlelady for her time. And, again, I want to thank the two colleagues on both sides of the aisle for pursuing this and moving it forward.

And I yield back to the gentlelady from California.

Mr. Pitts. The chair thanks the gentleman.

The chair now recognizes Mr. Pallone to offer an amendment.

Mr. Pallone. Thank you, Mr. Chairman.

I would like to offer an amendment. Do you have my amendment at the desk.

Mr. Pitts. The clerk will report the Pallone amendment.

The Clerk. Amendment to discussion draft offered by

Mr. Pallone.

[The amendment of Mr. Pallone follows:]

\*\*\*\*\* INSERT 2-12 \*\*\*\*\*

Mr. Pitts. The chair recognizes Mr. Pallone 5 minutes on his amendment.

Mr. Pallone. Thank you, Mr. Chairman.

This amendment is simple. It would increase the cap on the number of patients physicians can treat at a given time with buprenorphine to 300. While I would prefer to eliminate the cap entirely or adopt the 500-patient cap that passed the Senate HELP Committee with bipartisan support, I am offering an amendment to increase the cap to 300 because I believe that is a fair and reasonable level and should be a level that we can support on a bipartisan basis.

We all know the numbers. Each day, 78 Americans die from an opioid-related overdose. Between 1999 and 2010, the death rate from prescription opioids more than quadrupled. We also know the sad reality that this epidemic continues to worsen and those numbers continue to climb each year.

We have all learned from our constituents the tragic consequences of this epidemic, and such is the story for one of my constituents from Old Bridge, New Jersey. She had already lost one son to the opioid epidemic and has had to fight to find substance abuse treatment services to save her remaining son's life as he suffers from his own opioid use disorder. And it is seemingly endless stories like hers that compels us to do all that we can to provide the tools necessary for individuals, families, and communities to combat the opioid abuse crisis.

The very existence of a cap on the number of patients a provider can treat with a particular medication I think is nonsensical. In

every other area of medicine we trust healthcare providers to manage their patient load responsibly. In this instance we are not trusting doctors who are on the front lines of this crisis to use their professional judgment in order to provide treatment for individuals facing the battle of their lives with opioid addiction. Moreover, these physicians are either addiction specialists or doctors who have taken specialized training to treat patients struggling with addiction, and we still aren't trusting them.

Why are we asking these doctors to operate with one hand tied behind their back, possessing the skill and knowledge to help improve a patient's health and potentially save their life but imposing an arbitrary numerical cap on the number of patients they can treat? I just don't think it makes any sense.

The entire Data 2000 framework smacks of stigma and prejudice against people with substance use disorders. Proposals to ration or limit the amount of prescription drugs a provider can dispense for any other medical condition would be uniformly met with consternation from Members on both sides of the aisle, but we treat addiction differently because society continues to view it as a moral failing or a flaw of character rather than as a medical condition and a chronic disease. And I think it is time for our attitudes and for this outdated statutory regime to catch up with the science.

While expanding access to buprenorphine must include allowing nurses and physician assistants to prescribe buprenorphine, this expansion does not lessen the need for a higher cap for physicians.

According to the written testimony on the TREAT Act provided Dr. Waller to this subcommittee, nearly half of those surveyed by the American Society of Addiction Medicine had waitlists of over 100 patients in 2013. The crisis has gotten worse since then, so I can only imagine that waitlists have gotten longer as well.

While including nurse practitioners and physician assistants will expand access to treatment, particularly in medically underserved communities, I don't think it is safe for us to assume that the new nurse practitioners and physician assistants capacity will be the same communities with physicians with those waitlists. That means that we could pass legislation and still leave individuals on waitlists, waitlists that could mean the difference between a patient's family supporting their loved one through their treatment and recovery or a family member preparing an obituary for that loved one who died as a result of an opioid overdose, and I believe promoting the public health should push us to reject that outcome.

Although I would prefer to eliminate the arbitrary cap on buprenorphine prescribing limits altogether, I think a cap of 300 is a fair increase and will improve our ability to respond to this crisis, and I urge my colleagues to support this amendment.

I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Anyone else wish to speak on the amendment?

Mr. Bucshon. Mr. Chairman.

Mr. Pitts. Dr. Bucshon.

Mr. Bucshon. Mr. Chairman, I am going to speak in opposition to the amendment.

The administration listened to all the same viewpoints that we have, and they landed at a number of 200. As we see today, some people want the caps at 200 or lower, some at 300 or higher. As part of our good faith effort to reach a compromise, we went even further than HHS to 50, and the Secretary maintains the authority to change the cap however she sees fit.

As HHS said, their goal is to increase access and minimize diversion while providing high-quality care. That is our goal as well. They walk through how they arrived at their number with staff from both sides of the aisle, and it is obvious that they did their homework. Again, to maximize patient care and limit diversion, a number of 250 is a good place to be.

We have worked in a bipartisan, transparent fashion for months, and I again believe a reasonable compromise has been reached. I would ask the Representative to withdraw his amendment.

Mr. Pallone. I am sorry, I am not withdrawing the amendment.

Mr. Bucshon. Okay. Thank you.

In that case, I would urge my colleagues to vote no on this amendment, given the extensive bipartisan hard work put into this piece of legislation and the compromise that has been reached.

I yield.

Mr. Pitts. The chair thanks the gentleman.

Does anyone else wish to speak on the Pallone amendment?

Mr. Green. Mr. Chairman.

Mr. Pitts. The chair recognizes Mr. Green.

Mr. Green. I would like to strike the last word.

I have heard the arguments about the average capacity a methadone provider should determine a cap for buprenorphine providers. While I understand that treatment setting is the most readily available data that can inform this discussion, the most closely related treatment setting to office-based setting that prescribe, there are some critical differences that must be considered.

Methadone is a Schedule 2 drug whereas buprenorphine is a Schedule 3 drug and it does not have the risk of methadone. Methadone can cause life-threatening respiratory depression. Such risk supports the delivery of methadone in a highly structured clinic with additional controls and standards not usually provided in a physician's office. Patients receive prescriptions to take buprenorphine at home while many -- I am going to pronounce it every way I can -- most patients must physically go to a methadone treatment facility each day to receive their dosage.

I think these are important differences we must keep in mind when trying to analogize the methadone treatment framework to the buprenorphine treatment framework.

Additionally, I think it is fairly ironic that my colleague is suddenly conveniently choosing to side with the President on this issue. I cannot recount the number of hearings we have had and votes we have taken that make clear that the administration opinion means

so little to my Republican colleagues.

But, again, the Senate bill actually has 500. And I think between 250 and 300 to 500 is probably a pretty good compromise.

With that, I am glad to support Mr. Pallone's amendment.

Mr. Pitts. The chair thanks the gentleman.

Anyone else seeking recognition?

Mr. Upton. I might ask that the previous gentleman might be able to revise and extend his remarks so that we know exactly what those words were.

Mr. Green. How many ways do you want me to pronounce it, Fred?

Mr. Pitts. Do you want a recorded vote?

Mr. Pallone. No.

Mr. Pitts. All right. The question now occurs on the Pallone amendment to the Opioid Use Disorder Treatment Expansion and Modernization Act.

All those in favor, say aye.

Those opposed, no.

The noes appear to have it, the noes have it, the bill is agreed to. All right.

The question -- are there any other amendments? The amendment is not agreed to, I am sorry.

Are there any other amendments to the bill? If not, the question now occurs on forwarding the Opioid Use Disorder Treatment Expansion and Modernization Act, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes appear to have it, the ayes have it, and the bill is agreed to.

Without objection, staff is authorized to make technical and conforming changes to the legislation approved by the subcommittee today. So ordered, without objection.

The subcommittee markup stands adjourned.

[Whereupon, at 3:13 p.m., the subcommittee was adjourned.]