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RPTR MARTIN

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LIVES WORTH LIVING: ADDRESSING THE FENTANYL CRISIS, PROTECTING CRITICAL LIFELINES, AND COMBATING DISCRIMINATION AGAINST THOSE WITH DISABILITIES

WEDNESDAY, FEBRUARY 1, 2023

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2123, Rayburn House Office Building, Hon. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Bucshon, Burgess, Latta, Griffith, Bilirakis, Johnson, Hudson, Carter, Dunn, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio), Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, and Pallone (ex officio).

Staff Present: Alec Aramanda, Professional Staff Member, Subcommittee on Health; Kate Arey, Content Manager and Digital Assistant; Jolie Brochin, Clerk, Subcommittee on Health; Sarah Burke, Deputy Staff Director; Kristin Flukey, Professional Staff Member, Subcommittee on Health; Theresa Gambo, Financial and Office Administrator; Seth Gold, Professional Staff Member, Subcommittee on Health; Grace

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Graham, Chief Counsel, Subcommittee on Health; Nate Hodson, Staff Director; Peter Kielty, General Counsel; Emily King, Member Services Director; Chief Krepich, Press Secretary; Clare Paoletta, Professional Staff Member, Subcommittee on Health; Carla Rafael, Staff Assistant; Michael Taggart, Policy Director; Lydia Abma, Minority Policy Analyst; Jacquelyn Bolen, Minority Health Counsel; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Perry Hamilton, Minority Member Services and Outreach Manager; Saha Khaterzai, Minority Professional Staff Member; Una Lee, Minority Chief Health Counsel; Juan Negrete, Minority Professional Staff Member; Greg Pugh, Minority Staff Assistant; Andrew Rosario, Minority Health Fellow; Andrew Souvall, Minority Director of Communications, Outreach, and Member Services; Tristen Tellman, Minority Health Fellow; Rick Van Buren, Minority Senior Health Counsel; and C.J. Young, Minority Deputy Communications Director.

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Mr. Guthrie. The Subcommittee on Health will now come to order.

The microphone is not on? It should be on. Yeah, it is. Wow. I hit the button.

Anyway, things you have to learn, right?

Well, thanks a lot. I appreciate everybody being here today. And I appreciate working with Democrat Leader Eshoo. We enjoyed working together last Congress, and we will continue to do so. We have a lot of things before us.

But the subcommittee will come to order. And the chair now recognizes himself for 5 minutes for an opening statement.

As we turn the page on both 2022 and the 117th Congress, thousands of Americans and their families are still reeling from failures by this administration and the last Congress to meaningfully address one of the greatest public health threats of our lifetimes, the fentanyl crisis.

Over the past several years, the United States has seen a historic rise of drug overdoses, driven by an increased supply of synthetic opioids such as illicit fentanyl analogs. In 2021 alone, there were over 107,000 drug overdoses reported, according to the Centers for Disease Control and Prevention, and over 60,000 of these were caused by synthetic opioids. My home State of Kentucky experienced a 14-percent jump in drug overdose deaths between 2020 and 2021, with over 70 percent of these deaths being caused by fentanyl alone.

Sadly, you cannot go a week without reading or hearing about the stories of mothers, sons, sisters, brothers, and cherished friends and even babies losing their lives to fentanyl overdoses.

How could this be possible? We don't have to look farther than the crisis right

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now at our southern border. Since last October, October of last year, our Border Patrol authorities have seized over 7,000 pounds of illicit fentanyl at our southwest border. This is on top of the over 14,000 pounds of illicit fentanyl seized the prior year. The dual crises, both the fentanyl and border crises, have effectively turned every community across the United States into a border community.

Fortunately, this very subcommittee has the ability to take action and do what we know will work to help keep illicit fentanyl out of our communities and save lives.

One of the bills before us today, H.R. 467, the Halt All Lethal Trafficking of Fentanyl Act, also known as the HALT Fentanyl Act, would take the critical step of permanently scheduling all fentanyl-related substances as Schedule I drugs under the Controlled Substances Act.

Congress has enacted temporary extensions several times over the last few years. These continued temporary solutions are not sustainable. We need a permanent solution and must pass the HALT Fentanyl Act now. Doing so will be my top priority as long as I am chairman of this Health Subcommittee.

I want to address the demand for illegal and dangerous drugs here in the United States while simultaneously focusing on support for recovery services for those who want help. We will have an opportunity later this year to reauthorize key parts of the SUPPORT Act, and we will be able to examine how to get people into recovery and keep them safe.

But if we have learned anything over the past few years, it is that these illicit fentanyl analogs are an entirely different class of drugs than any other deadly substance that our country has faced thus far and has the ability to make other illegal drugs that much more lethal.

Further, the Block, Report, and Suspend Suspicious Shipments Act, introduced by

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one of our newest subcommittee members, Representative Harshbarger, would also address the overdose crisis. This bill would require drug manufacturers and distributors to report all suspicious shipments of controlled substances to the Drug Enforcement Agency and require these entities to decline to fill such orders.

Fighting the overdose epidemic necessitates a multipronged approach and a strong partnership between the public and private sectors, which this legislation accomplishes. I thank Representative Harshbarger for leading on this issue.

The other important pieces of legislation before us today are equally as focused on protecting the sanctity of life. The 988 Lifeline Cybersecurity Act would ensure that the lifesaving 988 Suicide and Crisis Hotline is protected from cyber vulnerabilities.

This comes after the lifeline suffered a cyber attack in early December which resulted in an hours-long outage of the lifeline. This cannot happen again, and I look forward to moving this bill through committee.

Finally, we are examining legislation to permanently ban the use of quality-adjusted life years in all publicly funded healthcare programs like Medicare and Medicaid. It is long overdue for Congress to take the necessary step of banning QALYs. With the Protecting Health Care for All Patients Act before us today, this would be finally achieved.

Such policies arbitrarily put a value on someone's life and are especially discriminatory towards those living with disabilities. A life worth living is always a life worth saving, regardless of someone's health status. I know this bill is personal and very important to our chair of the full committee, Chair McMorris Rodgers.

I urge all of my colleagues on this subcommittee to support these four bills before us today.

Thank you, and I yield back.

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[The prepared statement of Mr. Guthrie follows:]

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Mr. Guthrie. The chair now recognizes the subcommittee ranking member, Ms. Eshoo, for 5 minutes for an opening statement.

Ms. Eshoo. Well, good morning, everyone.

And thank you, Mr. Chairman. And, first of all, my warmest congratulations to you on becoming the chairman of this, what I think is an extraordinary Health Subcommittee.

And welcome, to the new members of this subcommittee. You are going to love serving here. And I know, from this side of the aisle, that we look forward to working with you for the benefit of the American people.

Our first hearing today focuses on an issue this subcommittee has been struggling with for nearly 25 years, the opioid crisis.

Over 900,000 Americans have died from opioids since 1999, including more than 107,000 deaths in just the last year. The country has had three waves of opioid deaths: prescription opioids, heroin opioids, and now fentanyl.

Fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine. According to the CDC, over 66 percent of the overdose deaths in 2021 were caused by fentanyl.

Today, our subcommittee considers H.R. 467, the HALT Fentanyl Act, to address this epidemic.

What is unfortunate is that the HALT Fentanyl Act does nothing to change the status quo. For the past 5 years, all fentanyl-related substances have been considered Schedule I drugs. The HALT Fentanyl Act would continue that scheduling.

Scheduling doesn't stop deaths. Since 2018, when fentanyl-related substances first became Schedule I, fentanyl deaths have risen by over 50 percent. So we have to

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do much more to save lives.

First, I think we need to stop the supply of illicit fentanyl. We are making progress through record-breaking DEA seizures. For example, last year the DEA seized 10,000 pounds of illicit fentanyl powder -- 10,000 pounds. I mean, it is so difficult to get your head wrapped around these figures.

There is another part of this, though, and it isn't really very often spoken about. I believe that we have broken gun laws. In this case, Mexican cartels are trading -- they are trading illicit fentanyl for readily available American guns. We need to stop this so-called "iron river" of death between our two countries.

Another major contributing factor to overdoses is the difficulty finding treatment. According to SAMHSA, only 11 percent of people -- only 11 percent, so 89 percent of people with opioid addiction do not receive medication-assisted treatment.

Importantly, in December, Congressman Tonko's MAT Act became law. The new law eliminates bureaucratic guardrails that limit the availability of medication-assisted treatment. Medication-assisted treatment is proven to reduce overdose deaths and curb illicit drug use.

Naloxone is another miracle medicine that saves lives. Anyone can use it to rapidly reverse opioid overdose. And I commend the FDA's recent work to make naloxone available over the counter. And I urge all the makers of this drug, including Emergent and Kaleo, to begin switching their product labels from prescription to over-the-counter.

I look forward to hearing from ONDCP, SAMHSA, and the DEA today about what else Congress should do to change the status quo and save lives.

We will also hear two other bills unrelated to fentanyl. H.R. 498, the 988 Lifeline Cybersecurity Responsibility Act, is a commonsense bill that requires the 988 network

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administrator to report potential cybersecurity threats to SAMHSA immediately upon discovery. I support that bill.

H.R. 485 is focused on ending the Federal Government's use of quality-adjusted life years metrics, also known as QALYs. I support ending the use of discriminatory QALYs, because the metric devalues the lives of people with disabilities.

So I look forward to learning more about the bill and its impact, Mr. Chairman, during today's hearing.

So congratulations once again. It is your opening day. And, again, look forward to working with you.

And I yield back.

[The prepared statement of Ms. Eshoo follows:]

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Mr. Guthrie. Thank you very -- I thank the gentlelady for yielding back.

And the chair will now recognize the chair of the full committee, Mrs. McMorris Rodgers, for 5 minutes for an opening statement.

The Chair. Thank you, Mr. Chair.

Welcome, everyone, to the legislative hearing titled "Lives Worth Living: Addressing the Fentanyl Crisis, protecting Critical Lifelines, and Combating Discrimination Against Those with Disabilities." We will hear from a diverse panel on how we can advance solutions that will help people in need of hope and healing in our communities.

Last month, the Energy and Commerce Republicans held a roundtable on the fentanyl crisis, and we heard from Deb and Ray Cullen, who had lost their son, Zach. They told us they will never forget the moment that the police showed up at their door asking if they were Zach's parents. He was just 9 days past his 23rd birthday, and he was targeted and poisoned by a drug dealer.

Today, we will hear from Molly Cain from my hometown of Spokane, Washington. She lost her son, Carson, to fentanyl poisoning when he was also 23 years old.

Deb, Ray, and Molly have experienced immeasurable pain from losing their children, and they deserve justice. That is why Reps Griffith and Latta are working on the HALT Fentanyl Act. This bill would permanently place fentanyl-related substances into Schedule I of the Controlled Substances Act and make sure that our law enforcement can keep these weapons-grade poisons off the streets.

Unfortunately, the administration is proposing to treat these deadly poisons differently from fentanyl and other currently scheduled fentanyl-related substances. The administration supports exempting the entire class from mandatory minimums that are typically imposed upon drug dealers, drug traffickers, preventing law enforcement

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from stopping those who would bring deadly substances into our communities.

If the temporary legislation were to expire, it would mean the criminals who kill people like Zach and Carson could keep trafficking these lethal substances with little consequences. So let's make it permanent.

And I am hopeful that we can work together, both sides of the aisle, to make sure that we take action that will punish those who make and import and distribute these poisons to our children.

I also want to recognize Mrs. Harshbarger's bill in introducing the Block, Report, and Suspend Suspicious Shipments Act.

The opioid epidemic is fueled in part by suspiciously large shipments of pain medication being delivered across the country, especially in places like Tennessee and West Virginia. This bill would stop this practice and save lives by requiring drug manufacturers and distributors that discover a suspicious order for controlled substances to halt the order and report the information to DEA.

Additionally, just last month, we learned about a cyber attack on the 988 Suicide and Crisis Lifeline. This lifeline is a network of local crisis centers that promotes emotional support to people in suicidal crisis or emotional distress. It is a critical tool that was established by the bipartisan work of this committee, and we must ensure that it is protected from future cyber threats.

Representative Obernolte's 988 Lifeline Cybersecurity Responsibility Act would do just that. It requires coordination and reporting to improve cybersecurity protections for the 988 Lifeline.

Finally, we will discuss why it is important to take action to protect people with disabilities with the Protecting Health Care for All Patients Act. It would ban quality-adjusted life years, or QALYs, that discriminate against people with disabilities and

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patients with debilitating or life-threatening health conditions.

QALYs undervalue treatments for patients who have shorter lifespans than others. In countries with QALYs, the most vulnerable get pushed to the back of the line for treatment. People like those with cystic fibrosis, ALS, or people like my son with Down syndrome, the government says that their lives don't matter as much; they are not valuable enough.

In America, where we have led the world in amazing medical breakthroughs and innovation, we must ban QALYs and strongly affirm that every life is worth living. It is my sincere hope that we can move forward on this bill with bipartisan support.

Families need hope. And there is inherent dignity in every human life. And that is why we are coming together today in our first legislative hearing this Congress, and I look forward to hearing more.

I appreciate everyone being here to testify as we work together to promote life, liberty, and the pursuit of happiness for all.

Thank you, and I yield back.

[The prepared statement of the chair follows:]

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Mr. Guthrie. I thank the chair for yielding back.

The chair recognizes the ranking member of the full committee, Mr. Pallone, for 5 minutes.

Mr. Pallone. Thank you, Chairman Guthrie.

And I believe the top priority of this subcommittee is ensuring all Americans have access to quality and affordable health coverage so they can live long and healthy lives.

And I am also proud of this subcommittee's work in the last Congress, which is a testament to the life-changing and lifesaving policies we can achieve if we work together.

Last Congress, we passed landmark laws that make healthcare and prescription drugs more affordable; we expanded access to healthcare, including to children and mothers, through CHIP and Medicaid; we equipped the Food and Drug Administration and the Centers for Disease Control and Prevention with critical tools and resources to maintain and enhance our Nation's public health; and we made significant investments to address the mental health and substance use disorder crisis, including implementing historic policy reforms to address the overdose crisis. Specifically, we included the MAT Act, which will increase access to lifesaving treatments for those experiencing substance use disorders.

We accomplished a tremendous amount, and I commend every member of the subcommittee for their dedication and hard work.

Now, today, we will discuss the scourge that is illicit fentanyl and fentanyl-related substances, which have caused so much harm and death to our families, friends, and constituents.

The policies passed in the fiscal year 2023 omnibus in December, some of which I just mentioned, are concrete examples of the work we are doing to save lives.

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I am disappointed that our first hearing in the Health Subcommittee does not build on the successes of last Congress but, rather, that my Republican colleagues have chosen to take a different route with the partisan HALT Fentanyl Act.

We have learned time and time again that we cannot incarcerate our way out of a public health crisis and that a broader public health approach is needed to address what is at its root a health problem.

Moreover, my Republican colleagues were unwilling to consider any Democratic bills to address the overdose crisis for inclusion in this hearing, and that is disappointing. If Republicans are serious about finding a long-term solution, then they should be willing to discuss bipartisan, evidence-based policies to address the substance use and overdose crisis.

One such bill is the bipartisan Save Americans from the Fentanyl Emergency Act, which was introduced by Representatives Pappas, Newhouse, and Gonzales. This legislation reflects the administration's comprehensive approach to address the fentanyl crisis. Our Nation's law enforcement and public health agencies both agreed to this approach.

I am disappointed that this bill was not included in the hearing, as well as many other bipartisan bills that would help us address the overdose crisis. Representative Tonko's bipartisan Reentry Act would ensure that individuals transitioning out of the justice system and into our communities have access to treatment for substance use disorders.

We are also considering a bill today to ban the use of quality-adjusted life years, often referred to as QALYs, in value measurements and price determinations set by Federal agencies and States.

While I appreciate and respect the perspective of those in the disability

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community about any economic metrics that value certain lives differently, I fear this bill is a solution in search of a problem. Federal law already prohibits the use of QALYs in Medicare, and Medicaid is required to cover, with limited exceptions, every outpatient drug covered by the program if a manufacturer has a rebate agreement in place.

As I mentioned earlier, Democrats delivered on our promise to lower drug prices last year with the enactment of the Inflation Reduction Act. That new landmark law provides the Secretary of Health and Human Services with the authority to negotiate lower drug prices for Medicare beneficiaries for the first time, while also explicitly prohibiting the use of QALYs in this process.

I fear this bill would be a Trojan horse that goes far beyond just banning QALYs by potentially banning all other kinds of ways of measuring a drug's value. This would result in artificially keeping drug prices and healthcare costs high, while also tying the hands of the Federal Government in determining the value of healthcare services and treatments.

So, again, if my Republican colleagues want to discuss how to best protect the disability community, we should consider the impacts of proposed cuts that the Republican majority wants to make in exchange for a debt ceiling increase.

The Republican Study Committee's budget for fiscal year 2023 calls for cutting Medicaid and CHIP by $3.6 trillion and cutting Medicare by $2.8 trillion. These drastic cuts will be devastating for the millions of people with disabilities who rely on Medicaid for their health and well-being.

The Republican plan to slash and burn Medicaid is an existential threat to a major source of health insurance for individuals with disabilities, and Democrats will aggressively oppose these cuts.

As for today's hearing, I welcome the discussion on how we move forward to

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address the fentanyl crisis, and I hope that in the coming weeks the subcommittee can discuss bipartisan solutions that were unfortunately not included in this hearing today.

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

[The prepared statement of Mr. Pallone follows:]

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Mr. Guthrie. The gentleman yields back. And I do look forward to working together as we move forward on reauthorizing the SUPPORT Act this year.

We now conclude with member opening statements. The chair would like to remind members that, pursuant to the committee rules, all members' opening statements will be made part of the record.

[The prepared statements follow:]

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Mr. Guthrie. We will now move to our witnesses. We want to thank all of our witnesses for being here today and taking the time to testify before the subcommittee.

Each witness will have the opportunity to give an opening statement, followed by a round of questions from members.

Our witnesses today are: Mr. Kemp Chester, a senior advisor at the Office of National Drug Control Policy with expertise in international relations and supply reduction. Then we will have Dr. Neeraj Gandotra, the Chief Medical Officer for the Substance Abuse and Mental Health Services Administration. And, finally, we will be joined Mr. Jon DeLena, the Associate Administrator at the Drug Enforcement Administration.

We appreciate you being here today. We will recognize each for 5 minutes. I think you have all testified before and know the lighting system. You will have a yellow light just to give you a warning, and then a red light means to wrap up.

So we appreciate that, and we appreciate you being here.

I will now recognize our first witness to give 5 minutes for an opening statement. Mr. Chester, you are recognized for 5 minutes.

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STATEMENTS OF KEMP CHESTER, SENIOR ADVISOR, INTERNATIONAL RELATIONS AND SUPPLY REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY (ONDCP); NEERAJ GANDOTRA, CHIEF MEDICAL OFFICER, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA); AND JON C. DELENA, ASSOCIATE ADMINISTRATOR, BUSINESS OPERATIONS, DRUG ENFORCEMENT ADMINISTRATION (DEA)

STATEMENT OF KEMP CHESTER

Mr. Chester. Chairman Guthrie, Ranking Member Eshoo, members of the subcommittee, thank you for inviting me to testify today on the illicit drug environment we face in the United States and our efforts to address it.

The administration is taking a number of tangible steps to reduce drug-related deaths, expand access to treatment for substance use disorder, and target the global production and trafficking of synthetic opioids like illicit fentanyl, which currently kill more than 107,000 Americans every year.

The administration's National Drug Control Strategy focuses on attacking the two drivers of the opioid epidemic: untreated addiction and the drug-trafficking profits that fuel this crisis.

In terms of public health, we are expanding access to substance use prevention, harm reduction in addiction treatment, and recovery support services.

And I want to thank the Congress for including key provisions of the MAT Act in the bipartisan omnibus government funding bill, which will allow prescribers across the country to treat their patients who have opioid use disorder with buprenorphine without

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additional Federal licensing.

We are also working to remove barriers to naloxone, make permanent the COVID-19 flexibilities that expanded access to treatment, address emerging threats like xylazine being added into illicit fentanyl. And we look forward to working with the Congress to make permanent the 2-year extension of the scheduling of all fentanyl-related substances as a class.

But while the opioid epidemic is a daunting public health issue, it presents a serious national security and economic prosperity challenge for the United States as well. The vast majority of the substances harming Americans are produced outside the United States and brought across our borders through a variety of means.

To address this very real threat, we have taken a new and more comprehensive approach to this problem: to commercially disrupt the global business of illicit synthetic drug production and trafficking.

We will target not only the finished drugs themselves and those who sell them but also the raw materials and machinery used to produce them, the commercial shipping that moves these items around the world, and the illicit financial structure that allows this global business to operate and allows drug traffickers to profit from the suffering of others.

Using new authorities provided by executive order, the Department of the Treasury has imposed sanctions against dozens of individuals and entities involved in the illicit drug trade, including illicitly manufactured fentanyl.

In 2022 alone, Customs and Border Protection seized nearly 262,000 pounds of illicit narcotics, including 15,000 pounds of fentanyl. And our HIDTA task forces seized more than 737,000 pounds of drugs, including 26,000 pounds of illicit fentanyl in the United States.

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These are drugs permanently removed from the illicit supply chain, not killing our citizens. And domestic seizures alone denied $9 billion in profits and critical operating capital to drug traffickers.

And the President has asked for increased funding for both Customs and Border Protection and the Drug Enforcement Administration to enable their vital work in keeping our Nation safe from these dangerous drugs.

However, this problem does not begin or end at the United States border. This is a global problem that has negative effects not only in the United States but also the rest of the world. And American leadership at the global level is absolutely essential.

These deadly drugs are manufactured using precursor chemicals made available by criminal elements, often in the People's Republic of China, that are shipped to Mexico, where they are used to produce illicit fentanyl or one of its analogs and often pressed into the counterfeit pills that have poisoned so many Americans.

The administration is working bilaterally with our international partners, particularly Mexico, the People's Republic of China, India, and others, and multilaterally to address the global threat of illicit synthetic opioid production and trafficking.

I am pleased to say that, as a result of our work in the public health and law enforcement domains, we are beginning to see some progress, with 5 straight months of decreased drug-involved deaths.

Together, the administration and the Congress are changing the trajectory of a complex national security, criminal justice, and public health challenge that has vexed the Nation for the better part of three decades. There are signs of hope, but we have a very long way to go.

On behalf of Dr. Gupta and the men and women of the Office of National Drug Control Policy, thank you for your foresight and leadership on this difficult issue, and we

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look forward to continuing our work with you in the months and the years ahead.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Chester follows:]

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Mr. Guthrie. Thank you.

The gentleman yields back.

And I will now recognize Dr. Gandotra for 5 minutes for your opening statement.

STATEMENT OF NEERAJ GANDOTRA

Dr. Gandotra. Good morning. Thank you, Chair Guthrie, Ranking Member Eshoo, Chair McMorris Rodgers, Ranking Member Pallone, and members of the subcommittee, for inviting me to testify at this hearing covering fentanyl and the 988 Suicide and Crisis Lifeline, among other topics.

My name is Dr. Neeraj Gandotra, and I am Chief Medical Officer for the Substance Abuse and Mental Health Services Administration, also known as SAMHSA. SAMHSA leads public health efforts to improve behavioral health of our Nation.

I am pleased to be here along with my colleagues from the White House Office of National Drug Control Policy and the Drug Enforcement Administration.

I look forward to discussing our work at SAMHSA, which aims to support all aspects of the care continuum, from prevention and harm reduction to treatment, crisis care, and sustained recovery services.

Ultimately, SAMHSA envisions people with, affected by, or at risk for mental health and substance use conditions receive care, thrive, and achieve well-being.

Over the past few years, we have seen the opioid overdose epidemic evolve. We are now faced with the reality that fentanyl and substances laced with fentanyl are far more deadly than other opioids or stimulants alone.

That is why addressing addiction and the overdose epidemic are one of the four

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pillars of the Unity Agenda that the President outlined in last year's State of the Union Address.

Additionally, at the beginning of the Biden-Harris administration, Secretary Becerra released the comprehensive HHS Overdose Prevention Strategy, which is designed to increase both access to primary substance use prevention activities and access to the full range of services for individuals at risk for overdose as well as services for their families. This strategy prioritizes four key areas: primary prevention, harm reduction, evidence-based treatment, and recovery support.

SAMHSA's substance abuse prevention programs target at-risk populations and specific age groups to stop substance use before it starts. We work with State and local partners to reach people where they are and to reduce the impacts of substance misuse. For example, SAMHSA's First Responders-CARA program trains first responders on how to respond to overdose-related incidents and provides training on naloxone administration.

SAMHSA also provides funding and support for evidence-based harm-reduction services. Our harm-reduction grants support activities such as expanded distribution of overdose-reversal medications and fentanyl test strips. It also provides overdose education and counseling and works to stop the spread of infectious diseases.

Fentanyl test strips are an important component of harm-reduction programs, education-and-awareness-building toolkits, and low-threshold, on-demand treatment programs. All of these are efforts that help save lives.

Because of Congress's commitment to treatment programs and thanks to December's omnibus, SAMHSA is actively working with Federal partners to implement the removal of the DATA 2000 waiver and related policies so that more Americans can access this lifesaving medication.

In addition to preventing and treating substance use, we also ensure that patients

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in mental health and substance use crisis are quickly directed to the appropriate level of care. This work includes helping States and localities coordinate crisis services through the 988 Suicide and Crisis Lifeline. The lifeline helps connect individuals with trained counselors and, if needed, crisis intervention and stabilization services. It may also include warm handoffs to treatment providers.

Thanks to the support from Congress, the lifeline is serving more Americans in crisis. For example, when comparing December 2021 with December 2022, the 988 Lifeline answered 434,000 contacts, which is 172,000 more calls, chats, and texts versus 2021, and it has also significantly improved how quickly these contacts were answered. Additionally, when comparing December 2022 to December 2021, calls, chats, and texts answered all increased -- 48 percent, 263 percent, and 1,443 percent respectively.

In closing, on behalf of my colleagues at SAMHSA, thank you for supporting our programs and for working to improve our Nation's behavioral health. I would be pleased to answer any questions that you might have.

[The prepared statement of Dr. Gandotra follows:]

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Mr. Guthrie. I appreciate your testimony.

The gentleman yields back.

And I will recognize Mr. DeLena for 5 minutes for an opening statement.

STATEMENT OF JON DELENA

Mr. DeLena. Good morning, Subcommittee Chairman Guthrie, Ranking Member Eshoo, Committee Chair McMorris Rodgers, Ranking Member Pallone, and distinguished members of this subcommittee.

On behalf of the Department of Justice and, in particular, the approximately 10,000 employees of the Drug Enforcement Administration, it is my honor to appear before you today. I thank the committee for bringing attention to this important topic.

Today's hearing comes at a critical moment in our country's history. Our Nation is in the midst of a devastating drug poisoning epidemic that claimed the lives of over 107,000 people this past year. An estimated 294 people die every day from drug poisoning, and countless more overdose and survive.

I have had the privilege of being a DEA special agent for nearly 27 years. I have worked in Colorado, Florida, Virginia, and my home region, New England. The current drug poisoning epidemic is like nothing I have ever experienced in my career.

In 2022, DEA seized more than 50 million fake pills and 10,000 pounds of fentanyl powder. That is approximately 379 million deadly doses of fentanyl taken off of American streets. That is enough fentanyl to supply a potentially lethal dose to every member of the U.S. population.

As a country, we must do everything we can to stop this national crisis. For our

part, the men and women of the DEA are relentlessly focused, day in and day out, on combating the deadly drug poisoning epidemic and on saving lives.

DEA leads and coordinates the whole-of-government response to defeat the two Mexican drug cartels, the Sinaloa Cartel and the Jalisco Cartel, that are responsible for driving the drug poisoning epidemic in all of our communities.

A unified response, with DEA in the lead, ensures that the whole of government is moving in one direction. Through this unified response, we can protect the safety and health of Americans.

The Sinaloa and Jalisco Cartels pose the greatest criminal drug threat the United States has ever faced. These ruthless, violent criminal organizations have associates, facilitators, and brokers in all 50 States as well as in more than 40 countries around the world.

The Sinaloa and Jalisco Cartels control the supply chain for illicit fentanyl. They obtain precursors from China and use these precursor chemicals to manufacture fentanyl and other synthetic drugs in clandestine laboratories in Mexico. The cartels take that fentanyl and press it into fake prescription pills and other drugs. The cartels then transport fentanyl in pill and powder form, as well as other drugs like methamphetamine, heroin, and cocaine, into the United States.

I have seen firsthand what the Mexican cartels have done to our great country. The cartels are destroying families and communities with callous indifference and greed.

The DEA is working across its global operations to defeat these two cartels and protect our communities. I would like to briefly highlight three initiatives in particular.

First are the counter-threat teams. DEA launched two cross-agency counter-threat teams that focus exclusively on defeating the Sinaloa Cartel and Jalisco Cartel. The teams use a network-focused approach. They are mapping, analyzing, and

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targeting the cartels' entire operations. The teams will use all of the resources at their disposal to defeat these two cartels.

The second initiative is Operation Overdrive, which targets drug-trafficking organizations and gangs that are responsible for the greatest number of deaths and violence. Operation Overdrive is a data-driven approach that is currently in 57 locations across the country, and we will expand.

The final initiative I would like to highlight are DEA's family summits. In June and November of 2022, DEA brought together families from across the country who have lost loved ones to drug poisoning. The summits were incredibly impactful. They were an opportunity for DEA to explain what we are doing to combat the drug poisoning epidemic, but, more importantly, it was an opportunity for families to share their stories with one another and with us.

Throughout my career, I have partnered with families, local groups, prevention specialists, and community outreach organizations for events big and small, and I appreciate the great work that they do and feel very strongly that the connections we have made with these people and these families will help educate, spread awareness, and save lives.

Congress, of course, has an important role to play. I personally want to thank and extend my sincere thanks to the Members of Congress who have worked so hard to ensure the temporary class-wide scheduling of fentanyl-related substances does not expire. Class-wide scheduling is critical to DEA's ability to seize FRS when they are encountered and to investigate and prosecute those that manufacture and traffic in these deadly drugs. I urge Congress to make the temporary scheduling permanent. This is critical to the safety and health of Americans.

Thank you for the opportunity to testify before your subcommittee on this

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important issue, and I look forward to your questions.

[The prepared statement of Mr. DeLena follows:]

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Mr. Guthrie. Thank you.

The gentleman yields back.

I thank the witnesses for their testimony.

And we will begin -- we will now move into the Q&A portion of the hearing. I will begin the questioning and recognize myself for 5 minutes.

So, Mr. Chester, first, we had Dr. Gupta in Bowling Green, Kentucky, my hometown, with Leader McConnell. And a lot of my law enforcement guys were real concerned. And it goes back to a comment that you made in a hearing in December 2021. And you were defending the context of -- what they were upset about is that -- and a lot of us are concerned about -- is the administration's position to schedule fentanyl-related substances as a Schedule I but exempt it from the mandatory minimums.

And in defending that policy before, you made this statement, and I will quote it to you. It says: The administration, quote, has gathered up an entire class of substances uncreated that, within the class of substance, there may be substances that either have medical merit or are not the least bit harmful. They are not any more harmful than water, unquote. That was a direct quote.

I just can't imagine anywhere that a cartel would smuggle fentanyl analogs into our country that is not as harmful as water. Would you clarify that statement?

Mr. Chester. Thank you for your question, Congressman. Yes. And I remember that. I remember that very clearly --

Mr. Guthrie. I do, too.

Mr. Chester. -- when we were talking about two sides of the same coin, with gathering up an entire class of substances that have not been subjected to testing. And so it is chemically possible that there are alterations to the fentanyl molecule that have

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no effect on the body.

The question is, we don't know that. And so, not until they are subjected to the three- and the eight-factor analysis that the FDA does that the effect on the body of these substances can be determined.

Traffickers often create new substances based upon their chemical structure and then move them in and then ask for customer feedback afterwards. And this is something that we see quite often. They experiment with substances by sending them out and then hear what the users provide in terms of feedback.

So there is a possibility that a trafficker creates a substance based upon the fentanyl molecule, maybe a deletion of the fentanyl molecule, sends it out, and it winds up having no effect on the body at all.

Mr. Guthrie. That just seems -- maybe that -- I just can't imagine a cartel -- maybe they do send some of this.

But, anyway, you have illegal cartels smuggling drugs into our country. Say, they have no effect, somebody takes them and complains, "I took this pill; it has no effect." That is still an illegal cartel moving drugs into this country.

The other one you said may have medical merit. You know, fentanyl in itself has medical merit, except it is illegal and is subject to mandatory minimums if you illegally traffic fentanyl.

So I just -- it is concerning the administration has that position and -- it is concerning to me.

So, Mr. DeLena, you are in the DEA. Do you believe that we should permanently -- you said in your testimony that permanently scheduling illicit fentanyl analogs has an effect and you have the ability to -- it gives you more authority. Would you care to just talk about how important it is for your administration to have this bill in

place?

Mr. DeLena. Thank you for the question, Congressman.

It is the top legislative priority for DEA to permanently schedule fentanyl as a class-wide substance. We have never seen a deadlier drug, and we have seen the impact throughout the entire United States.

Mr. Guthrie. Have you ever seen a cartel smuggle a harmless drug into the country?

Mr. DeLena. I can't speak to every single thing that has ever been smuggled, but what I can tell you --

Mr. Guthrie. But have you ever seen a harmless drug smuggled into the country?

Mr. DeLena. -- the two cartels that we are laser-focused on, the Sinaloa Cartel and the Jalisco Cartel, are producing fentanyl and methamphetamine at epic rates. And it is fentanyl and methamphetamine that is ending up in our communities and causing the devastation and harm that we have seen play out. 107,735 Americans died between August 2021 and August 2022. It has to stop.

Mr. Guthrie. You do see drugs that have medical merit, that are prescription drugs that have been diverted, that are smuggled into our country. That should be a crime and subject to the same as well.

I mean, the administration says, it could have medical merit; we need to test it first. But if a cartel is smuggling even prescription drugs that have been diverted, it still should be punished and subject to mandatory minimums. Do you agree?

Mr. DeLena. Thank you for the question, Congressman.

DEA is a law enforcement agency. We conduct investigations, and we bring these cases forward to prosecutors. It is the prosecutors and the judges who ultimately

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make those decisions.

Mr. Guthrie. So, if we permanently schedule fentanyl analogs subject to Schedule I and some do come in that have medical merit, they will be treated just like any other drug that has medical merit? And if for some reason a cartel decides to send some that are harmless, you still want to have the ability to disrupt those cartels, correct?

Mr. DeLena. Thank you for the question, Congressman.

We are laser-focused on disrupting and defeating the two cartels, Sinaloa and Jalisco, that are causing the damage and destruction throughout all of our communities.

Mr. Guthrie. Thank you.

My time has expired, and I recognize Ms. Eshoo from California for 5 minutes to ask questions.

Ms. Eshoo. Thank you, Mr. Chairman.

And thank you to the witnesses for your testimony.

First, I want to go to Mr. DeLena.

Thank you for being here. A lot of passion in your voice and in your testimony. A career that spans decades.

I think you have answered my first question: Do Mexican cartels fuel the supply of illicit fentanyl in the United States? That is a definite "yes."

So just "yes" or "no" to the following: Do the Mexican cartels benefit from the availability of American guns?

Mr. DeLena. Thank you for the question, Congresswoman.

As I stated, the two cartels, Sinaloa and Jalisco Cartel, are driven by greed. They are producing methamphetamine and fentanyl at catastrophic rates and bringing those drugs into all of our communities --

Ms. Eshoo. So it is "yes"?

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Mr. DeLena. They are fueled by any type of greed, and they are paid and repatriated in any way possible.

Ms. Eshoo. Do they benefit from the guns, though, the trafficking of them?

Mr. DeLena. Thank you for the question.

These are ruthless, violent criminal organizations --

Ms. Eshoo. But is it "yes" --

Mr. DeLena. -- that are involved in --

Ms. Eshoo. We know they are ruthless. I mean, my God. But is it "yes" or "no"?

Mr. DeLena. They use violence, guns of all --

Ms. Eshoo. So it is "yes"?

Mr. DeLena. Yes.

Ms. Eshoo. Okay.

If the cartels had less access to American guns, would that diminish their strength and their firepower?

Mr. DeLena. Anything that we provide them --

Ms. Eshoo. I think it is obvious, but I want to hear what you think.

Mr. DeLena. -- less access to -- exactly. Thank you.

Ms. Eshoo. Uh-huh.

If the cartels were weakened, would that reduce the amount of illicit fentanyl coming into the United States from Mexico?

Mr. DeLena. Our focus is to defeat them, not just weaken them, but --

Ms. Eshoo. But is it "yes" --

Mr. DeLena. -- defeat those two cartels.

Ms. Eshoo. -- or "no"?

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Mr. DeLena. Yes. Yes.

Ms. Eshoo. Okay.

To Dr. Gandotra, as I said in my opening statement, only 11 percent of people who need substance use treatment receive it. So that is a very small number of people in our country.

Hopefully the number is going to grow soon, given the MAT Act that we passed that was signed into law. It is going to allow more doctors to prescribe medication-assisted treatment.

As quickly as you can, what are both SAMHSA and ONDCP doing to educate the providers about the MAT Act so that we can expand the access to medication-assisted treatment?

And if you can give us a specific, so that we have a clearer handle on what you are doing.

Dr. Gandotra. Thank you for the question.

Certainly SAMHSA, HHS, and our Federal partners at ONDCP and DEA are working together quickly to provide providers with education and direction.

Ms. Eshoo. Yeah, but what are you doing? Give us an example. When you say we are working to provide, what does that mean?

Dr. Gandotra. Well, we are having regular meetings to coordinate frequently asked questions. There has been a letter that has been sent out to DEA registrants. Certainly we are working with the professional societies to perform a framework of educational priorities and competencies for providers.

We have been reaching out to all of our stakeholders -- States, the State opioid treatment authorities, as well as providers themselves -- so that they can have the education. There are updates on our web pages, both for ourselves as well as for our

colleagues at the DEA.

Mr. Chester. Ma'am, I think my colleague from SAMHSA has summed it up well in terms of implementation, but let me just add that it is critically important that the elimination of the X waiver created the opportunity for physicians to be able to do this. Through greater education through SAMHSA and others, they are creating the willingness of physicians to be able to prescribe this very necessary drug as well. And SAMHSA is doing great work in that regard.

Ms. Eshoo. I think it is important to note here, as we talk about the need for medication-assisted treatment, how few in our country receive it today; what our goal is, certainly, with the new law; that Medicare currently covers an estimated 1.7 million beneficiaries with substance use disorder. That is Medicare, which may be surprising to some people. You think of older people; there is addiction there that -- it is a disappointment and a surprise. And Medicaid -- Medicaid covers about 6 million people with substance use disorder.

So I would say to my Republican friends that, as there is a nexus between debt ceiling and cutting Medicare, watch it. Because these are people that need, absolutely have to have this coverage.

With that, I yield back, Mr. Chairman.

Mr. Guthrie. The gentlelady yields back.

Mr. Burgess from Texas is recognized for 5 minutes for questions.

Mr. Burgess. Thank you, Mr. Chairman.

I wasn't going to bring this up, but the ranking member and the ranking member of the full committee have provoked me on this.

Look, cuts to Medicare over the past 2 years have been staggering. And you talk to any practicing physician out in the country and ask them, "Have you felt the effect of

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Medicare cuts in the last 2 years?" and the answer will be, "Absolutely, yes."

Now, the American Rescue Plan -- actually, one of the pay-fors of the American Rescue Plan was a sequester on Medicare. Yes, Congress has put a stay on that sequester, but that looms out there as a budget item in the future. The Inflation Reduction Act -- $300 billion of Medicare cuts to pay for money to go to insurance companies.

So, please, let's be careful about our language here, because it does matter.

But we have a very important issue at hand.

And, Mr. DeLena, thank you so much. Your testimony was very powerful. Your written testimony is some of the most disturbing that I have read since I have been on this committee, and that goes back to 2005.

I am grateful that you are working with the State Department. You referenced the State Department's International Narcotics Control Strategy Report. So I am encouraged by that.

What is concerning to me is the next paragraph. You say, "DEA has been willing to engage the People's Republic on fentanyl-related substances and precursors. However, due to diplomatic tensions between the United States, the People's Republic of China, the government" -- I assume that is the PRC Government -- "has suspended all counter-narcotics cooperation with the United States."

Is that an accurate statement?

Mr. DeLena. Congressman, thank you for your question.

DEA is working in China to stop the illicit flow of those precursor chemicals that are ending up in the hands of the two cartels, the Sinaloa Cartel and the Jalisco Cartel. We know that, every day, chemicals, precursor chemicals, are leaving China. China doesn't have a know-your-customer rule, or there is no oversight of any of that stuff that

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is ending up in Mexico.

And we also know that in China and throughout China there has been a dramatic increase in money-laundering activities as another way to get back involved with those two cartels, essentially undercutting all the other traditional forms of money laundering that had occurred up until now.

But the relationship right now, we know that China needs to do more to get more engaged.

Mr. Burgess. Yeah. There is the understatement of the year: "China needs to do more."

I mean, these are chemical weapons that are being dispatched into our country to kill our young people at a rate greater than 100,000 a year. Is that a fair statement that I have just made?

Mr. DeLena. Thank you for the question.

The chemicals, the precursor chemicals, that are essentially leaving China are ending up in Mexico, where those two cartels are mixing them in these clandestine laboratories into the synthetic drugs. And it has become a limitless supply now that we have, you know, switched to synthetics versus plant-based drugs.

Mr. Burgess. So a terrorist organization producing weapons of mass destruction that are coming into our country, it seems like we would do everything within our power to disrupt them financially under tools that are already in existence probably dating back to the PATRIOT Act after 2001.

So are we disrupting the financial instruments that are available to chemical precursors in China and the cartels in Mexico?

Mr. DeLena. Thank you for the question.

As a law enforcement agency, DEA has taken a network approach to try to fully

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map and analyze and identify where these cartels are operating. They are operating throughout the entire United States, obviously, and throughout Mexico but also in 40 countries around the world.

It is our goal to absolutely infiltrate and defeat those cartels as they exist.

Mr. Burgess. Well, let me give you a mission statement, then: Follow the money. Because I think, in this case, it is extremely important. And, further, disrupt the ability to continue to fund this operation.

I mean, it is great we are doing harm reduction. And I would go back to Nancy Reagan's "Just say no." I think that was the greatest harm reduction that was made available to the country, back in the 1980s. But if we do not disrupt the financial instruments that allow this warfare to continue, we can't win. You can't -- you can't harm-reduction your way out of this problem.

And let me just ask you this as one last thing. We hear over and over again, "Well, it is not -- you know, people coming over the border is really not the problem. It is points of entry." But it is the removal of Customs and Border Protection and even some of your agents, having to handle these vast numbers of people that are coming across the border illegally, and deflecting them from other activities that might be used to interdict fentanyl and even agricultural products that shouldn't be coming into this country. Is that something that concerns you?

Mr. DeLena. Thank you, Congressman.

I think, specific to your question, it is probably best served for the Department of Homeland Security and their components who actually control the border and those points of entry.

Mr. Burgess. They don't control the border is precisely the point.

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

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Mr. Guthrie. Thank you.

The gentleman yields back.

We are going to try to stick to 5 minutes. We have two panels today. So I know we had a couple run over. I want to try to get on to sticking to the 5 minutes.

So next up is Mr. Sarbanes from Maryland. You are recognized for 5 minutes.

Mr. Sarbanes. Thanks very much, Mr. Chairman. And congratulations on taking up the leadership of this subcommittee.

I want to thank all of you for your testimony today. You have responsibility for a broad set of initiatives. And, in particular, I want to thank your agencies for their work to combat the mental health and behavioral health crises that we see. We know that there is an intersection of those crises with the addiction crisis across this country, so that is a very important part of our response.

Last Congress, I was proud to work with colleagues on our committee to enact legislation that provided increased funding for mental health programs and reauthorize several key mental health and substance use disorder programs, including legislation I helped sponsor to bolster two programs that provide care for children and adolescents.

Both of these programs -- the first one, the Comprehensive Community Mental Health Services for Children With Serious Emotional Disturbances Program -- and let me break that down, because that is a mouthful. Comprehensive Community Mental Health Services -- so the idea that we have to take a holistic approach to this and make sure that it is a full community response -- with children who have serious emotional disturbances, so that is the particular audience that it is being addressed to. The other program, the Youth and Family TREE Program. These are administered by SAMHSA, which has been working closely with the Biden administration to implement evidence-based policies and programs that save lives.

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Dr. Gandotra, in your testimony, you note that many of the recent actions taken by Congress and the Biden administration have had a measurable impact on mental and behavioral health outcomes.

For example -- and this is pretty remarkable -- you note that the recent expansions in care through Certified Community Behavioral Health Clinics, which is an important part of the infrastructure in this area, have achieved a 74-percent reduction in hospitalizations and a 69-percent reduction in emergency department visits, not to mention a 31-percent increase in individuals' mental health functioning in everyday life.

So there has definitely been a very positive response to these programs. It is remarkable progress. We have to keep building on the success.

I do want to say that, in Maryland, we are working very hard to combat an acute crisis we face in pediatric mental health access, which has left far too many families struggling to find mental health care for their children, many of whom have been forced to remain in emergency departments or were turned away from care when they need it most.

Governor Moore, recently inaugurated in Maryland, has deemed addressing health issues as a core priority of his administration and proposed an investment of almost $1.5 billion in mental health care services in Maryland this year.

Dr. Gandotra, can you further explain how the recent investments in mental health through the Bipartisan Safer Communities Act and the bipartisan mental health package that I referred to are making a real difference in communities and why it is so important that we continue to invest in these programs?

Dr. Gandotra. Thank you, Congressman, for your question.

And, certainly, investing in children's mental health pays dividends for the community, for services throughout not just Maryland but throughout the country. We

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have seen investments really pay dividends with regard to improved functioning in school, decreased criminal justice involvement, decreased hospitalizations, decreased emergency department use.

As far as resources, SAMHSA's resources really do leverage a number of educational activities in terms of providing schools, counselors, teachers, as well as community organizations with the tools they need to help identify mental illness, prevent conditions before they worsen, and provide them with resources to link patients to treatment.

Also, we like to enhance the services we already have, by providing culturally competent workforce educational products, as well as an ensuring individuals who are identified early are not only linked to the right treatment but the appropriate level of care. That is also done with crisis management services as well.

Mr. Sarbanes. Thanks very much.

I am out of time. I was going to ask you about telehealth also being a means of expanding access. I know that is very important. We want to continue to explore the opportunities there.

With that, Mr. Chairman, I yield back. Thank you.

Mr. Guthrie. I thank the gentleman for yielding back.

The chair now recognizes Chair McMorris Rodgers for 5 minutes.

The Chair. Thank you, Mr. Chairman.

In 2019, China permanently scheduled all fentanyl-related substances. They were the first country in the world to do so. So far, the United States has stopped short of doing the same. A permanent American solution, like passing the HALT Fentanyl Act, is necessary.

Mr. Chester, can you discuss our working relationship with China to prevent the

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entry and sale of fentanyl and its analogs?

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RPTR MOLNAR

EDTR ROSEN

[11:01 a.m.]

Mr. Chester. Thank you for the question, Congresswoman. Our relationship with the PRC doesn't move in a straight line, but as you point out, we have, in the past, had success in dealing with the PRC, specifically the class scheduling of fentanyl that we asked them to do that they announced in 2019, and a couple of things happened when that occurred.

The first one was, shipments of finished fentanyl directly from the PRC to the United States, principally through mail and express consignment, dropped to almost zero where they remain today.

Traffickers moved from the business of finished fentanyl to the precursor chemicals that they supply to manufacturers within Mexico, and Mexico became the locus of illicit fentanyl production.

We have worked with the PRC on a number of issues in terms of accountability and the prevention of the diversion of illicit chemicals, pill presses, better oversight over the shipping companies.

And while it is true that within an environment of competition, there are some areas of cooperation and that the PRC stepped back last summer from many of them, we continue to have contact with the government of the PRC, and we continue to call upon them to partner with the United States on a global level because they share a large portion of the task in dealing with this issue.

The Chair. Would you speak to how they are enforcing this ban on fentanyl and fentanyl-related substances in China, and what mechanisms do we have to hold China accountable to its commitment to ban the export of fentanyl in its analogs?

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Mr. Chester. Within the PRC, their Ministry of Public Security and their law enforcement organizations take the issue of fentanyl trafficking very, very seriously, and in fact, when they announced in May 2019 that they were scheduling all fentanyl-related substances as a class, that September they invited members of our embassy over to witness the sentencing of 10 fentanyl traffickers.

And this was remarkable because not just a year before the government of the PRC had told me that no fentanyl was coming from the PRC. So what that tells us is, they take it very seriously.

We do have the opportunity to have progress, and when the government of PRC, takes this issue seriously, they can do very, very good things. What we are asking them to do now is exert more oversight over their shipping industries and their chemical industries --

The Chair. Yes.

Mr. Chester. -- that divert these chemicals for production.

The Chair. Right. It is frightening how many plants in China are producing the chemicals.

Mr. Chester. Yes, ma'am. There are about, we are told about 160,000 chemical plants, but the issue is that they are diverted on their way out of the country, destined for unknown and undeclared customers in Mexico who use them to produce the fentanyl-related substances.

The Chair. Have any other countries permanently scheduled all fentanyl-related substances?

Mr. Chester. I believe not, but I will get you that definite answer, ma'am.

The Chair. Okay. Mr. DeLena, offenses prosecuted under class wide scheduling can trigger a mandatory minimum of 5 years for 10 grams or 10 years for 100 grams of a

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drug mixture containing a detectable amount of fentanyl analogues.

To put it into perspective, how many grams are fentanyl are lethal?

Mr. DeLena. Congresswoman, thank you for the question. DEA estimates about 2 milligrams is a potentially lethal dose. That is about enough to fit on the tip of a pencil.

The Chair. And then what is a lethal dose of carfentanil, which is a fentanyl analogue?

Mr. DeLena. Thank you, Congresswoman. I would have to defer to some of the scientists and lab folks at DEA, but I can get you that exact, specific answer.

The Chair. Well, bottom line -- bottom line -- we know that there is enough fentanyl now in the United States to kill every person seven times over, and so, it is a huge amount of fentanyl that has come into the United States.

And it is lethal, and it is impacting those that are addicted, but it is also impacting people who don't know even what they are doing or what they are taking, some of these pills that are laced with fentanyl.

And so I really just appreciate all you being here. We are committed to taking action to ensure that we are doing everything we can to keep fentanyl and fentanyl-related substances off our streets. It is destroying families, individuals, and communities all across this country, so thank you. I yield back.

Mr. Guthrie. I thank the chair yields back. The ranking member, Mr. Pallone from New Jersey, is now recognized.

Mr. Pallone. Thank you, Chairman.

One bill that would have been a great addition to this hearing today is the Medicaid Reentry Act, and this bipartisan legislation would extend Medicaid eligibility to incarcerated individuals back to 30 days prior to their release. So let me start with

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Dr. Gandotra.

It is my understanding that individuals newly released from incarceration are at a much higher risk of overdose than suicide. Can you describe some of the reasons for that?

Dr. Gandotra. Thank you for the question. And as you accurately describe, individuals who are reentering society from incarceration are at higher risk for overdose, in particular, because during their incarceration, their tolerance levels have changed, and when they reenter society and they use again, they are much more likely to overdose if they previously -- amounts that they had previously used that they were tolerant to.

So it is vitally important that these individuals engage in treatment, both prevention and recovery services as well as evidence-based treatment well before they are actually released.

The most important aspect of that is the transition planning. There are certainly models that have been successful, such as the sequential intercept model, which not only encourages transitional planning by jail and end-reach providers, but also can facilitate other resources that are necessary for success -- social determinants of health, case management, resources that will be needed.

Sometimes a warm handoff and actual conversations with the service providers in the communities can really go a long way towards reducing mortality for those reentering society.

Mr. Pallone. And the problem now, Doctor, is that they are not eligible for Medicaid under the law now until they leave prison, and then oftentimes, we can't even find them to tell them to sign up or whatever, correct?

Dr. Gandotra. So certainly there are treatment gaps that need to be addressed, particular coverage gaps with regard to remuneration of services, but the prescriptions

themselves, having those before they leave, having a contact, peer recovery support specialist in the community that can help connect them and keep them connected to treatment, because we know the treatment retention yields better outcomes.

Mr. Pallone. All right. Now, I wanted to shift to Mr. Chester. In order to conduct quality research, investigators need access to fentanyl analogues as they might be useful in enhancing current treatments or developing new ones.

A key component of the administration's proposal involves how FRS are classified, or subsequently reclassified if found to have a lower risk profile. Can you explain the importance of the provision for off ramping and FRS?

Mr. Chester. Thank you, Congressman. That was a key component of the administration's proposal when it comes to fentanyl-related substances. So the first step is to scoop these substances up and make sure that Americans don't have access to them, that they can't be harmed.

But the second one is what you say, to determine two things: if those substances may have some medical merit, and what their qualitative effect is on the body. And it is critically important for researchers to be able to, even though they are in Schedule I, to have access to them.

And part of the proposal for FRS was not only FRS, but all Schedule I drugs, actually reworking the process by which researchers can have access to Schedule I drugs for the purposes of research.

Mr. Pallone. All right. Now, I am just going to rush through this because there is only about a minute left. What is your understanding of how the current administration's proposal differs from the Halt Fentanyl approach, and is the administration's approach evidence-based? Why is it important to use evidence-based approaches when it comes to scheduling of FRS?

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Mr. Chester. So on the first part, I apologize, I can't take a position on a specific piece of legislation, but what I can say is, the administration's proposal was comprehensive, and it was a consensus-based proposal that came across the interagency, and it is evidence-based. It is based on what we know about access to research, what we know about criminal justice outcomes, and also what we know about the trafficking of these substances.

Mr. Pallone. All right. I appreciate that. Thank you, Mr. Chester, for helping us understand some of the differences, if you will, from what the current administration is proposing.

And I just want to say appropriately studying and categorizing substances is key to addressing the opioid and fentanyl crisis. So it is important that we understand the differences between these various approaches.

And with that, I will yield back, Mr. Chairman.

Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Latta for 5 minutes for the purpose of asking questions.

Mr. Latta. Well, thank you, Mr. Chairman, and thanks to our witnesses for being here. First, I would just like to, once again, show people -- well, this is from the DEA website that I have used back in our district.

This is the amount of fentanyl that will kill you when you are looking at it next to a penny, and I think it is really important to see that because again, what everyone is up against in this country and how we are going to have to stop this, because -- and the testimony again being today, that 107,477 Americans that lost their lives last year.

And, Mr. DeLena, I really appreciate something you are saying. You are saying poisoning now. We are not talking about overdose deaths, we are talking about poisoning.

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And that is something that came up in the roundtable that we had with family members and law enforcement. It is no longer overdose. This is poisoning.

And when you think about the -- you mentioned 294 people died from drug poisoning every day in this country, and that, you know, what was interdicted, that we know of, is 7.5 million tons of fentanyl that came into this country -- 7-1/2 tons, not millions, excuse me -- 7-1/2 tons of fentanyl that came into the country. So I think it is really important that we keep that in line.

And something else I think is really important, I think, in your testimony. It is costing -- it says in your testimony, you say, it costs the cartels as little as 10 cents to produce a fentanyl-laced fake prescription pill sold in the United States. That is what we are saying then, is, they can kill us for 10 cents -- 10 cents.

So when we talk about do we got a crisis on our hands, we are past a crisis in this country, and I know my friend from Texas asked some of the questions especially dealing with the PRC, but -- and the paragraph before because, again, it is where these chemicals be coming in, when you talk about 160,000 chemical companies in the PRC and those that are distributing the precursor chemicals for use in fentanyl and meth.

The question, you know, right now is that since they are faking these labels as they are going from China to Mexico, we are talking to our Mexican counterparts, is there anything that they are -- being done within Mexico to try to find these fake labeled shipments as they come through?

Mr. DeLena. Congressman, thank you for your question, and to address the first part of it with drug poisonings, DEA -- and I have been a part of it -- has met with family members that have lost loved ones. We had 22 family summits, where we met with families who have lost loved ones, and, you know, we hear from them every day, you know, the pain and suffering that is caused by this drug, fentanyl.

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And it truly is a poisoning, that is how we look at it now, that it is Americans that are being poisoned across the country.

To talk about the chemicals that you ask about, these Chinese chemical supply companies, there is no oversight, or
"Know Your Customer" rule, and as you said, they are shipping these precursor chemicals into Mexico all the time.

We know, on one side, China needs to do a lot more, and we know the same has to happen in Mexico. The Mexican Government needs to do a lot more to enforce what is coming into that country and work with us to try to defeat these two cartels.

Mr. Latta. Great. Let me follow-up on, because, again, when you look at the, prior to 2018 with fentanyl, and what we want to do, my good friend from Virginia and I and our legislation on Halt Fentanyl, again, what will having it permanent because, again, you know, you always -- you talk in your testimony about the temporary scheduling order eight times. How will this bill help you on the crisis that we have with fentanyl?

Mr. DeLena. Thank you again for the question. The permanent scheduling will allow DEA to arrest and seize when we encounter fentanyl-related substances wherever that happens.

We also know that with class-wide scheduling, there has been less production of different analogues. It is just not worth the chemical brokers and chemists in Mexico when they are making this substance, when they know it is a class-wide, you know -- it is illegal class-wide, there is no benefit for them to try to create new substances.

Mr. Latta. Well, again, I appreciate, you know, the work that you are doing because, again, we need to get this legislation across the finish line because we want to stop this horrendous rise in deaths across this country. And it has got to happen now.

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

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

The chair now recognizes Mr. Cardenas of California for 5 minutes for asking questions.

Mr. Cardenas. Thank you very much, and congratulations, Chairman Guthrie. I have always enjoyed working with you and looking forward to working with you as the chairman of this very important committee.

And also to Ranking Member Eshoo, thank you so much for your diligent work, and I have enjoyed working with you, and this committee is going to hopefully do much, much good work over these next 2 years.

Before I ask my questions, I just want to mention a few words -- Purdue, the Sackler family, and crime pays. Still one of the richest families in the world. Where did all this start and who was a big part of where we are today.

Dr. Gandotra, thank you for joining us today and for sharing your informative and valuable expertise on mental health policy.

As you are aware, HHS recently implemented the 988 hotline, a potentially life-saving service for individuals experiencing mental health crises, spearheaded by my colleague here, Congressman Sarbanes.

Thank you so much for everything you do in the space of mental health.

While there is much work to be done, I believe that the promise of 988 and the momentum -- excuse me -- the continuum of crisis care built around it, offers some much-needed hope for those struggling with their mental health.

However, in December the 988 hotline experienced a service interruption after a suspected cyber attack on Intrado, a large telecommunications company that provides services to Vibrant, the administrator of the 988 hotline.

The bill before us today, which I am co-leading, aims to prevent this from

happening again. In the wake of the December Intrado service outage, how is SAMHSA mitigating the risk of similar incidents and hoping to keep that from happening again? Can you put your microphone just a little closer? Thank you.

Dr. Gandotra. Sure. Thank you, Congressman, for your question, and also for the ongoing support for the 988 program. And I would like to first state that our highest priorities are to develop additional redundancies in the event of any future outages.

While minimizing the likelihood of such events, we want to continue to protect personal information and be sure that there is clear communication protocols among the partners and the public. We certainly owe the public trust when it comes to their personal information.

We also want to be able to continue to expand services and understanding that when these problems arise, we want to quickly resolve them and provide clear guidance on where and how to seek help. Certainly, clear communication and protocols between the partners and public is going to be paramount.

Mr. Cardenas. Are more resources needed, and do you appreciate Congress actually providing more resources in the future?

Dr. Gandotra. Well, we thank Congress for the investment certainly as we recognize that mental health crisis services are always needed. As there has been a growing need recognized, not just in the past years, but throughout the past decade, we would appreciate all the support the Congress has given us.

Mr. Cardenas. Thank you. I look forward to working with you and SAMHSA on improving 988 and getting it to where it should be in the future.

I also want to take a moment to discuss our policy around fentanyl and fentanyl-related substances. Overdose deaths are skyrocketing in this country, and I share my colleagues' horror at the devastation we have seen at the hands of the fentanyl

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crisis.

But among other things, this is a complex, multifaceted public health crisis that requires a robust public health response. And candidly, I am concerned that this class-wide scheduling approach sets a precedent of guilty until proven innocent.

The proposal put forth by my Republican colleagues goes all in on applying harsh Federal penalties, but lays almost no groundwork to test for the potential harmlessness of these fentanyl-related substances, or even their potential therapeutic value.

We could be overlooking the next Naloxone, which has saved countless lives from opioid overdose because our focus is solely punitive, and I think that is a grave error with immense consequences. The responses are usually multifaceted, but not simple.

Mr. DeLena, under the current classification system, what kind of resources have you allocated toward testing the effects of Schedule I compounds which may have medicinal purposes?

Mr. DeLena. Congressman, thank you for the question. DEA is open to the testing of Schedule I substances. It is our partners at HHS that conduct those type of tests, and as I said, we are open to Schedule I testing and research for any scientific need, and for any medical evaluation that could come out of it.

Mr. Cardenas. Okay. Thank you so much. My time having expired, I yield back.

Mr. Guthrie. Thank you. The gentleman yields back, and now Mr. Griffith is recognized for 5 minutes for the purpose of asking questions.

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

There is some confusion about the Halt Fentanyl Act that I am hearing in some of the questioning and in some of the statements that have been made. The Act does, in fact, include the ability to do research and makes it easier to get through the pathways to

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get research done.

On some of those -- and to our colleagues on the other side of the aisle, they held a great hearing earlier, last year, sometime last year. If memory serves me correct, there are approximately 48,000 potential analogues to fentanyl, of which, we have looked at somewhere between 30 and 40.

But that is a -- you know, if you want more research, this makes it easier, and we probably need to get the appropriators to appropriate money to go in that direction, if that is the intent.

But we are -- the bill does allow for more research. I have been a big advocate for researching substances and their potential medical use since I came to Congress.

Also, Mr. Chairman, I would request unanimous consent for the introduction of a letter for the record from the Peace Officers Research Association of California, representing 75,000 public safety members and 930 public safety associations which expressed their support for the Halt Fentanyl Act.

Mr. Guthrie. Any objections?

Seeing none, so ordered.

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[The information follows:]

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Mr. Griffith. And from that letter, Mr. Chairman, they say, as the law enforcement community continues working to reverse these trends, the Halt Fentanyl Act would help to bolster the efforts by ensuring current Schedule I classification of fentanyl under the Controlled Substances Act does not expire. So there is that.

Let me ask a couple other things that I thought was interesting. Mr. DeLena, you indicated that because of the temporary ban, it is not worth it to the cartels to work on the analogues. That implies, and I believe it was happening, is that when there wasn't -- when the analogues were not illegal, they were looking for analogues that would be legal, that they could get around the laws and not face criminal punishment in the United States by importing these poisons into our country. And this has actually helped stop that.

It may not have stopped the fentanyl deaths, and certainly this is only one part of a complex answer. But I am I correct that they were looking for other ways so they could avoid criminal punishment, yes or no?

Mr. DeLena. Thank you for the question. We have actually seen that play out before where they can flip one molecule and keep moving it along. With the class-wide scheduling, it is just not beneficial for them to do that.

Mr. Griffith. And I appreciate that. I am going to switch gears for a second, Doctor, and I hope I am saying it right, Gandota, Gandotta?

Dr. Gandotra. Gandotra.

Mr. Griffith. Gandotra. In a recent study published in the Journal of the American Medical Association, they said there was no evidence that telemedicine has actually expanded access to care for opioid use disorder.

They also found that telemedicine opioid use disorder patients tended to be more

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concentrated in higher income metro areas. And I am a big believer in telemedicine, so what do you think we can do to expand access to more rural areas like mine?

Dr. Gandotra. Thank you, Congressman, for the question. Certainly SAMHSA is committed to expanding treatment access for medications for opioid use disorder. We have heard from numerous stakeholders, in particular, from rural areas or from our State opioid treatment authorities.

Mr. Griffith. So you are going to work with us on that?

Dr. Gandotra. Yes, sir.

Mr. Griffith. All right, I appreciate that.

Buprenorphine. Now there is no limit on the number of doctors prescribing, but even before that -- or the number of patients that a doctor can have to prescribe, but even before that, it was starting to become used as a street drug in a couple of my counties.

Are we monitoring to see if this is going to be a national trend? Are you all looking at that as a possibility? Because apparently, it is happening, according to some of my law enforcement folks.

Dr. Gandotra. Certainly expanding medications for opioid use disorder including buprenorphine is one of our goals for --

Mr. Griffith. Well, I want to know if we are looking to make sure that we are not creating a new street drug.

Dr. Gandotra. We are certainly -- we are certainly educating providers --

Mr. Griffith. Mr. DeLena, you too? You are all looking at this?

Mr. DeLena. Thank you, Congressman. Absolutely. Any threat that is posed to the American public, DEA will continue to monitor.

Mr. Griffith. And have you seen any uptick in buprenorphine being used as a

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street drug?

Mr. DeLena. Again, thank you for the question. I can't speak to that. I have not seen that in the area that I came from. My last assignment in New England, we did not see that trend.

Mr. Griffith. All right. And I am running out of time, so last question. Got all these cartels in Mexico. Is the Mexican Government capable of defeating those cartels on their side of the border?

Mr. DeLena. Thank you for the question. Those two specific cartels, Jalisco and Sinaloa, that are causing all of this harm are operating virtually with impunity. We need the Mexican Government to lean in and do a lot more.

Mr. Griffith. But right now, they can't do it, can they?

I yield back.

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

The chair now recognizes Dr. Ruiz for 5 minutes for questions.

Mr. Ruiz. Thank you. As an emergency physician, I have seen time and time again the devastating and often fatal effects of drug overdose. Fentanyl, in particular, continues to wreak havoc on our communities.

The most recent data from CDC shows that 67 percent of all overdose deaths in the U.S. involve synthetic opioids like fentanyl, and DEA Administrator Ann Milgram called fentanyl, quote, "the single deadliest drug threat our Nation has ever encountered," unquote.

Over the past several years, this Congress adopted many policies to try to stem the tide of the substance use crisis and increase access to prevention, treatment, and recovery services.

However, still more needs to be done. I think it is critical to remind everyone

that substance use disorder is a disease, and it needs to be treated as such. This means we need to focus on greater access to harm reduction programs and increase efforts towards prevention.

I approach this disease like I would any other, addressing how to get someone well after they are sick, but also how to prevent them from getting sick in the first place.

Our healthcare system is good at healing the sick, but often too frequently ignores or undervalues prevention so that people don't get sick in the first place.

So on that note, I would like to talk about the HHS overdose prevention strategy and what it is accomplishing in this regard. The strategy involves four priorities: primary prevention, evidence-based treatment, harm reduction, and recovery support.

This is especially important among youth as recent data from the nonprofit group Families Against Fentanyl suggested children under 14 are dying a faster rate than any other age group.

So we know you can't incarcerate a public health problem from ending, and you also got to think through how -- that, you know, the focus is on the drug cartels moving drugs over, but how about those who have the disease of addiction who are also fueling that through the enormous demand on our side?

So, Dr. Gandotra, what are the interventions and early prevention strategies used in the overdose prevention strategy to address opioid use, particularly among youth.

Dr. Gandotra. Thank you, Congressman, for that question. Certainly the prevention pillar is important in terms of the overdose prevention strategy. Our strategic prevention framework is one of our major grant programs that allows for community organizations, States themselves, and local jurisdictions, to identify the problem, also identify then the resources they have in terms of capacity.

Mr. Ruiz. Well, identifying a problem is not necessarily prevention because there

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is already a problem. So how do you prevent it from becoming a problem?

Let's say a school wants to start a program. Where can they go to get information or resources and moneys to create education outreach to prevent this from happening?

Dr. Gandotra. So SAMHSA's Block Grant Program -- substance use Prevention Block Grant, has a 20 percent set-aside where the local jurisdictions can determine what is best suiting their needs. That 20 percent set-aside has been incredibly effective for schools and community organizations.

Mr. Ruiz. Can you explain the concept of harm reduction and what that means in practice?

Dr. Gandotra. Certainly. Harm reduction is a practice that utilizes the principle to meet the patient where they are, to reduce the morbidities, or negative aspects of use.

This may mean that individuals who may not be necessarily ready to engage in full treatment can still mitigate some of the effects of their use. In particular, harm reduction can involve naloxone administration for preventing overdose, as well as fentanyl test strips for drug testing to allow for individuals to determine how safe the product is that they have in their hand.

Those are just two examples, and there is a number of other harm reduction interventions that can be utilized.

Mr. Ruiz. Thank you. And how does the strategy address helping people after they receive treatment for SUD? Or how important is it to facilitate a safe recovery environment?

Dr. Gandotra. So thank you for that question, and for really highlighting the part that individuals who engage in harm reduction are much more likely to later engage in treatment, and be retained in treatment.

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You have to reach patients where they are, where they are willing to actually engage with you. That means that if they are able to stay alive, you can treat them later. If you can't keep them alive, then there is no way that they can be engaged in treatment. So, certainly, the naloxone administration is a big aspect to that.

Mr. Ruiz. You know, I got to also mention that this illness of addiction is not just for the individual, but it is for their family, for their neighborhood as well, and treatment needs to go toward a family-based, home-based, community-based treatment programs for prevention and also harm reduction. Thank you. I yield back my time.

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

The chair now recognizes Mr. Johnson for 5 minutes.

Mr. Johnson. Well, thank you, Mr. Chairman. First I want to say how excited I am to have been selected to serve on the Health Subcommittee. Healthcare is such an important issue in my rural Appalachian district, everything from cost to quality to availability, and I look forward to working on these important issues under your leadership, with all of our colleagues.

For today, however, I want to read some excerpts of a letter I received from a constituent yesterday right near my home in Washington County, Ohio. The letter is from a grieving mother of a young man named Jason who tragically died exactly 2 years ago yesterday, January 31st, 2021.

Jason's mom wrote to me and said, Jason was prescribed Vicodin by our family doctor after a car accident. Why wouldn't we trust it? Our doctor prescribed it. Our son had a couple of relapses after a stint in the Marines and some college, but we had good insurance and a medication-assisted treatment helped him pick up the pieces.

His relapse in September 2019 set the stage for a terrible, 15-month battle to save our son's life. By the time we were in the throes of COVID in March 2020, our son was

in the worst of his disease.

She then went on to say, his drug of choice was heroin, and now that drug is laced with fentanyl. It was the first time I realized he was most likely going to die.

Fentanyl is a game-changer, she said. She closed with this. Jason was so much more than simply addicted. He was loved by so many, especially his own son, who we are now raising.

My friends and colleagues, this grieving mother is right -- fentanyl is a game-changer. We are in entirely new territory now compared to when we started confronting what we called at the time the opioid epidemic, particularly in rural areas, like where I live.

So, Mr. Chester, let me start with you. Thank you for being here. The 2021 Drug Free Communities report highlights that close to 98 percent of Drug Free Communities coalitions address prescription opioids.

But only just over half address fentanyl, fentanyl analogues, or other synthetic opioids. And as we know, an increasing number of overdose deaths are attributed to synthetic opioids like the situation I highlighted.

The victim started with prescription opioids but moved on to heroin and then an accidental, extremely potent, and fatal fentanyl overdose.

Why does this disparity exist within the Drug Free Communities program? Does ONDCP plan to revisit their efforts and strengthen its response to synthetic opioids?

Mr. Chester. Thank you very much for the question, and we all are incredibly sorry for your constituent and the many others --

Mr. Johnson. I got another question so if you could answer that one.

Mr. Chester. Yes, sir. The Drug Free Communities program, the more than 700 grantees, their programs are locally designed based upon local conditions, and there is

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not a single Drug Free Communities overlay over all of them.

Mr. Johnson. Yeah, but the fentanyl crisis and synthetic opioids is a nationwide problem. How can only half of them be digging into that area?

Mr. Chester. And the Drug Free Communities grantees decide based upon their local conditions what they want. Now, we do manage the program in cooperation with others, and we will absolutely be glad to address that. But the Drug Free Communities Program is centered at the community level.

Mr. Johnson. Okay. I have got one question for you, Mr. DeLena. Some say the problem with class wide bans is that potentially thousands of compounds are defined solely by their chemical structures without regard for their pharmacological activity.

It is my understanding that the DEA looked at more than structural similarity when arriving at the definition of fentanyl-related substances. Can you explain to our committee what structure activity relationships are?

Mr. DeLena. Congressman, thank you for the question. Unfortunately, I am focused on the enforcement side. That is my background and where I come from, but we do have scientists and experts that handle that. I would be happy to take that question back.

Mr. Johnson. Are you happy -- my time has run out, Mr. DeLena. Can you get back to your organization and those scientists and get us some information on that?

Mr. DeLena. We would be happy to. Thank you.

Mr. Johnson. Okay. Thank you.

Mr. Chairman, I yield back.

Mr. Guthrie. The gentleman yields back.

The chair now recognizes Ms. Kuster from New Hampshire for 5 minutes.

Ms. Kuster. Thank you, Mr. Chairman, and thank you to the witnesses joining us

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today for your testimony. In particular, I want to thank Mr. DeLena who has been such a great resource for us in New England. I really appreciate our work together.

I am co-chair of the bipartisan Task Force on Mental Health and Substance Use Disorder with my Republican colleague, Brian Fitzpatrick, and David Trone of Maryland.

And we are all grateful for the progress that this committee made in the 117th Congress, passing important mental health and substance use disorder legislation and, in particular, the Restoring Hope for Mental Health and Well-Being that I might add passed the House with 402 votes. I think it was probably the most bipartisan bill in the 117th Congress.

But as we all know, there is much more to be done. I am working closely with my colleague from Delaware, Congresswoman Blunt Rochester, to reintroduce our legislation, the STOP Fentanyl Act, and I hope that the chair will bring that up in a subcommittee on a future date.

This bipartisan bill was introduced in the 117th to invest in fentanyl detection and data collection, stem the supply of fentanyl, and address demand for synthetics through overdose prevention and substance use disorder treatments.

As Mr. Chester's testimony stated, fentanyl is a complex national security, criminal justice, and public health challenge that requires a multifaceted approach, and that is why the STOP Fentanyl Act devotes resources to enhance fentanyl surveillance, empowering officials at the State, local, and Federal level, to support detection and reporting.

We must continue to aggressively pursue the sources of fentanyl that have been described here today, stopping the flow of materials for synthetic drugs into this country, and cutting off the paths that bring these harmful substance into our communities.

This bill supports efforts to hold bad actors accountable both at the international governance level and with the social media companies that our families and friends use

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every day.

As the experts in this room know, a public health approach much be complemented by a well-resourced, data-driven plan to stem the supply of fentanyl. STOP Fentanyl is the path forward to respond to the challenges before us.

I look forward to hearing from my colleagues on this committee who are interested in a comprehensive approach to protect our companies from fentanyl -- our communities. I ask for your partnership and support.

In order to best craft solutions, it is essential to definitively understand the problems. Mr. DeLena, it is great to be with you, and I wanted to ask you -- you have seen how these issues affect communities like my district in New Hampshire, and the DEA has worked to prevent shipment through the postal system and crack down on chemists overseas as you describe -- what is the top way that fentanyl enters the country, and where should congressional efforts be focused to complement your agency's work?

Mr. DeLena. Congresswoman, thank you for the question and for your work when it comes to fentanyl.

A majority of the fentanyl that is coming into our communities crosses the southwest border, predominantly through the ports of entry, but they use any possible way to get it across.

Ms. Kuster. And, Mr. Chester, what role can HIDTAs play in expanding our surveillance and data collection efforts moving forward?

Mr. Chester. Our HIDTAs play a vital role because they are in all 50 States. They cover the vast majority of the population of the United States, and 99 of 100 major metropolitan areas. They are the one that can provide us the bottom's up information of what is actually happening in their communities, and they provide this information nationwide. They are an extremely valuable resource.

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Ms. Kuster. And is there coordination and sufficient resources for data collection and surveillance to know -- I heard a reference to a new substance today that I wasn't even aware of, but to know when they are emerging threats?

Mr. Chester. Yes, ma'am. In fact, the HIDTAs are very valuable, not only do they work effectively in their own right, but they are networked together very well, particularly through their drug intelligence officers, who are able to share that information, and be able to determine nationwide trends, based upon the local data that they are seeing from their particular HIDTAs.

Ms. Kuster. I think that data collection and surveillance is going to be really important.

Dr. Gandotra, I am going to probably have to leave this question for the record, but once fentanyl enters our borders, how does SAMHSA work with first responders to educate on interacting with fentanyl?

Dr. Gandotra. Thank you for that question. I will point to our grant program, the First Responders - Comprehensive Addiction and Recovery Act that educates first responders, firemen, police officers, on how to administer fentanyl, how to recognize the signs for overdose, and how to link to care.

Ms. Kuster. Great. Thank you. And with that, I yield back.

Mr. Guthrie. Thank you. The gentlelady yields back.

The chair recognizes Mr. Bilirakis for 5 minutes.

Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it. Thanks for convening this hearing today.

I would like to start by briefly sharing a news story from my district in Florida, the Tampa Bay area, and also the nature coast.

Just last week, the Citrus County Sheriff's Office apprehended a long-time drug

dealer who, as he attempted to flee arrest in his vehicle, threw a bag of drugs from his vehicle.

Having ruptured upon impact, the contents of this baggy were scattered throughout the grass shoulder. HAZMAT teams were deployed, and approximately 51 grams of fentanyl was collected, enough fentanyl to kill more than 25,000 people, believe it or not.

This, once again, highlights that we are in a crisis situation that deserves the highest amount of attention and response at every level of government, starting with the Biden administration.

It is clear they are not doing enough, and I am disheartened by the tragedies we are seeing on a daily basis. Headlines of toddlers, adolescents, young adults that have died already just 1 month into 2023.

Mr. Chairman, thank you for making this a priority.

Fentanyl coming into the country from Mexican cartels; fentanyl created with chemicals imported from China and India; enough fentanyl to kill every American in the country multiple times over.

Now I know there is no silver bullet as we all know that will solve this crisis right away, but Republicans on this committee are taking this threat seriously, and there should be serious doubts -- zero doubts though -- zero doubts or opposition permanently scheduling fentanyl-related substances to the Schedule I, again permanently.

And thank you for taking this on again, Mr. Chairman.

My question is to Mr. DeLena. You talk about the way these cartels are aggressively lacing other fake pills and distributing via social media networks. Can you tell us what your coordination is with social media companies, if any? How can you better improve communication to quickly respond to drug sales on these platforms?

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Mr. DeLena. Congressman, thank you for the question. It is very clear that social media has become a superhighway for drugs. The role of these drug cartels and the drug trafficking organizations that work on behalf of them, they are advertising, actually completing sales and effectuating payment using these types of applications.

And we know that the social media companies who control the algorithms, they control the content that is driven to the users, and they control all of the data therein, can do more and must do more.

You asked about our interaction with them. We interact with these companies on a regular basis in terms of the investigations that we are conducting.

Mr. Bilirakis. How much cooperation are you getting?

Mr. DeLena. These social media companies, Congressman, need to do more. As I stated, they control all of that content, and there must be more transparency. There must be efforts for preservation of evidence.

There is applications that have disappearing stories. Twenty-four hours, you know, later, all of that information can be gone. I can tell you firsthand that the men and women of DEA who are -- and our friends in law enforcement who are responding to these drug poisoning deaths, you know, the first thing they want to do is take steps to prevent another death from happening in that community.

And the way they do that is by identifying who that drug trafficker was that maybe sold those drugs to the decedent. If that information is gone, if there is no way that we can look at it, there is no steps that can be taken.

Mr. Bilirakis. Well, we must hold them accountable. In the spirit of being proactive and keeping pace to address new concerns on the horizon, I am also interested in addressing the drug xylazine, a tranquilizer drug with no approved medical use in humans. It is used for horses. It is used as a sedative and veterinary medicine, I

understand.

Florida has led the way in addressing this by scheduling xylazine on the State level. It is time that we follow suit and do this federally since it is being discovered in fentanyl overdose deaths and has horrifying side effects on the human body and does not respond to naloxone.

Mr. Chester, what can be done to properly trace and track the presence of xylazine in our drug supply? How important is it to accurately pinpoint the drugs that are contributing to overdose deaths throughout the U.S.?

Mr. Guthrie. Thanks. Can we get that on the record so we can -- can you give your answer on the record, do you mind?

I am sorry, your time is expired, and we are trying to get two panels through. So the gentleman yields back. The chair now recognizes Ms. Kelly from Illinois for 5 minutes.

Ms. Kelly. Thank you so much, and I have one dilemma. Congratulations to you, Mr. Chair, and I want to thank Chairman Guthrie and Ranking Member Eshoo for holding a hearing on this very important topic.

We need to eliminate the racial and ethnic disparities that plague the overdose epidemic and the broader healthcare system, and I do believe we all agree on that.

Unfortunately, overdose deaths are beginning to rise even before the pandemic, and Black and Brown communities are experiencing the fastest increasing rates of overdose deaths involving synthetic opioids.

In 2020, drug overdose death rates increased by 44 percent for Black people, 21 percent for Hispanic people, and 39 percent for American Indian and Alaska Native people.

Moreover, access to opioid and substance use disorder treatment is lower in

Black, Latino, and Asian communities.

We could go on forever in the remainder of this hearing, highlighting diseases and conditions for which people of color have higher incidences of illness and less access to healthcare.

Dr. Gandotra, what is SAMHSA doing to reduce disparities in substance use and mental health in the United States?

Dr. Gandotra. Thank you for that question, and certainly SAMHSA has recognized this issue as well. We require all new grant programs, recipients, to submit a data-driven disparity impact statement, outlining how they are going to address behavioral health disparities within their grants.

We also have several programs themselves to address closing equity gaps. In particular, we have the Tribal Opioid Response Program, which addresses the public health crisis caused by escalating opioid and stimulant misuse in Tribal communities.

We also have our Technology Transfer Centers, which disseminate information, specifically Technology Transfer Centers dedicated to American Indian and Alaska Native populations, and a separate one for Hispanic and Latino populations.

We also have three Centers of Excellence for African American populations, LGBTQI-plus, as well as older adults.

We also fund the Center of Excellence for historically black colleges and universities to help expand the workforce within behavioral health.

We have the minority fellowship program which provides stipends to increase the number of culturally competent, behavioral health professionals.

And finally, we fund the National Network to Eliminate Disparities in Behavioral Health Network, which really does exchange a lot of information between organizations and provide networking to advance best practices.

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Ms. Kelly. Thank you. I just want to make sure that Congress is taking a holistic approach by investigating significantly in prevention treatment and recovery.

And also, as my colleague, Mr. Griffith, had brought forward, my district is urban, suburban, and rural, and it has become even more rural in the remapping. I have over 2,000 farms in my district, so I want to make sure that we are paying attention to the rural areas also.

How are you addressing the social determinants of health and their impact on human well-being?

Dr. Gandotra. Certainly, social determinants of health can not only impact treatment outcomes, but they also impact treatment engagement. SAMHSA understands that not all services are clinical in nature, and they need to be covered.

Through our Block Grant Program, there are set-asides for wrap-around services such as case management. We have partnerships with other entities such as HUD to establish housing opportunities for those within -- who are suffering from HIV or AIDS.

We have a number of other programs that address the social determinants of health as well.

Ms. Kelly. And may I ask what other agencies you collaborate with to address health inequities?

Dr. Gandotra. I would say within HHS, our operational divisions, we with coordinate with HRSA, the Bureau of Indian Health Services as well, as well as the Bureau of Prisons. We work with a number of Federal entities when it comes to establishing treatment and evidence-based care.

Ms. Kelly. Thank you so much. We must intentionally address the root causes and the inequities, or else we will never get out of this situation. Thank you.

Mr. Guthrie. Thank you. The gentlelady yields back.

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And I should have pointed out to my colleagues on the other side earlier, Dr. Larry Bucshon will be vice chair of this committee, and we look forward to working together with him. So you will see him in the chair quite often. Just want to make that aware and that announcement.

But I will now recognize the vice chair of the committee, Dr. Bucshon, for 5 minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman, and I apologize, I have another hearing at the same time, as many of us do, but I have read through your testimony.

Thank you, Chairman Guthrie, for holding the hearing and drawing attention to this very important point we so often take for granted, that all life is precious and valuable.

Each of these bills before us today serves as an important reminder of that fact. Two of them touch on the issue of illicit drug trafficking and use which affects each of our districts.

As the medical community has attempted to deal with increasing rates of illegal drug use and addiction, we have developed medication-assisted treatment.

And just so you know, I was a physician before I was in Congress.

While this can be an important tool, and it is an important tool in the right circumstances, I have long voiced concerns about its potential to cause harm without the proper guardrails.

Furthermore, buprenorphine, the primary medication being used in medication-assisted treatment for opioid use disorder, is itself an opioid and is extremely vulnerable for misuse and diversion.

People who have been on the committee know that I have long been opposed to the broad expansion of prescribing authority under the umbrella of expanding the

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availability of treatment.

In medicine, sometimes we are in these situations where medications are dangerous potentially, and even though we want more access, we still have to stick with science and make sure the proper individuals, who are properly trained, are the only ones that have the ability to prescribe these medications.

Unfortunately, I haven't been able to convince all my colleagues of my view on this issue. So we have dramatically expanded it, and I hope that we don't see problems.

Mr. Gandotra, you spoke to my colleague, Mr. Griffith, earlier about the potential for buprenorphine diversion and said that you were not aware of it being used as a street drug. Is that correct?

Dr. Gandotra. Most cases are of buprenorphine have been utilized for treatment, or for withdrawal mitigation as far as --

Mr. Bucshon. Well, just, I mean, as you probably know, there is multiple peer-reviewed articles and even some NIH and DOJ intelligence research suggesting that it is a significant risk, that buprenorphine, being a diverted drug.

So even though it sounds like you think that that is a small issue -- we can agree to disagree -- what steps is SAMHSA taking to combat the possible diversion of buprenorphine?

Dr. Gandotra. Thank you very much for that question. Certainly we know that education on substance use disorder is important as practitioners diagnose and treat these conditions.

We are working with professional societies to ensure that there is appropriate and summative information provided to all members so that ongoing education and training becomes the standard. That is irrespective of the ex-waiver itself.

And certainly as far as diversion goes, I could also turn to my DEA colleague for

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specific diversion actions.

Mr. Bucshon. Yeah, sure.

Mr. DeLena. Congressman, thank you for your question. You asked about buprenorphine and you asked about potential abuse --

Mr. Bucshon. Yeah, potential diversion, and I mean, for many years it has been considered one of the highly vulnerable drugs to being diverted because it is an opioid itself, and as we increase access, and as I have previously stated, probably have people that aren't properly trained prescribing it. So what are you going to do when we start to see it on the street?

Mr. DeLena. I think the word you used, Congressman, guardrails, puts it best. While we want to make sure that people get access to the treatment that they need, it has to be done in a way that does not contribute to overprescribing, misprescribing, or diversion of that substance.

And we need to make sure that we educate and make aware our communities and our law enforcement partners as such.

Mr. Bucshon. Yeah, I would agree with that. And I mean, as probably anyone knows that works in this space -- and that is not my area of expertise, but I was a physician -- that ongoing counseling and therapy is extremely important. You know, showing up and getting medication-assisted treatment without proper counseling, follow-up, probably almost for the lifetime in many cases, doesn't give very good results.

I will save this question for your written response. Naloxone, it is going to come over the counter. This is for Mr. Gandotra. Will that change any, or affect any existing work or grant programs at SAMHSA, and how do you plan to deal with those changes? If you could submit that for the record, I would appreciate it.

Dr. Gandotra. Thank you.

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Mr. Bucshon. Thank you very much. I yield back.

Mr. Guthrie. Thank you. I appreciate the vice chair for yielding and now recognize Ms. Barragan from California for 5 minutes for questions.

Ms. Barragan. Thank you, Mr. Chairman.

Mr. DeLena, I am looking at your testimony, and under the Sinaloa cartel, you mentioned drug trafficking activity in various regions in Mexico, particularly along the Pacific coast. Would that include trafficking through boats across waters, or is that not included in that?

Mr. DeLena. Thank you for the question, Congresswoman. Those cartels, the Jalisco cartel and Sinaloa cartel, will use any method possible to get drugs into the United States and into all of our communities.

Ms. Barragan. So do you work with the Coast Guard for operations on water?

Mr. DeLena. Thank you. We work with all our Federal partners. We do work with the Coast Guard, and we work with State and local law enforcement throughout the country.

Ms. Barragan. Thank you. I was stricken by your testimony. You, on several occasions, mentioned your top priority -- your operational priority is to defeat these two Mexican cartels that are responsible for driving the drug poisoning epidemic in the United States.

You say it once there, and then you go on later to say, they are using cars and trucks and other routes to transport these drugs from Mexico to the United States. And then you continue to say it on the crossing points, and you even end with saying, again, that the cartels are driving drug poisoning and threatening the safety of our health communities.

And I guess I was struck by the number of times you mentioned driving, just

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because there has been a lot of misinformation sometimes put out there.

My understanding has been since I think 2020 about 97 percent of fentanyl seizures have been ports of entry. You previously testified the majority have been at ports of entry. Does that 97 percent sound about accurate?

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RPTR MARTIN

EDTR HOFSTAD

[12:00 p.m.]

Mr. DeLena. Congresswoman, thank you again for the question.

I don't have the specifics related to the border and the points of entry. That is probably a better question for the Department of Homeland Security and the entities therein.

Ms. Barragan. Okay. Well, thank you.

I think your testimony about the majority is important. It is also, I think, why Democrats have prioritized making sure there was more than $400 million in non-intrusive inspection systems at the southwest land border, because we know the majority of this is coming over through the ports of entry.

Democrats also funded additional staffing for CBP points of entry in the fiscal 2023 omnibus because it historically has been understaffed. These are the officers that are doing the interdicting drug attempts to enter our communities. And so we are going to continue to work on that as one of the tools. I think in your testimony you mentioned there has to be an entire -- a lot of tools that are necessary for that.

So I just want to thank you for the efforts that you are doing, and we certainly want to be helpful in making sure that Congress is funding efforts to help in your fight, in the DEA's fight.

Dr. Gandotra, I would like to now shift a little bit. In Los Angeles County and across the country, we are seeing the humanitarian crisis of people experiencing homelessness, and they are dying from fentanyl overdoses.

Between 2017 and 2019, people experiencing homelessness in L.A. County were more than 36 times more likely to die of a drug overdose compared to the general

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population. Drug overdose deaths involving fentanyl tripled between 2018 and 2020, and drug overdoses remains the primary cause of death for people experiencing homelessness in L.A. County.

I believe we need a drug policy aimed at reducing harm caused by fentanyl, and it must include a holistic public health approach.

So my question to you is: You know, the last time this committee came together, it was on a bipartisan basis to pass the Restoring Help for Mental Health and Well-Being Act, which reauthorized billions of dollars in programs to address mental health and substance abuse.

Can you discuss how the Substance Abuse and Mental Health Services Administration can use these programs to address social factors, like homelessness, that worsen fentanyl-related substance overdoses among the more than 500,000 people experiencing homelessness in our country?

Dr. Gandotra. Thank you for the question.

Certainly, when we try to address substance use disorder and mental illness, we have to address people where they are. Through our block grant funding, the Substance Abuse and Mental Health Services Administration does provide billions of dollars to each State, where they can identify the interventions that are best suited for their communities. This may involve wrap-around services, prevention efforts, harm-reduction efforts, as well as things specifically such as naloxone administration.

As far as homelessness goes, we also expanded our educational resources. We recently released our evidence-based resource guide, "Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness." This guide has strategies for engagement, retention, as well as involvement of recovery efforts. We also highlight key strategies to ensure success and measure that success in terms of

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recovery support for both the unsheltered and sheltered homeless.

Ms. Barragan. Thank you.

My time has expired. I yield back.

Mr. Guthrie. Thank you.

The gentlelady yields back.

The chair recognizes Dr. Joyce from Pennsylvania for 5 minutes.

Mr. Joyce. Thank you for yielding, Mr. Chairman.

And I further would like to thank our full committee Chairwoman McMorris Rodgers for holding this hearing today and for your continued focus on stopping the scourge of the illicit fentanyl substances and the tragic impact that they have on our Nation, specifically in my community in Pennsylvania.

Last month, we were able to hear powerful testimony here from two of my constituents, Ray and Deb Cullen, who tragically lost their son to fentanyl poisoning just months ago. Their loss and those who have felt this across the Nation over the past year underscores how critical it is that we act to permanently schedule fentanyl-related substances class-wide.

It is shocking to hear that in 2022 alone the DEA seized almost 379 million deadly doses of fentanyl, which is more than enough to kill every single man, woman, and child in the United States. And this is just what was seized.

Lack of operational control over our southern border has allowed the cartels, the drug traffickers, to flood our streets with these deadly substances, literally placing every community in America at risk.

Associate Administrator DeLena, the CDC estimates that illicit fentanyl or fentanyl-related substances are responsible for most overdose deaths in our country. I firmly believe that we must empower law enforcement with every tool that is necessary

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to stop those who traffic these deadly substances into our communities.

For this reason, I am troubled by the Biden administration's insistence that we should exempt certain fentanyl-related substances scheduled by class from all quantity-based mandatory minimums.

Associate Administrator DeLena, with this approach of less-harsh sentencing guidelines for fentanyl-related substances under the Biden plan, if a drug trafficker would bring, let's say, this amount of a fentanyl-related substance into the United States and, in contrast, had this amount of cocaine, the mandatory minimum sentences would be greater for this in cocaine than the more deadly fentanyl-related substances, which potentially could kill everyone in my district.

Wouldn't this incentivize the drug traffickers to bring fentanyl-related substances, more of them in, causing more tragedy, more deaths in the United States?

Mr. DeLena. Congressman, thank you for the question.

It is the top legislative priority of DEA for the permanent class-wide scheduling of fentanyl-related substances.

DEA is a law enforcement agency. We conduct investigations and make arrests. When it comes to the sentencing and everything that goes along with it, we defer that to the prosecutors that we work with and the judges.

Mr. Joyce. So the Biden administration does not recommend decreased or absent mandatory minimum sentences for fentanyl-related substances?

Mr. DeLena. Congressman, again, thank you. I would have to defer to those prosecutors and the judges that make those decisions, is the best answer to that.

As an investigative law enforcement agency, our goal is to target those cartels and the drug-trafficking organizations that are doing the most harm and to make those arrests. Then we move that forward for prosecution, and those decisions are made by

prosecutors and judges.

Mr. Joyce. Would you agree with me that mandatory minimum sentences for fentanyl-related substances should be equal to other narcotics that could be introduced into our country?

Mr. DeLena. Thank you, Congressman, for the question.

I would have to defer to the people that make those decisions. As a law enforcement agency, we are laser-focused on defeating the two cartels and reducing harm in all of our communities.

Mr. Joyce. And you talk about that harm in our communities. I think every Member, both sides of the aisle, has witnessed those harms and has heard those stories in our communities, in our families, in our neighborhoods.

I think protecting our southern border is utmost important. And I think those mandatory minimum sentences should not allow the exemption of fentanyl-related substances.

I think we have to agree that the impact of fentanyl-related substances and the ability to carry the similar mandatory sentencing has to stop the cartels from looking at it as a business decision, which would carry a great amount of harm throughout the United States.

I thank you for participating.

And I yield the remainder of my time.

Mr. Guthrie. The gentleman yields back.

The chair now recognizes Ms. Craig from Minnesota for 5 minutes for questions.

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

And especially to our witnesses, thank you for being before us today to address this absolute crisis here across our country and in Minnesota's Second Congressional

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District that I represent.

You know, families across America are suffering unthinkable losses as a result of these drugs. I know firsthand that our Nation's public safety and healthcare professionals are on the front lines of this battle. In November of last year, I was on a ride-along with the Shakopee Police Department in my congressional district. Our first call of the night led us to the scene of a public drug overdose, where I watched Officer Soto and two of her colleagues literally bring a young man back to life from the bathroom floor of a family restaurant.

I know that is just another night in the line of work that they are in, but addiction, mental health, and other challenges have stretched them thin. We in Congress owe them both the utmost respect and the conviction to address and fight these issues, or we face the possibility of losing countless more lives to this opioid crisis.

We owe the parents, the grandparents, the friends, and family of all that were not saved the responsibility to address these issues in a comprehensive way and not use these tragedies as another political wedge issue.

Look, I know this is complex. Congress doesn't do complex very well. I have learned that in my first 4 years in Congress. And I am disappointed this morning that my Republican colleagues, some of them, have decided to use this hearing as a partisan pulpit rather than address this as a forum to talk about bipartisan solutions to this deadly epidemic.

Yes, we have to disrupt the flow of these drugs and their raw materials into our Nation. Yes, we have to ensure that Customs and Border Patrol have what they need in order to detect and seize these drugs at our border. Yes, we must permanently schedule these drugs as Class I.

And, yes, we have to figure out what to do about social media companies across

our Nation that are promoting on Snapchat and other platforms these drugs to our young people. And, yes, we have to treat addiction across our Nation.

You know, we sit up here this morning and we ask you single questions in 5 minutes, and none of those individual questions encapsulates the enormity and complexity of these issues.

So I am just going to start with this, and I only have about 1 minute for each answer. But, first of all, the legal ports of entry, what else do you need to keep them from getting to our Nation in the first place? What do you need from Congress?

Mr. DeLena or Mr. Chester?

Mr. DeLena. Thank you, Congresswoman, for your question and for sharing that story of your ride-along and the heroic actions of the men and women in law enforcement that day. That is a scene that I have seen play out personally in all of the communities that I have served. I know that first responders are doing that same exact duty all day every day, and we are seeing it in communities throughout the entire United States.

What we need is the permanent class-wide scheduling of fentanyl-related substances. That is a critical step for us as we move forward.

I would like to thank Congress for the enhancements that came to our budget last year. That is very important to us. DEA's operations that I mentioned, Operation Overdrive and One Pill Can Kill -- One Pill Can Kill, not just an enforcement operation but an actual outreach and awareness program that is having such impact in all of our communities -- and the counter-threat teams that I talked about.

We need the support of Congress to be able to continue to move forward. We want to stay ahead of these cartels when it comes to our infrastructure, our digital and data. We need that support to be able to stay ahead of those violent, ruthless drug

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cartels.

Ms. Craig. Thank you so much.

And just one more time, why do we need to treat this as a public health topic? Why do we need a public health solution?

Dr. Gandotra. Thank you for that question.

Certainly, it affects all aspects of public health -- communities and schools, as well as employment, the GDP, as well as crisis services. We would like to address this on several fronts, as it affects all aspects of our lives.

Ms. Craig. Thank you so much.

And, with that, Mr. Chairman, unfortunately, my time has expired. I yield back.

Mr. Bucshon. [Presiding.] The gentlelady yields back.

I now recognize the gentlelady from Tennessee, Mrs. Harshbarger.

Mrs. Harshbarger. Thank you, Mr. Chairman.

Thank you to the witnesses today.

Mr. Chester, some Members of Congress and a number of State attorney generals, both Democrat and Republican, support designating illicit fentanyl analogs and all precursor chemicals as weapons of mass destruction, whether through executive branch action or congressional legislation, either way.

This would increase interagency coordination to stop fentanyl and would increase resources for technical development and deployment of sensors to detect fentanyl and analytical, data-based decisionmaking.

What are your thoughts on the merits of such a policy?

Mr. Chester. Thank you very much for that question.

That issue and the related issue of a foreign terrorist designation are something that the administration has looked very, very closely at across the interagency, and we

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have examined it from top to bottom.

The fundamental question is, would doing so provide us any capabilities, authorities, or procedures that we don't already have and are not already applying to this problem? And the answer is "no."

All of the architecture, the structure, the capability, and the authorities that we need to be able to deal with this problem in a comprehensive way we have available and we are already applying to this particular problem.

Mrs. Harshbarger. Okay.

I have another question for you, sir.

The High Intensity Drug Trafficking Areas, the HIDTA, program that was created back in 1988 is administered by ONDCP and provides assistance to law enforcement agencies at the Federal, State, local, and Tribal levels. They are operating in regions of the United States that have been deemed as critical drug-trafficking regions.

My district is east Tennessee, and we are part of the Appalachian HIDTA. And that plays an important role in pursuing the disruption and dismantlement of drug-trafficking organizations and drug threats in the Appalachian region. And we have been inundated, along with southwest Virginia and eastern Kentucky, with that.

Its activities include multi-agency intelligence-sharing and enforcement initiatives involving investigation, interdiction, and prosecution and also drug use prevention and treatment initiatives.

Over the past several years, Congress has steadily increased appropriations for this program, funding it at $280 million in fiscal year 2019 to a point most recently for fiscal year 2023 at $302 million.

My question is, do you believe it is sufficient funding for HIDTA? And explain your answer as to why or why not.

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Mr. Chester. First off, I agree with your characterization of the HIDTA program. And, particularly, the Appalachia HIDTA and Vic Brown do an enormous job in that part of the country. And we appreciate very much the Congress's continued support for the HIDTA program, and we appreciate the funding that we have received.

What I can tell you is that every single penny that the Congress provides the HIDTA program is put in the right place to do the right work that they need to do to protect our communities and protect our country. And we thank you for that.

Mrs. Harshbarger. Well, do you think it is sufficient?

Mr. Chester. Yes, ma'am. We appreciate all of the funding that we have gotten. Thank you.

Mrs. Harshbarger. Okay. Very good.

Mr. DeLena, the DEA -- I am very familiar with the DEA and a bunch of other three- and four-letter agencies in my profession, as a matter of fact.

My question to you is, can you provide us an update on the status of DEA's two proposed rules addressing controlled-substance prescribing via telemedicine? And when will they be released to the public for review and comment?

Mr. DeLena. Thank you, Congresswoman, for your question.

DEA takes telehealth very seriously, and it is something that we are moving forward towards. My understanding is that we are very close to making that. Anything beyond that, I could take it back and try to get back to you with a more accurate update.

Mrs. Harshbarger. Okay. So it is not open for public comment yet, but you are close.

Does that mean you have put rules on the books to where we can look at some of the -- I mean, I can't give you information if I don't know what you have talked about.

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Mr. DeLena. Thank you. I don't have that exact answer, but I will get it back to you.

What I can say is, you know, we want to ensure that Americans have access to telehealth, and it has to be done in a way that is safe and, you know, has guardrails that prevent from overprescribing and misprescribing and diversion.

Mrs. Harshbarger. Yeah. Absolutely.

With such a short timeframe before the end of COVID, what is DEA's plan to ensure patients don't lose access to those controlled substances that they need? And I guess that would include buprenorphine as medication for opioid use disorder.

And, you know, I look at that in different ways. I have seen it misused. There are people who take those strips, you know, heat them up, use them as injectables. There is a lot of diversion that goes on with that. But you can't just stop somebody. But you don't try to drag forward a drug either. You know, there is a lot that goes into that.

I just wondered what your thoughts are on that.

Mr. DeLena. Thank you, Congresswoman.

We are committed -- DEA is committed to continued access to medications for opioid use disorders. When the COVID-19 public health emergency has ended, we will address that when it happens, and we will take steps to make sure that everybody that is seeking medication has access to it.

Mrs. Harshbarger. Okay. All right. Thank you, sir.

And, with that, I yield back.

Mr. Bucshon. The gentlelady yields back.

I now recognize Ms. Blunt Rochester from Delaware for her 5 minutes.

Ms. Blunt Rochester. Thank you, Mr. Chairman, for the recognition, and

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congratulations.

I also want to thank the Biden administration officials testifying today for their tireless efforts to disrupt the global illicit drug-trafficking enterprise as well as your efforts to address the public health and national security challenges that this crisis presents.

Fentanyl remains the deadliest drug threat facing the people of Delaware and America. In 2021, Delaware had the fourth-highest rate of drug overdose deaths in the country, and over 80 percent of these deaths involved fentanyl.

That is why addressing the opioid crisis, now driven by fentanyl, is one of my top priorities in Congress. I am pleased my colleagues on the other side of the aisle have also prioritized addressing the fentanyl crisis, because, at over 100,000 overdose deaths per year, this crisis is sparing no one.

Unfortunately, the legislation we are considering today misses the mark. The approach we are considering today focuses almost exclusively on law enforcement solutions, and, as I have said many times before in this committee, we cannot incarcerate ourselves out of this public health problem.

I have been working on legislation with Congresswoman Kuster called the STOP Fentanyl Act to comprehensively address both supply-side and demand-side drivers of the fentanyl crisis. I want to run through a few important provisions of this legislation.

Our bill will help States improve their fentanyl surveillance and forensic laboratories so that States can distinguish between fentanyl, fentanyl analogs, and fentanyl-related substances.

It will improve access to all forms of medication-assisted treatment, including methadone, which, along with psycho-social therapies and community-based recovery supports, is the gold standard for treating those with opioid use disorder.

It will extend the reach of harm-reduction programs so that they can help keep

more people alive long enough to seek treatment.

And it will support law enforcement agencies in detecting and handling fentanyl.

And my first question: Dr. Gandotra -- make sure I say that correctly. Is that correct?

Dr. Gandotra. Thank you. That is correct.

Ms. Blunt Rochester. Can you describe SAMHSA's approach to expanding harm-reduction strategies and evidence-based treatment? And explain why focusing on those suffering from substance use disorder is important, why it is important, focusing there.

Dr. Gandotra. Thank you, Congresswoman, for this question.

This is part of SAMHSA's mission, to not only address substance use disorder but reduce the harms that are associated with its use. Harm reduction is an important pathway to ensure that patients who may not be ready to engage in full treatment are at least able to mitigate the harms associated with use.

Harm-reduction principles such as overdose mitigation with naloxone has been shown to be very beneficial, not just in training providers but also making them sensitive to asking the right questions. In addition to that, if we don't identify patients, we are not actually able to get them into treatment.

Of course, medications for opioid use disorder are the gold standard for preventing overdose mortality. So certainly we expand that with our substance use block grants as well as our State opioid response grants, as well, which dedicates billions of dollars to the States.

Ms. Blunt Rochester. Thank you.

Our legislation focuses heavily on public health surveillance and data collection, because data is a powerful tool that can help us target resources to those most in need.

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For example, through robust data collection on overdoses in Delaware, public health officials identified that 23 percent of overdose deaths in recent years occurred among those working in the construction industry.

Through this information grew a partnership between public health officials and the State's construction industry to directly distribute Narcan into the hands of workers at risk, train supervisors on overdoses, and train workers on the stigma associated with addiction.

Mr. Chester, can you share how Biden administration agencies currently track fatal and nonfatal overdoses? And do you have suggestions on how the many different data sources can be integrated in a way that is more helpful to policymakers?

Mr. Chester. Thank you, Congresswoman. I will be as quick as I can.

The tracking of fatal overdoses is done by the Centers for Disease Control and Prevention through the National Center for Health Statistics. What we were lacking was nonfatal overdose data, which is a prime indicator for the eventuality of a fatal overdose.

Just recently, within the last 2 months, ONDCP has launched a dashboard that works with other agencies to track nonfatal overdose data, which is incredibly important. And we work across the interagency in order to track that.

The most important thing that we can do -- and I think you brought this up in your statement -- is to use that data and bring it together to figure out those areas that have the greatest need, where we can surge resources and make the greatest effect. And that is principally how we use that data.

Ms. Blunt Rochester. Thank you so much.

I am over time. I will be reaching out to you with a question about data and DEA.

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

Mr. Bucshon. The gentlelady yields back.

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I now recognize the gentleman from Georgia, Mr. Carter, for his 5 minutes.

Mr. Carter. Thank you, Mr. Chairman.

And thank all of you for being here.

I think that we would all agree -- members of the committee, witnesses, everyone in America -- this is an epidemic. This is something that has got to be addressed. We all know what is going on here.

And there are a number of reasons, none that are more important than the fact that we have to secure our southern border. I mean, we all know that this is where the vast majority, if not all, of the fentanyl is coming across, and it is causing problems. A lot of people look at the border situation, the crisis that exists down there as being just illegal immigrants coming across, but we know that it is much more than that.

And we know that it is infesting all of our communities. In my district, we -- and I represent south Georgia. I represent the entire coast of Georgia, but I have a lot of rural areas in south Georgia. We had an incident just last week where we had a number of people who overdosed in a small community, a small rural community in south Georgia, and overdosed on fentanyl. And if it weren't for the heroics of the public safety personnel in administering Narcan and naloxone, they would have perished.

And we know what is happening here, and I won't take up my valuable time with repeating all the numbers. You know, 7 billion -- enough fentanyl in this country to kill 7 billion people, almost 21 times our population. Unbelievable.

You know, I want to share to you a quick story that happened to me. And, you know, I am a pharmacist, and it happened to me. I was at a townhall meeting this past August, and I made a comment about fentanyl addiction, and a mother rightfully corrected me. She said, "No, sir. You are wrong." She said, "It is not fentanyl addiction. It is fentanyl poisoning." She said, "My son took one pill, and he is dead."

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She was right, and I was wrong. It is fentanyl poisoning. And we have to do something about it, and we have to address it. The number-one killer, according to the CDC. It is the leading cause of death in the U.S. for adults age 18 to 45.

So, enough of that. Mr. Chester, I will start with you and ask you: In a White House press release dated September the 2nd of 2021, DEA Administrator Anne Milgram stated, "The permanent scheduling of all fentanyl-related substances is critical to the safety and health of our communities. Class-wide scheduling provides a vital tool to combat overdose deaths in the United States."

Is support for permanent scheduling the official position of the Biden administration?

Mr. Chester. Yes, Congressman, it is. We support the scheduling of fentanyl-related substances as a class. We do.

Mr. Carter. I want to remind members of this committee and everyone here that we are considering the HALT Fentanyl Act, and that would permanently schedule fentanyl-related substances and keep them out of our communities, hopefully.

You know, I dealt with this when I was in the Georgia State legislature and a member of the pharmacy caucus there. We dealt with this every year when trying to identify the analogs and trying to -- and every time we would identify them one year, they would come up with different ones the next year. It was just a vicious cycle.

This is something that has to be done. And I hope that we will have the administration's support with this, and I hope we will have everyone on this committee's support.

Mr. DeLena, I want to ask you -- and I can't help but bring up this report that was in The Washington Post recently about some of the problems that we have had with the DEA agents down in Mexico. In fact, we had a 6-month time when we were without

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personnel down there that we should have had.

And I just need -- I need reassurance from you that the personnel problems that we have had down in Mexico, particularly with the DEA agents, have been straightened out.

And I think you know what I am talking about. I am talking about, specifically, the DEA's Mexico office was in turmoil for more than 6 months, with the director recalled to Washington while investigators probed his conduct.

Mr. DeLena. Congressman, thank you for your question.

While I can't comment directly on a personnel matter, what I can tell you is that DEA's top operational priority is defeating these Mexican cartels. And the --

Mr. Carter. That is not what I asked you. Come on, now.

Mr. DeLena. The administration --

Mr. Carter. You need to give me confidence that you all got this straightened out. This is too important. Two hundred people are dying every day.

Mr. DeLena. Thank you, Congressman.

The Administrator in summer of 2021 ordered a review of all of our foreign operations to make sure that we have the right people and that we are most effective in all of the places where we are situated --

Mr. Carter. This article also indicates that the Mexican Government is not working with us on this. Can you shine any light on that with us?

Mr. DeLena. Congressman, thank you.

The Mexican Government needs to do more. We are there in Mexico laser-focused on the cartels and the fentanyl and methamphetamine that they are producing, but we know that they need to do more when it comes to collaboration. And --

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Mr. Carter. I trust that you all are getting your staff worked out, straightened out, your situation straightened out. Two hundred people every day. We don't have time. We don't have time for this. We have to do something about this right now.

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

Mr. Bucshon. The gentleman yields back.

I now recognize the gentlelady from Washington, Ms. Schrier, for her 5 minutes.

Ms. Schrier. Thank you, Dr. Vice Chair.

And thank you to these excellent witnesses for being here today. I have learned a lot from this conversation.

In my State of Washington, like every other State, fentanyl has had profound and devastating impacts. Just months ago, in my hometown of Sammamish, a Seattle suburb, two parents of a toddler were buying, using, and dealing fentanyl. They left pills on their nightstand. Their toddler found them, and the toddler died from the overdose.

On the other side of my district, in Chelan County, a rural county in the eastern part of my district, the coroner recently reported that deaths from fentanyl overdose rose from 6 in 2021 to 20 in 2022.

And, in recent years, local high schoolers have died from fentanyl overdoses because they did not know that a pill that a friend gave them or that they got elsewhere or online was laced with fentanyl.

And I know that every one of us -- and we have heard them today -- every one of us has stories just like this from our own districts.

Mr. DeLena, you noted in your testimony that the Drug Enforcement Agency investigated more than 129 cases directly linking the sale of fake pills containing fentanyl to social media sites, and then alluded to Snapchat just earlier with links that disappear. And this is where teens are getting these pills.

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So, as a pediatrician, I need to ask, can you talk a little bit more about what the DEA is doing on this issue to make sure we don't keep losing our kids? Because they are all on social media.

Mr. DeLena. Congresswoman, thank you for the question.

And your references to the tragedies that occurred in your district -- at DEA, we have over 4,800 photos of those that have been lost to fentanyl poisoning in our lobby. The youngest is 17 months, and the oldest is 70 years. So, you know, this drug does not distinguish.

We are laser-focused on the cartels that are pushing this drug into our country, and we know that those drug cartels and their entire drug-trafficking organizations are using social media platforms to try to reach hundreds of millions of potentially new customers. Because that is truly where Americans are spending time, is on those social media sites, particularly young people, which is something that, you know, is gravely concerning to all of us.

We need to continue with programs like One Pill Can Kill, where not only are we conducting enforcement and seizing these pills -- 50 million pills DEA seized last year -- but we are educating and getting the word out there. We --

Ms. Schrier. In addition to educating parents and students, what is your interaction with social media sites on this? Do you get cooperation? And what do you need from Congress to get those tools?

Mr. DeLena. Thank you, Congresswoman.

We do interact with the social media companies. We do so on a regular basis, specific to each investigation that we are conducting. But we know that these social media companies can and must do more.

They control all of the algorithms. They know how content is being pushed to all

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of their hundreds of millions of users. They control all of the data. And unless we can get a look inside there, as DEA, or, as you said, for Congress to be able to do something, we can't make those type of recommendations.

So there needs to be more transparency. If they want to fix this problem, they can fix this problem.

Ms. Schrier. Thank you. This is an area that I look forward to working with my colleagues on both sides of the aisle to figure out for a variety of reasons.

I have another question for you. As you may know, Washington State has many ports. And I have supported legislation to build up law enforcement capacity to detect synthetic drugs.

And I appreciate that your testimony also focuses on the southern border. Can you tell me a little bit about what DEA is doing to monitor at our seaports?

Mr. DeLena. Thank you, Congresswoman.

First of all, DEA is focused on wherever the threat takes us and wherever these investigations shall lead. We do work in all of our communities not only with our other Federal partners but with our State and local partners as well. I have personally been involved, in my tenure, particularly in my time in Florida, with investigations that lead us, you know, to the sea. And we work hand-in-hand with those that are conducting those investigations.

And each of it is threat-based. If we know that there is a threat, you know, in your specific area coming in through the seaport, we are going to be focused on that.

Ms. Schrier. Thank you.

I don't have time to get an answer to this, but, Dr. Gandotra, I would love it if you could, afterwards, submit perhaps a list of places that parents can consult so that they can have conversations with their children about how to not fall prey to fentanyl

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poisoning online.

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Ms. Schrier. Thank you. I yield back.

Mr. Guthrie. [Presiding.] Thank you.

The gentlelady yields back.

The chair recognizes Dr. Miller-Meeks for 5 minutes for the purpose of asking questions.

Mrs. Miller-Meeks. Thank you very much. And I thank the chair and all the witnesses that are here for this extraordinarily important topic.

And just as an introduction to you, I am a physician, as is Dr. Schrier. I am the former director of the Iowa Department of Public Health, under which behavioral health, substance use disorder was a part. And I also was a State senator and, as a State senator, passed no pre-authorizations for medicated-assisted treatment, or MAT, for substance use disorder in one session; also, schools as a site of service for behavioral health, which I think was very forward-thinking at the time.

And so my question, Dr. Gandotra: SAMHSA's 2022 report titled "National Guidelines for Child and Youth Behavioral Health Crisis Care" outlines best practices for implementing mobile crisis response teams. And we have set these up in Iowa, when we have set up our child and mental health -- or like I would prefer to call it, brain health -- systems. These mobile crisis teams are typically made up of mental health professionals, nurses, and peer support providers.

The report recommends that these teams respond to crises without law enforcement accompaniment unless special circumstances warrant their inclusion.

And let me also say that in SAMHSA's September 2021 Ready to Respond, also on mental health, on page 20, it also notes shifts away from traditional law enforcement responses in many cases.

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So my question: Is it SAMHSA's position that mobile crisis teams should respond to calls in lieu of law enforcement?

Dr. Gandotra. Thank you for that question.

Certainly, we understand that, when it comes to crisis management, providers who are going to deliver the service have to maintain their safety but also approach this from a trauma-informed perspective, understanding that sometimes individuals who have experienced past trauma may be more vulnerable and more sensitive to the application of law enforcement entities. Certainly, that has to be balanced with public safety as well as the information that is given.

And that is really the key, is having the most information, most up-to-date information, so that the approach can be tailored and individualized for those purposes, would be my first and ideal situation. Certainly --

Mrs. Miller-Meeks. So, just to make sure I am understanding, you are saying it is not in lieu of law enforcement.

Dr. Gandotra. I am saying it should fit, from the information, from the clinical perspective, what is best required for the safety of the patient as well as for the community provider that is delivering that service, certainly.

Mrs. Miller-Meeks. So, as in an episode we saw -- and this was not a child, but -- in subways in New York City where someone was pushing somebody else off a train track but they are in a mental health crisis, how do you respond to that then? Because you may not have that information when a 911 call is made to know clinically what is the best approach. So, again, is it in lieu of law enforcement?

And, then, what are the criteria for determining special circumstances that warrant the involvement of law enforcement? That perhaps will better answer this question.

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Dr. Gandotra. So the strategy that should be employed would be an evidence-based strategy that would still incorporate trauma-informed approaches but still maintain safety for the individual delivering the care as well as the individual needing the care. We would try to encompass all aspects of the needs of the provider as well as for the patient.

Mrs. Miller-Meeks. Well, I can certainly see that, perhaps, if someone is calling a crisis line before there is a crisis. But when there is an actual incident, as you may see in public, it could be very difficult to do that.

So thank you so much for the answer, and perhaps you could elucidate that further in writing.

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Mrs. Miller-Meeks. And I yield back my time.

Mr. Guthrie. The gentlelady yields back.

The chair now recognizes Mr. Crenshaw from Texas for 5 minutes for asking questions.

Mr. Crenshaw. Thank you, Mr. Chairman.

Thank you all for being here.

I would like to direct most of my questions towards you, Mr. DeLena. I do have an interest in battling what seems to be a war with the cartels south of our border.

One of my first questions to you is: You know, you laid out three strategies the DEA is currently engaged in, but do you really have enough resources? And do you need more engagement from other entities, such as the intelligence community and perhaps the Department of Defense? What else do you need that would help battle this problem?

Mr. DeLena. Thank you for the question and for your commitment to this issue, Congressman.

DEA is equipped right now with the resources that have been allocated to us to focus on these two cartels. Any additional resources is something, obviously, that, you know, we would be open to and to discuss, but it would have to be sort of specific to, you know, maybe what you are talking about.

Mr. Crenshaw. Well, yes, you have certainly been allocated the resources, and that is what you are working with. I understand that to be the case. But the question is not that. It is, is it enough? Are you making an impact against these cartels?

And if not -- clearly not, because they are able to wage a war against the Mexican Government at will in the state of Sinaloa just recently, a couple weeks ago. So,

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obviously, we are not doing enough. What more is needed?

Mr. DeLena. Congressman, thank you.

I think, you know, with the successes that we talked about, that DEA seized over 50 million pills last year and 10,000 pounds just of fentanyl and, you know, an exorbitant amount of methamphetamine as well, you know, our focus right now is to defeat those two cartels and --

Mr. Crenshaw. Okay. Okay. What about authorities?

So I have a bill that I am reintroducing today called Declaring War on the Cartels Act. And what this does is deliver the same authorities that you would have to go after ISIS without necessarily labeling them as a terrorist organization.

Would that be helpful? Because that would allow you to go after their financing. It would allow the U.S. Government to sanction officials in Mexico that operate with the cartels. Would that be helpful?

Mr. DeLena. Congressman, thank you.

I can't comment on pending litigation like that. We would work the interagency process as those things came in.

Mr. Crenshaw. Sure. I imagine it would be helpful if you had more authority. That is not a trick question. Yeah.

All right. What is your cooperation like with the Mexican Government? Is it good? Is it bad? Has it been better? Does it mirror at all the longstanding cooperation we have had with, say, the Government of Colombia during Plan Colombia and the successes we have had there?

Mr. DeLena. Thank you, Congressman.

This is obviously a fluid and rapidly evolving situation. We see these cartels in their switch from plant-based drugs to synthetic-based drugs. This thing continues to

evolve every single day.

We know that the Mexican Government needs to do more. They need to take steps in their own country, and they need to assist us additionally than how they are already doing that right now.

Mr. Crenshaw. Okay. So, no, they are not doing enough. They don't cooperate with you to the extent that you would like.

Do you trust them? If you give them intelligence -- like, for instance, I am assuming that you know where some of these clandestine labs are that they are making fentanyl that is killings tens of thousand of Americans a year. I am assuming you know that. You currently do not have the authority to go raid that facility in Mexico. The Mexican Government does. If you tell them about it, will they go take care of it?

Mr. DeLena. Congressman, thank you.

I don't want to get into specifics of investigations, and that is essentially --

Mr. Crenshaw. I am not asking you to get into specifics. I am asking you in generalities. You know where a bad guy is; you tell the Mexican Government to go get them. Will they do it? Do you even trust them with that information, or do you think they will tip them off?

Mr. DeLena. Thank you, Congressman.

The Mexican Government needs to do more. They need to seize those drug labs. They need to disrupt those drug labs. They need to assist with extradition on the investigations that we build.

Mr. Crenshaw. All right. You are being very diplomatic, and that is fine.

Earlier, you mentioned specifically the Jalisco Cartel and the Sinaloa Cartel. It is worth also naming the leaders of those cartels and how dangerous these two particular people are to tens of thousands of Americans. The leader of the Jalisco Cartel is

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Nemesio Oseguera Cervantes. They know him as El Mencho. The leader of the Sinaloa Cartel is Ismael Zambada Garcia, known as El Mayo.

Everyone should know who these two guys are, because they are killing tens of thousands of Americans. We all know who Osama bin Laden is. We started a war just to go after him. And we should start a war with these cartels, because they are at war with us. And I would encourage all of my colleagues, across the aisle, all Republicans, all Democrats, to join with us on this issue.

I have currently introduced an Authorized Use of Military Force to go after the cartels specifically with every aspect of our government's power. I think this needs to be a whole-of-government approach. And I think we need to be unified, as Democrats and Republicans, in dealing with this problem.

Thank you.

Mr. Guthrie. Thank you.

The gentleman yields back.

The chair now recognizes Mrs. Trahan from Massachusetts for 5 minutes to ask questions.

Mrs. Trahan. Thank you, Chairman Guthrie -- and I am sorry the elevator closed on us earlier -- Ranking Member Eshoo.

Thank you to the administration witnesses for being here today.

Based on today's hearing, it is clear that passing policy solutions to address the fentanyl crisis is top of mind for Democrats and Republicans alike. And I hope this will be one of many hearings this subcommittee holds to build on the bipartisan addiction prevention and treatment policies like the MAT Act that we passed at the end of last Congress.

The Biden administration's proposal to permanently schedule FRS within

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Schedule I includes an important off-ramp to reschedule an FRS found to have medicinal value, as well as research provisions which have been adopted by my Republican colleagues in their HALT Fentanyl bill.

It is important because fentanyl itself has an approved medical use, and it is possible there are unknown pharmacological effects and therapeutic potential for the entire class of substances if studied and regulated properly. For example, studying FRS may be key to discovering the next generation of naloxone, commonly known as Narcan, which will help to save lines.

Our recent trends in overdose deaths show the emergence of fentanyl adulterated with a powerful animal sedative called xylazine, which has been talked a lot about today, more commonly known as "tranq dope."

According to the Lowell Sun, the paper in my district, first responders have already seen this deadly drug make its way into Lowell, the gateway city where I grew up and I represent. In fact, the Lowell Police Department has sent out alerts to residents to inform them of the dangers of this drug. The city worries that Narcan does not counteract xylazine like it does with fentanyl. And the FDA issued a similar alert back in November.

So, Dr. Gandotra, can you please shed light on how naloxone was discovered and how research into FRS may lead into similar opioid antagonists?

Dr. Gandotra. Thank you, Congresswoman, for the question.

Certainly, we know naloxone is an important tool for reversing opioid overdose. It was discovered in the 1960s by a researcher who was trying to alleviate symptoms of constipation from chronic opioid use, and it is derived from oxymorphone.

I will also state that it is this property as an opioid antagonist that makes it incredibly useful as a mono product for reversing overdoses but also as a combination

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product with buprenorphine for Suboxone for opioid treatment and has quite a different risk profile and diversion profile, making that a wonderful, evidence-based practice for treating opioid use disorder.

Mrs. Trahan. Thank you, Doctor. It seems that we do agree that reforming the research landscape is key to finding new therapeutic treatments and those lifesaving antidotes.

I am going to attempt to switch gears a bit, because I would like to focus on access to treatment for opioid disorder.

Since March 2020, the DEA, under authorities associated with the public health emergency, has allowed registered clinicians to prescribe some controlled medications after a telehealth examination for patients suffering from mental health issues.

The expansion of telehealth services has been vital to patients across the country who rely on controlled-medication prescriptions to support their mental health care and aid in their recovery. And there is broad support across the medical community for maintaining access to controlled-medication prescribing through telehealth to ensure patient access to treatments even if they can't make it into the doctor's office.

I was pleased to see that a very recent study published in GEMMA Network found that rules permitting doctors to prescribe buprenorphine via telehealth to treat OUD did not increase overdose deaths involving the drug.

Congress has directed the DEA to establish a special registration for providers to prescribe controlled medications through telehealth. Congresswoman Kuster and I have urged DEA to release this special registration and maintain access to OUD treatment via telehealth.

With the public health emergency ending on May 11th of this year, it is unlikely that the special registration process will be in place, and patients may lose access to a

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critical pathway of treatment.

So, Mr. DeLena, what is the timeline for this special registration proposed rulemaking? And to avoid a gap in access to treatment and care, does DEA intend to extend that waiver allowing clinicians to prescribe controlled medications through telehealth until the special registration process is in place?

Mr. DeLena. Congresswoman, thank you for the question.

DEA strongly believes that Americans should have access to telehealth but it has to be done so in the appropriate way to avoid overprescribing and misprescribing.

I can't speak to the specific dates and what you are asking for, but I can certainly take that back and try to get you some of that information.

Mrs. Trahan. Terrific. Thank you so much.

[The information follows:]

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Mrs. Trahan. I have run out of time. I yield back.

Mr. Guthrie. Thank you.

The gentlelady yields back. And that does conclude our first witness panel.

And I will just say to all three of you: A couple of things we might have had a difference of opinion on, but I know we are going to have to all work together. And I respect all of you, and we look forward to going forward, because this is a crisis.

There are other bills on the agenda as well, but certainly the fentanyl crisis is first and foremost in everyone's mind. So hopefully we can find opportunities to move this legislation forward in a way that we all can support in the end but also be effective. So we have to have both moving forward.

So thank you very much. Thanks for your patience. Thanks for being here, and thanks for your answers. And there was a couple of "ran out of time; you are going to have to answer on paper." I know we have a record of that, and we look forward to your timely responses for that.

So the first panel is dismissed, and we will set up for the second panel.

[Recess.]

Mr. Guthrie. Well, thank you. The subcommittee will come back to order.

We appreciate all of our witnesses being here today.

This is the beginning of our second panel. And I will introduce our witnesses, and then we will begin our witness testimony.

First we have Ms. Kandi Pickard, the president and CEO of the National Down Syndrome Society.

Then we will hear from Frederick Isasi -- is that correct? Because we all want to know how to say your names correctly -- Isasi, the executive director of Families USA.

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And then from Molly Cain, a parent advocate who has been directly impacted by the fentanyl crisis.

And then Dr. Stephen Loyd, the chief medical officer of Cedar Recovery.

And, finally, we will hear from Dr. Timothy Westlake, an emergency room physician and former chairman of the Wisconsin Medical Examining Board as well as former member of the Badger State's Controlled Substance Board.

So we thank you all for being here and thank you for your testimony. It is all important to know. Some of you bring in personal stories.

And some of you haven't testified here before, so I am just going to explain. You will see the lights in front of you. You have 5 minutes to do your opening statement. After 4 minutes, you will see a yellow light to kind of let you know when moving forward.

But I know you have some stories to tell, so we are not going to gavel you down too hard. We want to hear your stories. And so, just relax. And if you are not -- people that haven't testified before, sometimes that can be daunting, but we are glad to have you here.

And we will begin with Ms. Pickard. You have 5 minutes -- you are recognized for 5 minutes for your opening statement.

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STATEMENTS OF KANDI PICKARD, PRESIDENT AND CEO, NATIONAL DOWN SYNDROME SOCIETY (NDSS); FREDERICK ISASI, EXECUTIVE DIRECTOR, FAMILIES USA; MOLLY CAIN, PARENT ADVOCATE; STEPHEN LOYD, CHIEF MEDICAL OFFICER, CEDAR RECOVERY; AND TIMOTHY WESTLAKE, EMERGENCY MEDICINE PHYSICIAN

STATEMENT OF KANDI PICKARD

Ms. Pickard. Thank you.

Chairwoman Rodgers, Chair Guthrie, Ranking Member Eshoo, and members of the committee, thank you for inviting me here today to testify on quality-adjusted life year measures, or QALYs, in combating discrimination against people with disabilities.

My name is Kandi Pickard, and I proudly serve as the president and CEO of the National Down Syndrome Society. I am also the proud parent of four children, including my 10-year-old son, Mason, who has Down syndrome.

As the leading human rights organization for all individuals with Down syndrome, NDSS stands in strong support of a nationwide ban of the use of QALYs and similar measures in coverage determinations under Federal healthcare programs, like the one proposed in the Protecting Health Care for All Patients Act of 2023.

As you know, QALYs place numerical value on the quality of one's life before and after healthcare treatments and interventions, and these calculations are then used by Federal health programs to determine the cost-effectiveness of treatments and services and, thus, coverage for patients.

Since a substantial number of individuals with disabilities receive their healthcare through Medicaid, this flawed and discriminatory metric directly impacts access to necessary healthcare treatments when they are not deemed cost-effective enough to

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administer to individuals with disabilities.

At NDSS, we are very concerned about the use of QALYs and other value assessments in all instances. And I would like to share two examples of how these discriminatory practices are affecting the Down syndrome community.

People with Down syndrome are uniquely situated in the Alzheimer's landscape because of their extra copy of chromosome 21, which carries the amyloid precursor protein gene that is strongly associated with Alzheimer's disease.

As a result, individuals with Down syndrome have a higher than 90 percent lifetime risk for developing Alzheimer's disease, with the onset of symptoms coming earlier and progressing faster than the general population. In fact, Alzheimer's disease is the number-one cause of death for individuals with Down syndrome.

CMS recently cited several studies that relied on QALYs in their national coverage decision for Aduhelm, a first-of-its-kind Alzheimer's treatment.

Access to treatments for this life-altering disease is paramount for our community, yet value assessments such as QALYs and other similar one-size-fits-all approaches are heavily relied upon in coverage decisions. Medicaid coverage decisions cannot be made based on flawed assessments that devalue the lives of people with disabilities, especially when those lives are uniquely at risk, as is the case for our loved ones with Down syndrome.

Discriminatory metrics and value assessments are also experienced by individuals with disabilities in the organ transplant system. A 2019 report from the National Council on Disability, an independent Federal agency, found that discrimination against people with disabilities persists in the organ transplant system, rooted in biased attitudes about the value of the life of an individual with a disability.

NDSS is proud to champion the bipartisan Charlotte Woodward Organ Transplant

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Discrimination Prevention Act, named after NDSS staff member Charlotte Woodward, who is here with us today, which prohibits discrimination based solely on disability in the organ transplant system.

While advocating for the passage of this bill, we remain vigilant in our responses to other forms of value assessments, such as QALYs, that persist in many aspects of our healthcare system and threaten to access nondiscriminatory healthcare for people with Down syndrome and other disabilities.

Today, alongside a diverse and nonpartisan group of stakeholders, including the National Council on Disability, the Consortium for Constituents with Disabilities, and 100 other disability advocacy groups, I urge you to ban the use of QALYs in Federal programs.

A person's value is more than what can be determined by a metric. My son Mason is no less valuable than my other three children who don't have a disability just because he has Down syndrome. I see the value in how hard he works at school, the love of his siblings, and the joy he brings our friends and family.

It is outright discrimination to deny individuals with disabilities access to treatment and the care they deserve and they need because a calculation determines their value.

Congress deals with many challenging and controversial issues. This should not be one of them. No party condones discrimination against people with disabilities, and both Democrats and Republicans are on the record against the use of QALYs.

I implore you to support this legislation and take the important step of protecting people like my son from healthcare discrimination.

Thank you all for inviting me here to speak today. I look forward to working with the committee on commonsense health reforms that value patients and people with disabilities.

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[The prepared statement of Ms. Pickard follows:]

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RPTR MOLNAR

EDTR ROSEN

[1:00 p.m.]

Mr. Guthrie. Thank you, for your testimony. Let us welcome Charlotte. Charlotte Woods, did you say? What was her last name?

Ms. Pickard. Charlotte Woodward.

Mr. Guthrie. Woodward, stand up, and welcome to our committee. Yeah, thank you. Thank you very much. Appreciate you being here.

So now, Mr. Isasi, you are recognized for 5 minutes for an opening statement.

STATEMENT OF FREDERICK ISASI

Mr. Isasi. Thank you very much, Chairman Guthrie, Ranking Member Eshoo, members of the subcommittee. Thank you for the opportunity to testify today.

I also want to say thank you to Ms. Pickard for the beautiful testimony you just gave.

For more than 40 years, Families USA has been working to achieve our mission of a Nation where the best health and healthcare are equally accessible and affordable to all. We are very proud to have always been, and will always be, a very strong partner with the disability community in support of their healthcare needs.

I know the topic of this hearing is personally very important to many of us, especially full committee Chair McMorris Rodgers.

No matter what our ideology, we are all much more alike than we are different. Everyone struggles with how to care for a loved one, and so many live with the financial stress of high-cost medical bills and the unaffordablity of our healthcare system.

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We at Families USA believe that every person in the United States should have high quality affordable healthcare that prevents illness, allows them to see a doctor, and helps to keep their family healthy.

Yet, almost half of all Americans report having to forego medical care due to unaffordable costs, and almost the same number live under the stress and burden of healthcare debt.

For people with disabilities, the situation is considerably worse. Disabled people are 2-1/2 more times likely to delay or to skip or delay healthcare because of cost, and they are significantly more likely to have unmet medical, dental, and prescription drug needs.

It is because of our dedication to the needs of all families, including people with disabilities, that I urge the subcommittee to oppose the anti-value legislation that is under consideration.

First, the proposed legislation's prohibition on the use of quality adjusted years, or such similar measures, is a solution in search of a problem. The Inflation Reduction Act drug negotiation provisions already have very specific guardrails against discrimination from many groups, including people with disabilities.

Quoting directly from the text of the drug price negotiation law, it explicitly and unambiguously bars measures that treat extending the life of an elderly, disabled, or terminally ill individual as a lower value.

Moreover, similar guardrails exist in other elements of Federal law like the Affordable Care Act. In fact, Families USA, working with our disabled partners, supported inclusion of these very guardrails in the drug price negotiation law.

So given the explicit Federal protections that already exist, what is the real effect of the legislation being considered by the subcommittee today?

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This legislation is a giant loophole to allow the greed of drug companies to continue and would let other elements of our corporate healthcare sector to continue to price gouge, unchecked, hurting millions of families, employers, taxpayers, and healthcare costs will continue to soar.

The proposed legislation uses very broad language that drug company lawyers will argue bans any attempt to develop an understanding of whether a drug is worth the astronomical price being charged across pretty much all Federal programs.

We know that terrible pricing abuses and waste are rampant in our healthcare system, totaling almost a trillion dollars a year. That is right, almost $1 trillion in healthcare spending each year is flat-out waste, hurting both the economic security of families and the U.S. taxpayer.

But we also know that many American families are being hurt because of low quality care. Over a quarter of a million people die each year, not from their illness, but from the medical system itself.

Let me say that again. A quarter of a million souls in our Nation die each year because our healthcare sector is killing them through low value, poor care, all while we continue to spend two or even three times more on healthcare than other Nations.

It is time for this to end, period. It is time for our Nation to hold our corporate healthcare sector responsible for providing high quality care that is affordable.

If Federal policymakers want to live up to our collective ideals of supporting people with disabilities, we should refocus our efforts, and the Medicare disability waiting period, extend Medicaid program in every State, fully fund and staff Medicaid home and community-based services, and train a healthcare workforce that will provide high quality care to people with disabilities with dignity and without discrimination.

I urge members of the subcommittee to oppose this ill-conceived legislation that

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is simply playing into the hands of drug companies' greed. Thank you very much.

[The prepared statement of Mr. Isasi follows:]

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Mr. Guthrie. Thank you for your testimony. I appreciate that.

Ms. Cain, you are now recognized for 5 minutes for your opening statement.

STATEMENT OF MOLLY CAIN

Ms. Cain. Thank you, Chairs Guthrie and Rodgers and Ranking Members Eshoo and Pallone and members of the committee for inviting me to come and speak out about fentanyl, how it has invaded our communities, devastated families, and how it has become a public health crisis.

My name is Molly Cain, and I lost my beloved 22-year-old son Carson to fentanyl poisoning on November 27th, 2020. Thank you for allowing me to share his story.

I would like to begin by painting a story of who Carson was. Carson had a beautiful soul. He loved deeply and was wise beyond his years, and his heart was true.

Carson persevered in the face of adversity. When Carson was 6, he was diagnosed with dyslexia; at 7, he was diagnosed with a familial tremor that progressively worsened, and at 10 years old, he watched his healthy father be ravaged by and ultimately succumb to brain cancer.

Carson and his brother took on more responsibility within our family without being prompted or asked. Carson graduated high school with both his high school diploma and his AA degree and went on to Gonzaga University to further his education.

During his college years, Carson was prescribed Xanax for anxiety. Carson was a genuine and empathetic person who wanted to better the world around him. He would lend a hand or an understanding ear to those in need and did not expect anything in return.

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He was the shoulder of strength others leaned on, especially those friends who had lost a parent. Carson helped to guide them out of the dark abyss they now faced.

During his college years, Carson would plow snow in the early morning hours without request or compensation, would stop at the parking lot of a local cancer center to clear the lot. When asked why he made the stop, he replied, the patients going for treatment have enough challenges, they don't need one more to navigate. These actions embodied his compassionate and devoted spirit.

At 22, Carson was diagnosed with appendix cancer. After a battery of scans and procedures, it was determined the cancer had not spread, but a spot found on his lung needed to be monitored. The anxiety my son had became elevated, and suddenly COVID hit.

Carson, feeling immense pressure, went to counseling and was given Xanax again. He told me he felt counseling online was impersonal, and he was only offered appointments during his working hours. He stopped going.

On November 26, 2020, Carson came home for Thanksgiving. He was exhausted. He said he was not sleeping. He had been working long hours and wasn't able to get the rest he needed. He hugged me goodbye and thanked me for a wonderful dinner and told me he loved me.

The next day, after not hearing from him as I usually would, I called him with no answer. I went to his home, and I found my beautiful, loving son on his living room floor, deceased. I cannot put into words the guttural pain of finding Carson dead and knowing I couldn't save him.

We had to wait almost 3 months for the toxicology report to find out that fentanyl had killed him. During this waiting period, we had Carson's phone, and he began to receive Snapchats with pictures of drugs and emojis from an individual.

We dug into Carson's Cash App account and discovered a payment to the same individual the night he passed away. For months, the individual continued to Snapchat pictures of drugs and emojis.

The EDA did a sting. The individual served less than 24 hours in jail.

I was the one who brought the drug dealer's account to the attention of Snapchat. Snapchat claims they have filters in place to monitor for such illicit activity. Then why for 5 months did this individual continue to Snapchat such things if Snapchat's filters were operational?

In my opinion, Snapchat is the courier, and they provide the get-away for the traffickers of this poison.

In the months and now years that have ensued, I have grieved immeasurably. I knew what devastation was after losing my husband, but losing my child has left a gaping hole within my being.

The heartache and pain is gripping. My son bought something, thinking it would ease anxiety, a mistake that cost him his life. It was not his intent to die. These individuals who are dying are not overdosing. They are being poisoned.

In the 2 years since Carson's death, tens of thousands of people have lost their lives to this weapon of mass destruction. Many victims were unknowing.

We need to be educating our children and families alike about fentanyl and its lethal effects. It has been published that in Seattle, the fentanyl crisis is so bad the medical examiner is running low on storage for the dead bodies.

I was told by a DEA agent that we will not see an end to fentanyl in my lifetime. I find these words exceptionally chilling. I never thought my son's photo would be hanging on the DEA's wall as one of the victims of fentanyl. Heartbreakingly, he is a statistic.

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How many lives must be lost before we hold the players in this hellish nightmare accountable? We must do more to prevent fentanyl from coming into our country, so one more mother, one more family, will not have to be brought to their knees in sorrow. I plead with you to take action. Thank you for allowing me the opportunity to speak.

[The prepared statement of Ms. Cain follows:]

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Mr. Guthrie. Thank you for your very moving testimony. Thank you.

Dr. Loyd, you are recognized for 5 minutes for an opening statement.

STATEMENT OF STEPHEN LOYD

Dr. Loyd. I am so sorry, Ms. Cain.

Good afternoon, Chairman Guthrie, Chairwoman Rodgers, Ranking Members Eshoo and Pallone, and members of the committee. I am Stephen Loyd. I am an addiction medicine physician, and I am in recovery from opioid and benzodiazepine addiction myself.

Through my work as a physician in Tennessee, I see at least 5,000 patients a year in opioid treatment and recovery, and I serve as the chief medical officer at Cedar Recovery, which is an outpatient addiction medicine practice in middle and east Tennessee.

Also, I am the medical director for an opioid treatment program in Cocke County, Tennessee, which serves an inmate population, as well as the medical director at Renewal House, a Nashville organization, which serves marginalized women with underlying substance use disorder.

Thank you for the opportunity to appear here today as you consider these important bills and continue to discuss how to best address the fentanyl crisis in the United States.

This is something I deal with every day, and I hear stories like this, every day, in my work in Tennessee, Kentucky, and Virginia, in both the patients I treat, but also in my role as Tennessee's opioid czar, that has been tasked with figuring out how to best abate the

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crisis in our State.

This includes working with our citizens in jails and prisons as we consider best how to serve their needs along the needs of other Tennesseans who have been impacted by the opioid crisis.

Under the Americans With Disabilities Act, those with substance use disorder are considered to have a disability. This protects individuals who are in recovery, or who have used drugs in the past, a category that would apply to many individuals who are incarcerated in the United States.

Under the ADA, as interpreted by the U.S. Department of Justice, people in recovery but who would be limited in a major life activity, including activities like communicating, caring for oneself and thinking, in absence of treatment of recovery services are protected.

This extends to inmates within the correctional system who are prescribed medications for opioid use disorder. In my own experience, both as someone who has been previously addicted to opioids and benzodiazepines, and was given a second chance, as well as an addiction treatment doctor, a pathway to recovery is essential for all individuals including those who may be incarcerated on drug-related charges.

I have seen that many, not all, of the individuals who are incarcerated on drug-related crimes are dealing drugs as a means to get their own drugs in the midst of their own substance use disorder.

In those cases, minimum sentencing won't work. If you want these individuals to stop dealing drugs and reenter society, you must safely stop their use. This includes not only medication if needed, but other things like safe housing and education.

For the past few years, I have been fortunate enough to work with Judge Duane Slone who runs a drug recovery court in Tennessee's Fourth Judicial District, which covers

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four rural counties. This includes a TN ROCS docket, a program that serves offenders who have an urgent need for treatment, but do not qualify for drug recovery court.

Judge Slone and myself agree that addressing the social determinants of health are key to helping offenders with persistent substance abuse problems break the cycle of their addiction. This includes access to medical care, as well as food, steady income, housing, access to transportation and education opportunities.

While I believe that violent drug offenders should be appropriately punished under the law, I would argue that those who were merely engaging in a system that are actively addicted to the drugs they sell should be afforded the same opportunity that I was given two decades ago.

I appreciate the opportunity to appear before this committee, and I look forward to answering any questions you might have.

[The prepared statement of Dr. Loyd follows:]

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Mr. Guthrie. Thank you for your testimony, Dr. Loyd, and the chair now recognizes Dr. Westlake for 5 minutes for your opening statement.

STATEMENT OF TIMOTHY WESTLAKE

Dr. Westlake. Great. Thank you, Chairman Guthrie, Ranking Member Eshoo, and distinguished members of the subcommittee. Fentanyl-related substances, or FRSes, are highly active opioids almost identical to fentanyl except for a tiny difference in their chemical structure, created by tweaking the chemical scaffold of fentanyl during synthesis in Chinese and cartel labs.

The result of this chemical tweak is a new potent opioid with the same deadly effect as fentanyl and which before FRS class scheduling was put in place, would have been legal until causing numerous deaths, raising them on the radar to be scheduled reactively by DEA.

As an emergency physician telling parents, unimaginably at times, even friends, that their kids will never come home is the worst part of my job.

It was shortly after one such conversation with my good friend, Lauri Badura, that the idea for fentanyl class scheduling reform came to mind. Lauri's son Archie was an was an altar server with my daughters.

It started with prescription opioids, then snorting heroin, and, unknowingly, fentanyl. I resuscitated Archie on his second to last overdose. At that time I pulled out a body bag, laid it down next to him, and warned him that that is where he would end if he didn't accept help.

He stayed clean for 6 months until illicit fentanyl ended his life. One of the last

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things my friend Lauri saw of her son Archie was him being zipped up into a body bag.

Motivated to act by hundreds of such deaths, FRS scheduling legislation, which is proactive and not reactive, as had previously been the case, came together quickly and was enacted with unanimous vote in the Wisconsin State legislature in 2017.

Almost immediately, DEA adopted it as national policy, but only temporarily. Before that, scheduling new fentanyls was like a lethal game of Whac-A-Mole. We literally had to wait for people to die before we could take action.

So why isn't the Wisconsin law permanent Federal law yet? Some who of oppose FRS scheduling point to the recent spike in deaths from illicit fentanyl as the proof that it doesn't work. In reality, they are confabulating and misconstruing the facts.

FRS scheduling does not address illicit fentanyl -- it was never designed to do so -- rather, it removes the incentives for transnational criminal organizations to create new fentanyl-related substances, thus stopping them from ever existing in the first place.

It is truly the ultimate form of overdose prevention and harm reduction. At its core, it is not a law enforcement tool designed to put criminals in jail. In fact, in the years since FRS class scheduling has been in place, there have been a total of eight Federal prosecutions -- I will repeat that -- eight Federal prosecutions -- in the entire United States under the FRS scheduling language, half of whom had already known ties to drug cartels.

As well, there has never been a prosecution for a nonbioactive fentanyl-related substance because there are no nonbioactive fentanyl-related substances. All FRSs encountered in research to date have been found to have potent opioid activity.

Concerns raised about the potential negative impacts of FRS scheduling on research are purely theoretical and have already been addressed by discussions with stakeholders.

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These proposed research accommodations, that have been signed off on, are supported by the very agencies and organizations representing academic scientific research in the U.S., including the National Institutes of Drug Abuse, the National Institute of Health, the Department of Health and Human Services, and the FDA.

These agreed-upon accommodations would significantly loosen research restrictions into studying all Schedule I substances, not just FRSs, and would open up wide, promising areas of research into substance abuse.

Any dampening or restriction of research is purely theoretical. Fentanyl and its derivatives have been extensively researched since its discovery in 1960. And since then, not one fentanyl-based reversal agent or medication-assisted treatment agent has ever been found.

It has been said that FRS class scheduling would impede research into life-saving opioid reversal agents, and that Narcan isn't a strong enough antidote. Take it from me, someone who sadly uses Narcan to resuscitate fentanyl poisonings far too often, Narcan works almost miraculously if given in time.

Our kids are dying because they have ingested a lethal dose of toxic opioids, not because Narcan isn't potent enough.

In conclusion, for 5 years now, FRS scheduling has been Federal policy, albeit temporary. I can't be more pleased about that and the big impact my small idea has had.

According to NFLIS, the National Forensic Laboratory Information System, in a matter of a few short years, the creation and distribution of new FRSs from China has ground to a halt, as have the associated deaths.

In the devastating battle we are in against the scourge of fentanyl, the elimination of related substances that had previously escaped our scheduling and made their way to

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devastate communities across the Nation is surely one bright spot.

Fentanyls are so toxic and lethal that they can be classified and actually have been used as chemical weapons. The lethal dose is 2 milligrams, which is equivalent to five grains of sand. This means that one teaspoon can kill 2,000 people.

That is the amount in this packet of sugar.

Thank you for -- I think I ran out of time. Thank you for the testimony.

[The prepared statement of Dr. Westlake follows:]

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Mr. Guthrie. Thank you. And after -- I will give you a couple seconds since that was interrupted. But you are completed? All right. Thank you. So the gentleman yields back. That concludes testimony. This will begin the question and answer portion of the hearing, and I will begin the questioning and recognize myself for 5 minutes for such.

Thank you, Ms. Pickard, for being here. You know, if I would have come into this meeting -- so you have already learned something today -- from you, I would have thought the number one killer was probably heart disease or something such as that, but it is Alzheimer's. And I just didn't know that at all.

So that gives us -- and I was talking with the Democrat leader, and we said, well, that was a statistic we just didn't know. So thanks for coming, and sharing testimony is important when you come here and testify, put it on the record.

I am going to kind of focus on the fentanyl side of it, but, Ms. Cain, thank you for coming. You are absolutely right, it is not necessarily people that are addicted or have addiction issues, there are people that may have prescription Xanax or Adderall.

I have heard that for some reason they get one, they don't have their prescription filled, somebody, a friend, has one, and they use it, thinking they are using it medicinally and it is laced with fentanyl.

And I tell everybody anywhere I go, if it doesn't come from a prescription bottle from a pharmacy, don't take it. But you just don't know that, and that is something that -- you being here is important, and you being here continues -- your child continues to live on that way, and we appreciate you being here for that.

I just want to talk more with Dr. Westlake, though, on the bill before us, and, you know, the administration's position is, we should schedule illicit fentanyl, fentanyl-related

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substances, but not make them subject to the mandatory minimums. And they said because as they appear, there may be some medicinal purposes, they may be as harmless as water, as we heard before, and that just doesn't ring true to me.

One, I don't think there is anything going to be more harmless. Why would a cartel go to the effort to sell something as harmless as water? So it doesn't ring true.

But if there is medicinal purposes, if it is trafficking illegally, like I said before, you know, other diverted narcotics that are prescription narcotics you can have that are diverted, are of medical merit.

But if they are being diverted and trafficked illegally, they would still be subject to the same punishment. And so, what is your view of -- I know you are kind of the founder of this idea -- so what is your view of the administration's position? I mean, what effect would it have, if they say, okay, we are going schedule them, we are not going to make them subject to the mandatory minimums like other drugs are?

Dr. Westlake. Yeah, great question. I think the whole -- what you really have to remember about FRS scheduling is that it is not about locking people up. It is not a criminal justice bill. What it is about doing is purely preventing. So it prevents the existence and creation of these new fentanyl-related substances --

Mr. Guthrie. Would you say it is not about locking people up, but if the risk of getting locked up is not there, then it changes people's behavior?

Dr. Westlake. Absolutely. I mean, the effect is a preventative effect, but the law enforcement aspect is the key component to keeping it in place. And the reason that -- that it is important to understand that the research behind structured activity relationships.

So there is 60 years of research into fentanyl-related substances and fentanyl, and so there is a wide dearth of research -- if you take a look at my written statement, it goes

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into detail about that -- a wide -- a mountain of literature of little tiny modifications that you can do to the fentanyl molecule to make it bioactive.

And that is why the structural language that we used was targeted specifically for those modifications only. It is not this -- you know, the opposition would say it is this broad-based thing, and, you know, like you said, it could be water or something.

And of the 27 substances studied of the 36 that were found by DEA, all of them have been highly, highly active, bioactive opioids. One of them is 7,000 more potent than morphine, almost as potent as carfentanil is.

Mr. Guthrie. So if we were to schedule fentanyl without subject to mandatory minimums -- I am not saying -- that is another debate whether we have a debate on, overall, the program. But if we were to schedule fentanyl and not subject it to the same penalties of other similar situation, then it would be a negative?

Dr. Westlake. Yeah. Because then it would take -- what it would do, because right now, the cartels are producing illicit fentanyl because there is no reason to move to fentanyl-related substances because they are scheduled, you know, as a class. If that was removed, then there would be a lot of incentive to go back to making --

Mr. Guthrie. Which can be more potent or probably more likely to be more potent and less harmless?

Dr. Westlake. Exactly.

Mr. Guthrie. So, Dr. Loyd, in your practice, what do you see as the number 1 thing that Congress needs to be doing? We are going to look at -- I know it is not before -- better look at the SUPPORT Act as we move forward.

I only have about a half a minute left, but what do you think -- because we need to do the enforcement side, but we also need to the recovery side.

Dr. Loyd. Thank you, Chairman. The recovery side is extremely important.

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The number one thing is something we all have control over, and that is stigma, how we look at people with substance use disorder and allow them to step out and ask for treatment.

But when that happens, the treatment has to be there, and it has to be evidence-based, meeting people where they are.

I heard the definition of "harm reduction" in the last panel, and I would argue that harm reduction is keeping people alive. I haven't figured out how to treat dead people, and so we got to keep them alive and then set up a system of recovery that allows them to succeed like the one I stepped into.

Mr. Guthrie. Thank you. Well, my time is expired, so I will yield back the time and recognize the ranking Democrat leader of the subcommittee, Ms. Eshoo, from California.

Ms. Eshoo. Thank you, Mr. Chairman, and thank you to each one of the witnesses. Thank you for your patience in waiting to reach the witness table. To the two mothers at the witness table, thank you. I can't -- I don't think that there can be a greater sorrow than burying one's own child.

And, you know, our work here is -- what you come and share with us is a source of inspiration to us, because this is really what all of the work is about. So thank you to each one of you.

I want to say something about fentanyl. I know that it is going to be ongoing because we have legislation that is being proposed. You know what, I am struck by -- and I am for the legislation, I think it should be scheduled, but I think that we are, in a way, deluding ourselves, because when I look at what has taken place over the last 5 years with fentanyl being scheduled, Schedule I, deaths have not been reduced in the country. They have gone up.

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I don't think it is a result of their being Schedule I that it has gone up. I just don't think scheduling -- I think scheduling is a whole other issue when it comes to law enforcement, what tools they have, et cetera, et cetera.

And I also think there is a 10 billion-pound gorilla in the middle of the room, and that is that sadly, tragically, the United States of America is the most extraordinary market for drugs. We have an insatiable appetite for drugs in our country.

And then look at all the things that we are dealing with -- the grief, the sorrow, the wrecking of families, of human life, dealing with addiction, and all the things that we need to do to help people. So I just wanted to place those words on the table.

On QALYs, for those that are tuned in and don't know, have never heard this word before, it stands for quality adjusted life years. And they may still not understand it, but that is what it stands for. And these are measures to determine the value of drugs or treatments.

I think that QALY measures are discriminatory, period. They are discriminatory, because they don't give equal weight to the lives of people with chronic disease or disabilities, as they do to the lives of healthy people.

And as my beautiful mother used to say, God never created any junk. Each one is precious. Each one is precious.

Now, maybe some legislators know this, others may not. It is why the Affordable Care Act banned their use in Medicare. That is very important. So this has not been lost on at least some of us.

I welcome the legislation, but there is something in this that refers to the legislation we are considering, where it refers to similar measures. I don't know what "similar measures" are.

Now, Mr. Isasi, I think that is what you were referencing in your testimony.

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Mr. Isasi. Yes.

Ms. Eshoo. Is that term anywhere in the law today?

Mr. Isasi. So that term is in aspects of the law, but very importantly as you are pointing out, the legislation that is proposed is about one thing: It is about price. It is about similar measures being applied to price, and it applies --

Ms. Eshoo. Well, that is what QALYs are, aren't they?

Mr. Isasi. Right. So it is not just about --

Ms. Eshoo. I mean, the end result is discriminatory?

Mr. Isasi. That is right. But the problem here is, you know, as we know, in -- so this is all about one thing. The pharmaceutical companies are trying to create a legal loophole so that we cannot actually negotiate fair prices with them.

And in this case, they are trying to drive a huge hole through the drug negotiation law by saying, any measures to try to measure value, any measures that are based on any assessments, would be barred from being used to set a price. So it is just a gaping hole.

We are 100 percent with the disability community that they cannot be discriminatory. As I pointed out in my testimony, the law already says those prices cannot be set using metrics that are discriminatory against people with disabilities, against the elderly, against people who are terminally ill.

So the law has the protections already in place. This is about giving lawyers for the pharmaceutical companies a giant loophole to fight against fair prices for American families.

Ms. Eshoo. Well, I think that all of us, including the disabilities community, would rise up against what you just described.

We are going to have to get this straight now, Mr. Chairman, because I think that there is full support on the issue of QALYs. We know it is discriminatory, but -- and we

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need to get that done, but we are going to have to address this other language. Thank you and I yield back.

Mr. Guthrie. Thank you. I thank the gentlelady for yielding back. And the chair now recognizes the chairman of the full committee, Mrs. McMorris Rodgers, for 5 minutes to ask questions.

The Chair. Thank you, Mr. Chairman, and I think I will just start with a little follow-up to Mr. Isasi, because I saw in your testimony that you say, quote, "IRA already includes explicit disability and other safeguards." So why shouldn't we apply similar prohibitions and protections to all Federal health payers? Why would that be a problem?

Mr. Isasi. So in this case, the proposed negotiation goes much, much further. It doesn't just ban discrimination, it bans in setting a price. And it is really important to say that.

This is only about one thing in the legislation. It is about the price that is being set in drug negotiation, and it is saying clearly that any measure -- and the language is so broad and so vague that a lawyer for the pharmaceutical industry will drive a truck through it and say you are trying to assess value --

The Chair. Okay. Thank you. We are going to work on this.

Mr. Isasi. You bet.

The Chair. And I do want to work with the ranking member to figure out how we can get this language where we need it to be, to make it clear.

Mr. Isasi. And we are one --

The Chair. Okay. Thank you. I am sorry.

Mr. Isasi. Sure.

The Chair. Okay. Ms. Cain, I understand you gave pretty compelling testimony,

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and we have had the chance to sit down before, and I greatly appreciate you making the trip to be here. Carson should be here. Carson should be here today.

And, you know, we have been, especially on our side of the aisle, the Republicans have been sounding the alarm on fentanyl and the need for Congress to act. Just last week, we held a roundtable that was more focused on fentanyl and what is going on on social media platforms that are making it so available, and platforms that are not taking their responsibility to moderate illegal activity on their platforms seriously enough.

I just wanted to ask, from your perspective, how can lawmakers make the post impact, to spread awareness, and curb the buying and selling of illicit fentanyl? What do you think that we can do that would be most effective?

Ms. Cain. I think that we need to begin by educating -- educating. Education is a huge thing. I think that I can only speak to Carson's case. The individual who sold him the bill served no time for my son's death because of these social media companies and Snapchat especially.

Once that chat is open, the evidence is gone. And because they said that -- I believe they said that they hold them for 90 days in their server. It was already gone by the time we got the toxicology report.

In my opinion, which I am sure many will disagree with, I do think that we need to hold these people accountable. We need to have tougher laws. In this day and age, when we know that it is a poison, they are being poisoned, and, again, not all of these individuals are -- many of them are taking it unknowingly. And we shouldn't be holding them accountable. I think we need to be, as Dr. Loyd said, we need to be looking at this through a different lens.

The Chair. Yes. Thank you, thank you for speaking out, thank you for being here. I will go back and listen to your testimony. I am sorry I had to step out.

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Ms. Cain. Thank you very much.

The Chair. Ms. Pickard, I appreciate you being here also, and as you know, our son Cole was born with that extra 21st chromosome that people know as Down syndrome. And I remember when he was born and just the doctors telling us, you know, what to expect. And in so many of the cases, they got it wrong. They got it wrong.

He is a freshman in high school now, a 15-year-old, has big dreams. He wants to go to college. He wants to play football. You know, he is going to be in a band, he plays the drums. He is going to do it all.

And, you know, he just reminds me every day as to the potential of every life. So, you know, I have heard some statements today about the QALY bill, and I am not sure that it is fair, or conveys the full truth about QALYs.

For example, it has been asserted that banning QALYs is not necessary in Medicaid, for example, because States are already required to cover all drugs. However, we know that States have limited drugs for muscular dystrophy to those who can walk rather than those who can't, because it is not necessarily seen as worth the cost of paying for it.

So my question is, what would you like to say about QALYs in 6 seconds?

Ms. Pickard. Myself?

The Chair. Yes.

Ms. Pickard. Thank you, thank you. So it sounds like Cole is just like every other 15-year-old young man. And I have to say, in the healthcare system, I can tell you that children and adults with Down syndrome regularly face deficiencies in care, including access.

Doctors who specialize in care for patients in our community are scarce. There

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are only 16 adult clinics that specifically serve individuals with Down syndrome in the country, leaving patients in States such as Kentucky or New Jersey without access to specialized care.

And in the moment of greatest need, discriminatory policies can even restrict individuals with Down syndrome from receiving those life-saving organ transplants.

Banning QALYs is a step in the right direction, but so much more needs to be done, and I look forward to working with the committee to address these important issues. Thank you for being here.

The Chair. I yield back.

Mr. Guthrie. The gentlelady yields back.

We are trying to -- are we going to have time for one more, we think? Are we going to have time for one more?

Mr. Cardenas. I am willing to risk it.

Mr. Guthrie. Mr. Cardenas of California is recognized for 5 minutes.

Mr. Cardenas. Thank you so much, Mr. Chairman, and thank you for all your testimony and your important information that you are sharing with us as policymakers for our country. Thank you, Molly and Dr. Loyd. You inspired me to call my son.

I want to apologize to my staff who wrote my questions, but I created my own after talking to my son.

I am one of the lucky ones. My son is in AA. He goes every day. Thank God.

So I asked him, what should I say? What should we talk about? What is the answers, et cetera? He doesn't have them all, but he did give me some advice.

He says, you know, one of the things that I was taught when I go to this group, there is a boulevard in my district called Sepulveda. Two people end up in jail because they were buying drugs on Sepulveda. One has a drug problem. He wakes up in jail,

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never going to do that again. Maybe he stops taking drugs.

The person who has an addiction, they wake up in jail and go, where am I, what is going on, I am never going to buy drugs on Sepulveda Boulevard. They are going to do it again.

So my first question to you, Dr. Loyd, is this: On a per-person basis, based on your testimony, what you provided for us, do you think that punitive incarceration answers is more or less expensive, in all aspects, than prevention, intervention, and support like you have been describing to us?

Dr. Loyd. Thank you, Congressman Cardenas, and I am glad about your son. It is the best news. I am here to bring hope today. My son is in this audience today, watching me sit before my Congress and my country. It is because I got quality help.

I am talking about people with addiction. I am not talking about cartels. I am talking about those suffering from the disease of addiction. Incarceration won't help them. It won't cure them, because they will do exactly what your son said they will do, and I would have done it too, and I am a practicing physician, and I was a practicing physician when I was addicted.

Our money is much more better spent on prevention, education, and treatment. Carson didn't know he was getting fentanyl. He didn't know it. It shouldn't be a death sentence.

And so I think we have to understand as a body, and as human beings, that the disease of addiction is not a moral failure. It is a chronic, treatable disease of the brain, and it is driven by cravings.

And when you have somebody sitting in there -- me today, I would look at it and go, I am not going to do that again, period. But in the throes of addiction, the response that your son gave to his friend is exactly right, and it is exactly what will happen. And

the case I always made, if that worked, nobody would go back to jail a second time.

Mr. Cardenas. Yes. Doctor, you are blessed and fortunate, you are still with us.

Dr. Loyd. Yes.

Mr. Cardenas. Molly, your son isn't. You are not one of the lucky ones. If we make good policy here, we are going to create more lucky ones, right, if we do it right.

But if we do it wrong, people are going to continue to die in the United States of America in a way that no one should ever leave us.

Is there any other advice you would like to give us, Molly?

Ms. Cain. As I said, we -- I can't speak to -- I know that Carson's last year was a perfect storm. I can't speak to -- I know that he was prescribed Xanax, and I know that he wasn't sleeping.

I have heard from people on social media, criticizing the parents and the people who have used, and that is so detrimental to the healing. We need to be addressing this problem.

It is not a problem that just affects -- fentanyl is indiscriminate. It affects all walks of life, every party.

I am not a lawmaker. I came to share my son's story. I am asking of you to please make some sort of change so another mother can look across the dinner table, can celebrate her child's birthday with them.

The only thing I can think of is, we have to educate and we have to educate young. I think about the Mothers Against Drunk Driving and how that started. And maybe this is something that we need to do.

Mr. Cardenas. Thank you so much. My time having expired, I yield back.

Ms. Cain. Thank you.

Mr. Bucshon. [Presiding.] The gentleman yields back.

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I recognize the gentleman for Texas, Dr. Burgess, for his 5 minutes.

Mr. Burgess. Thank you, Mr. Chairman, and I want to thank our witnesses for being here today.

Ms. Cain, I will just tell you, we have worked on this problem of opiate dependence and addiction up here for a long time, but until our chairwoman, Mrs. McMorris Rodgers, did a roundtable last week, I had no idea about the Snapchat focus.

And clearly that has -- when I talked to the previous panel, really concerned about fentanyl, because a lot of the work we have done has been more geared toward, oh, a dentist who prescribed too many Percodan after a wisdom tooth extraction and someone took it inappropriately.

Fentanyl is a different disease. It is so much more deadly than anything that could be contained in a diverted prescription.

And then Snapchat has added yet another dimension to this and, quite honestly, one that I had not appreciated, as I say, until we had done the roundtable up here.

So as painful as it is, I appreciate you coming and sharing your story because we have to focus on these delivery modules that weren't even in existence when I started on this committee many, many years ago.

I am up against a vote. I just want to ask, Ms. Pickard, briefly, thank you for your work that you have done for National Down Syndrome. We heard from our ranking member, Mr. Pallone, and I think we have seen in written testimony that this QALY legislation is a solution in search of a problem. Would you agree with that characterization?

Ms. Pickard. I believe -- thank you for the question. I believe that more research is needed. I think there is more research needed to really further develop and

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test those alternative methods and frameworks for determining the value of healthcare treatments.

And we must ensure that individuals with disabilities, their voices, are included in this conversation.

Mr. Burgess. Well, I wanted to ask unanimous consent to include two articles in the record. One is by three authors, one of whom is well known to this committee, Ezekiel Emanuel, and this is from The Lancet, Principles for Allocation of Scarce Medical Interventions.

And as frightened as I am about QALYs, he also talked about disability adjusted life years, and clearly that is a focus that I think will be exceedingly pernicious, and I do want us to focus on that.

And then the other is from early in the pandemic from an article that was published in ProPublica that was from the Arizona Daily Star, dealing with the problem of scarce or limited resources when we thought we needed more ventilators than we turned out to need, and who gets to go on the ventilator and those questions that came up.

ProPublica -- I can't believe I am saying this -- ProPublica actually did a very fair report on this, and, Mr. Chairman, I would just like to add these two articles for the record.

Mr. Bucshon. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

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Mr. Burgess. And then I have got to go vote. Thank you very much. I will yield back.

Mr. Bucshon. At this time, we are going to take a brief recess, probably for about 15 minutes, so members can vote, and we will come back right after that. The subcommittee stands in recess.

[Recess.]

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[2:19 p.m.]

Mr. Bucshon. [Presiding.] The subcommittee will come to order. We will restart with questioning, and I recognize the gentlewoman from Washington, Dr. Schrier, for her questions, 5 minutes.

Ms. Schrier. I should change this. I could take a new title.

Thank you, Mr. Chairman, and I especially want to thank you, Ms. Cain, for coming out from Washington State today to share your son Carson's tragic story, and from one mom to another mom, I can only imagine your heartbreak. And I think about this frequently as I have a 14-year-old boy. And your account makes so clear why we need to crack down on social media companies, the avenue by which so many teens get access to these deadly drugs, poisons.

I am in the process of working on legislation to bring some of these issues to light and to make sure families have the tools to keep their children safe. And thank you for sharing your story because it helps parents and the rest of this country and world understand how to keep others safe.

Fentanyl has had profound, devastating impacts in my State of Washington. And parents want to engage with their children, sometimes they don't know how. Just this morning, I met with the Enumclaw Youth Empowered Coalition from my district, and their focus is on reaching families early to prevent drug use, experimentation, anything that gets their kids even close.

Given the importance of educating kids and schools and prescribers and patients, I was wondering, Dr. Loyd, if you could highlight some of the ways that parents can find guidance on having these conversations.

Dr. Loyd. Thank you for the question, and it is very difficult. You know, today is a different world than I grew up in with social media and what Molly shared with us.

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But it is also the world of "take one pill and you die." And that is the message that is very, very hard.

So when I talk with parents, it is always about being open and not thinking that you know everything. I see parents make mistakes all the time, oh, I know what is going on inside my house and I know -- and the truth is, Congresswoman, we don't have near as much control as we think we do.

And so these opportunities to talk with our children and be open and honest, most of us have some kind of experience with things in our past that maybe we could have handled better, and we are not perfect, and our kids need to see that.

And so my son, I told you, is in this room, and so he was 9 when I got into recovery, and I started sharing my stuff with both him and my daughter at that time. So I think for parents, it is important to realize that it is not the world that we grew up in, and now, not that anything is okay, but it is a one-time thing and you can literally die this afternoon.

`And that is the part, if you don't know where it came from, you know, please don't take it, because it will look just like what comes out of somewhere.

And the other thing I see, Congresswoman, is this. Just because it comes out of a bottle that a doctor wrote a prescription for, it is not okay. And I think a lot of times that kids will look at that, and, well, a doctor wrote this, this is okay -- I have seen it with numerous teenagers -- and it is absolutely not. Those are the places I would start.

Ms. Schrier. I think those are great points, and I will tell you, even as a pediatrician, it is challenging to have these conversations, but just last night, I had the conversation again with my 14-year-old because he can't -- I am just speaking to parents out there -- you can't have this conversation enough, and reminding teenagers who are, by their very nature, impulsive and experimental and trust their friends sometimes more

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than their parents, that anything anybody hands you, whether they tell you it is an ibuprofen or somebody is trying to hand you an Adderall, telling you it can help you focus better, that that could be the pill that ends your life. And so thank you for bringing this to the forefront, and I will yield back my time.

Mr. Bucshon. The gentlelady yields back. I now yield 5 minutes to the gentleman from Florida, Dr. Dunn.

Mr. Dunn. Thank you very much, Mr. Chair. So we have an important opportunity today to advance legislation that will protect all Americans, including the most vulnerable, the ones that Dr. Schrier mentioned, the children who are susceptible to accidental fentanyl exposure and experimentation with street drugs. So I am proud to support the bills before us today.

Importantly, the Halt Fentanyl Act will permanently place all fentanyl-related substances into Schedule I. This bill addresses a failure of the administration and represents an important step towards getting this deadly fentanyl analogues off our streets.

However, I believe that to wholly address the fentanyl crisis, we need to do some other things. We need to designate the entire class weapons of mass destruction.

That is not a frivolous proposal. It empowers the DHS to help us with this effort. It also makes international policing substantially easier.

We also have to better educate our youth again and again about the dangers of drug use. There is no street drug that is safe. There is no pusher who can be trusted. Everything could be laced with fentanyl.

We also have to work to address recidivism in our communities, and frankly fix the broken families. An example of that, one of the counties in my district that was hardest hit by fentanyl poisonings has 40,000 citizens.

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Of those 40,000, 22,000 of them have spent time in the county jail. If we can address some of these root challenges that these communities face, we can decrease the demand for all street drugs.

Another important bill we are going to discuss today is the use of QALYs, quality adjusted life years, by government insurance programs.

I am a doctor. I think the entire concept of QALYs is contrary to the American values that set our free society apart from socialist healthcare systems that restrict care and choose for you and your family what life is worth.

It is disappointing to me that we have to legislate to prevent such tactics from driving our Federal healthcare policy. Our Nation supports some of the greatest biomedical research in the world. Regardless of one's ability or disability, all Americans should have the right to choose their care.

Ms. Pickard, can you give us some examples of how QALYs are used internationally, where they are used, how they limit access to care, and how are they used in the United States?

Ms. Pickard. Thank you, Congressman. Many countries, including our friends in the U.K. and Canada, heavily rely on QALYs. They help determine who is worth treating and who is too expensive, thus determining which medicines or treatments are available to patients.

For example, from 2016 to 2019, the U.K. used QALYs to restrict access to the first-ever approved treatment for cystic fibrosis. Unfortunately, it is important to note that these metrics are not here, you know, used here in the United States as well.

As you asked about examples about the U.S., most recently CMS relied on a report from ICER, the Institute for Clinical and Economic Review, that used QALYs and similar one-size-fits-all metrics in its national coverage determination for aduhelm, the first

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treatment approved for Alzheimer's disease.

The initial coverage determination excluded individuals with disabilities. This was particularly concerning as individuals with Down syndrome have that heightened lifetime risk, higher than 90 percent, of developing Alzheimer's disease.

Access to treatments for this debilitating disease is paramount to our community, and we will continue to work with Members of Congress and this committee to ensure individuals with disabilities are not left out of this conversation.

Mr. Dunn. You know, I think my professors from med school would be rolling over in their graves if they heard us having this conversation. It defies belief.

Dr. Westlake, as a fellow physician, I agree with you regarding the importance of permanently scheduling the fentanyl-related substances into Schedule I. We all know this is a crisis. What the heck is the challenge here? We have been working on this for years. What is the head wind?

Dr. Westlake. Yeah, you and my wife have both the same question. I first testified at a hearing for House Judiciary 5 years ago on this topic and brought this up. I don't know. I don't know if it is politics, if, you know, there is advantage in trying to, you know, access criminal justice reform.

I think there is confusion between what this bill, you know, what the fentanyl-related scheduling does. You know, it is not going to stop all fentanyl deaths. It is going to stop fentanyl-related substance creation and fentanyl-related substance deaths, which it has.

So I really don't -- it is very simple to me, but I think it gets cloudy when you involve what happens in Washington.

Mr. Dunn. I don't know, honestly, for the life of me, I have never come to one of these hearings and heard somebody say, fentanyl is pretty good stuff, we ought to have

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more of it, or push it out on the streets. Nobody says that. In China, it is Schedule I.

Dr. Westlake. Yeah. The last thing we need is another fentanyl.

Mr. Dunn. This is crazy. Well, thank you. My time is elapsed, and I will yield back to the chairman.

Mr. Bucshon. The gentleman yields back.

I now yield to the gentlelady from Tennessee, Mrs. Harshbarger.

Mrs. Harshbarger. Well, thank you, Mr. Chairman, and thank the witnesses. And, Ms. Cain, I am sorry about the loss of your son. I guarantee that there is not one person in this room who has not been touched by either the loss of a family member or friend to some type of drug overdose.

You know, I have been a pharmacist 36 years, so I have dealt with a lot of this. And, Mr. Loyd, I have dealt with a lot of impaired physicians, a lot of impaired pharmacists, you know, employed some to give them a chance to get their hours so they can practice again. So it is not anything that is new to me.

And I am telling you, I visited a lot of rehab clinics in the district, and I read that you have -- you know, you are doing the incarcerated gentlemen at Cocke County in my district. And Judge Slone, I have met with Judge Slone, I have talked with him, and he walks the walk because, if I am not mistaken, he even adopted a child from a mom who was addicted to drugs.

So, you know, these are the kind of judges we need on the bench in these drug courts, and I have talked to numerous drug court judges and heard the stories. And he has offered to come let me sit in with them as they go through that process, and I said, absolutely, I will come. I want to hear that.

You know, when I visited some of those rehab clinics and talked to some of the physicians, you know, they have a multi-step approach. It is not just giving them a drug

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to get off of a drug, because that is a problem. They can take those drugs -- I have said this in the last session -- they can heat those foils up. They can inject them. They can abuse that drug.

But what they do, they have the counselors, they have the group sessions, you know, and there is limiting factors. And one of the pharmacists left Walgreen's to do a pharmacy there at one of the rehab centers because he said these guys don't have a place to go.

A limiting factor is having a bed, having a home, and to get them back as contributing citizens to society, there is things that you have to address.

So I guess with all that said, and as an ER physician, you see this. They come to me, years ago, we would have to come up with modalities as a compounding pharmacist. We would have to help them with different drugs. They used to use clonidine to get them off the drugs.

There is so many things they do. Used to do things for patients with special needs or Down syndrome, you know, when you couldn't get specific products. We still do that. My son is a pharmacist now.

But I guess my question is, you know, sometimes insurance won't cover them. I know Blue Cross Blue Shield dropped a lot of the clinics, and they would not cover that, you know, the drugs that they needed to rehab them.

I guess my question is, what do you believe are the most important things Congress and/or the FDA or other Federal agencies can do this year to help us conquer this addiction?

I am saying close the borders for one thing, hold those people who are selling these narcotics accountable, make those laws to where -- if it were up to me, I would probably label the cartel as a terrorist organization, but, you know, they probably don't

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want me to talk about that. But go ahead, anybody can answer that.

Dr. Loyd. Thank you, Representative Harshbarger. You are actually the Representative from my boyhood home district. I am from Jonesborough, Tennessee.

Mrs. Harshbarger. Jonesborough?

Dr. Loyd. Yes, ma'am.

Mrs. Harshbarger. For heaven's sake, who knew.

Dr. Loyd. So thank you, and I am very familiar with that area, it is my home, the foothills of the Appalachians. So the things that we can do as a society I have already talked about it, is, decrease stigma.

As a legislative body, the areas that move the needle the most in our country, in my opinion, is the criminal justice system and emergency departments, because these are the places that our patients are showing up being overdosed.

And the system of care needs to be designed to, one, allow them to stay alive. And you are exactly right, medication will allow them to stay alive, but that is a pretty low bar.

If I stop one of my young pregnant women from, you know, using a needle and putting drugs in her body, that is a good thing. But if I am sending her back to the environment where she is getting abused at night, that is a pretty low bar.

So we have to have a system set up that allows us to reimburse for care, to help people with physical, sexual, and emotional abuse, which, a lot of times, are the underlying drivers of addiction.

And until we can do that and support things like safe housing, I don't know how all of us would be here today if we slept on the street last night, probably not in very good shape.

And so our system needs to be designed as a comprehensive level of care to help

people find what is right for them.

And a lot of times we judge people on medication, and we have to stop doing that. Sometimes it is the only thing keeping them alive.

And I really appreciate the plug for our drug court, and I invite everybody to come. It is good for your soul.

Mrs. Harshbarger. Yeah, it is.

And, Ms. Cain, I just had a dear friend, she went up to wake her 17-year-old son up, and he was dead. It is the same thing, it only takes one pill. And people need to be aware of that. Two grains of sand is all it takes to kill you, and fentanyl is showing up in everything, and I have talked to a multitude of people about that.

So we have a problem, we need to fix it, and you can't fix it if you don't understand it. So I appreciate you being here. And with that, I yield back.

Mr. Bucshon. The gentlelady yields back.

I now recognize the gentlelady from Iowa, Dr. Miller-Meeks, for 5 minutes.

Mrs. Miller-Meeks. Thank you very much, Mr. Chair, and, again, I thank our witnesses for their patience throughout this and then throughout the brief recess as we voted.

I am a physician. I am the former director of the Iowa Department of Public Health, as I had mentioned earlier, and then also as a State Senator. And it is a very timely topic.

As a State Senator, I successfully passed -- I can't speak, but passed in one session no preauthorization for Medicaid-assisted treatment through our programs, including Medicaid.

I was also able to get behavioral health treatment as a side of service at schools, so for those individuals who either don't have transportation or can't get to their

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providers, so that we make sure there is a continuum of care.

And, Dr. Westlake, as you referenced in your testimony, what can Congress do, and you mentioned the Halt Fentanyl Act. I am an original cosponsor of that, and I agree that there is a lot of misinformation about that.

And I am also interested, so we are kind of sisters, I am Iowa, you are Wisconsin, and Wisconsin has a program, but in Iowa, we have the Billion Pledge Program which is another one of Iowa's leading opioid prevention initiatives.

Specifically, this program aims to remove 1 billion opioid bills from the medicine cabinets, using evidence-based protocols, peer-to-peer education, nurse support, and also preparation for surgery, because as we know, a lot of opioid addiction has started through post operative care and pain management, pain relief.

As part of this, they have a tool kit that has an ice-heat pack, a nurse responsive, or someone that they can call in addition to their regular provider. It has a nutritional water supplement, which gets to the NPO, or nothing by mouth, for, you know, hours before surgery which leads to increased pain afterward. And then a regimen of alternating ibuprofen and Tylenol.

So I think this program is a critical program that, you know, looking at their results and statistics, probably should be replicated. And I know that your experience is largely in the emergency room setting, but you were very instrumental in setting up Wisconsin's programs.

So I would like to ask if you have knowledge or information about what can be done regarding post-op monitoring to reduce the number of Americans that come away from a surgery with an opioid addiction and whether you have experience with enhanced recovery after surgery guided care.

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RPTR MARTIN

EDTR HOFSTAD

[1:33 p.m.]

Dr. Westlake. Yes. Thank you for the question.

I think that education is key. You know, I led the prescription reform efforts in Wisconsin starting 8 or 9 years ago, 10 years ago, and educating the physicians about prescribing. But I think we also need to continue to educate the public.

And, you know, one of the things is -- there is a study out of Michigan that, you know, 1 out of 16 kids that gets exposed to Vicodin for wisdom tooth extraction becomes addicted to it.

And so it is stopping the initial exposure. And I think as a society we have to understand that there are going to be things that are painful. I tell people when they have a broken wrist: It is going to hurt. You can take Tylenol, you can take ibuprofen, you do ice. You know, take this tramadol or hydrocodone only if you have to, at night, and realize that if you take it there is a potential you could be addicted to it.

I think education is out there, though. I think we are moving forward significantly on that respect. I think prescription drugs are not nearly the problem they were 10 years ago.

Mrs. Miller-Meeks. Thank you for that.

We also have increased access to harm-reduction tools, and we have mentioned that. And I remember going through these as director of the Public Health Department. And as beneficial as they are, I just want to also mention that, in my meetings with both public health and with law enforcement, that we now also have, you know, individuals who are abusing those very same tools that we are using to save lives. So, when I am speaking with individuals in recovery and in law enforcement, mentioning the use of

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Narcan -- overdosing on medication, knowing that there is Narcan available. So I think it is an extremely important tool, but we also have to be cautious and be mindful of that.

There have been significant efforts at the Federal and State levels to increase access to naloxone, but I want to ask you, Dr. Westlake, in the little time I have, what more can be done to ensure individuals, families, EMS, first responders, emergency departments have the tools they need to give individuals who have overdosed another chance at recovery?

Dr. Westlake. Yeah, I think that is key. I think, you know, making it over the counter would be ideal. There is no reason that you would need a prescription for it. There are no side effects to it, other than it stops opioids from, you know, affecting the nerve. And so there is really no downside to it.

I think that would be a huge step, and then it could just be -- you know, it could be widespread much more easily.

Mrs. Miller-Meeks. Thank you.

And, Dr. Loyd, my time has expired, but if you had comments, please feel free to submit those in writing to us afterwards.

[The information follows:]

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Mrs. Miller-Meeks. Thank you. I yield back.

Mr. Bucshon. The gentlelady yields back.

I now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes.

Mr. Bilirakis. Thank you, Doctor. I appreciate it very much.

Ms. Pickard, thank you for sharing your story with regard to Mason. Your words provide insights into the joy he brings to you and your family.

The topic of the quality-adjusted life year can get highly technical. Can you share with us the real-world implications for the use of QALYs in decisionmaking, particularly for people living with rare or chronic conditions, such as veterans?

Ms. Pickard. Thank you for the question.

Mr. Bilirakis. My pleasure.

Ms. Pickard. Well, I cannot speak directly to the rare patient disease community. I can imagine that they encounter very similar problems as the disability does in regards to the utilization of QALYs in all of our Federal healthcare programs, specifically access to those necessary and at times lifesaving treatments.

All lives have value, and no one should be discriminated against based on arbitrary, one-size-fits-all metrics.

Mr. Bilirakis. I agree.

Ms. Cain, I am sorry and sadden to hear about Carson's story, and I thank you for your bravery and your calls for action and need for accountability at every level, from Big Tech companies like Snapchat to the DEA itself.

We are losing this battle. And I agree with your testimony calling this a weapon of mass destruction. It is completely appalling that the drug dealer only served in jail for less than 1 day. Unbelievable.

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Can you explain how we can better hold these bad actors and drug traffickers accountable and why both social media and the Federal agencies like the DEA need to coordinate better, please?

Ms. Cain. That is a big question, and I don't know if I am qualified to answer that, to tell you the truth.

I am a teacher. I believe in education. I believe we need to be educating, even as young as kindergarten -- I am a kindergarten teacher this year -- "Don't touch a pill. Don't -- touch nothing. Take nothing. Ask your parents."

We need to -- as far as Snapchat, I think that they have been given a free pass, and there is no accountability on their part. And I think it is time we start holding them accountable.

I would encourage you to go visit the DEA and see the faces of fentanyl, because it is eye-opening. There are 4,800 pictures hanging in there. There is a family that lost three of their children -- three. There are children as young as 17 months. You walk around and you look at those faces, and it hits home. It hits home.

I would encourage you to go do that. They have a thousand more they haven't hung yet. They don't have the room to keep hanging them, and they are still coming in.

Mr. Bilirakis. It is affecting all our communities. And, you know, this committee has made it a priority --

Ms. Cain. I thank you.

Mr. Bilirakis. -- to go after fentanyl.

Ms. Cain. Thank you so much.

Mr. Bilirakis. But, Dr. Westlake -- thank you again. I know it is very difficult, but thanks for your testimony, ma'am.

But, Dr. Westlake, you say in your testimony that fentanyl-related substance

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scheduling is preventive, not punitive.

As we see other varieties of substances being laced and mixed in with fentanyl and other drugs like xylazine becoming more prevalent, can you explain how we can be more proactive -- we need to be ahead of the game -- more proactive and preventive to stay ahead of the latest drug-trafficking trends?

Dr. Westlake. Yeah, I think the first thing that can be done is to pass the HALT Fentanyl Act. I think that -- I mean, just -- the way I look at it, drug use and opioid poisonings are like a fire hydrant, and there are different nozzles on the fire hydrant. And you have got illicit fentanyl, which is this big, and you have got fentanyl-related substances, which is smaller. But right now it is closed off and it is closed. And to not permanently enact it is to let it reopen and to start that spewing again.

It is a huge problem, you know, fentanyl and illicit fentanyl deaths and poisonings. And Congress -- you know, I think there is always a push to have a legislative solution to do everything, and I don't know that for a lot of things there is a legislative solution. I think this is a cultural solution to the drives for drugs.

But I think this is a legislative solution for FRSes, that you can stop that, and it doesn't impact, you know, other things. It is just going to stop the creation of these, and that is all it does.

Mr. Bilirakis. Thank you very much.

I yield back, Mr. Chairman.

Mr. Bucshon. The gentleman yields back.

I now recognize the gentleman from Pennsylvania, Dr. Joyce, for 5 minutes.

Mr. Joyce. Thank you for yielding, Mr. Chairman.

And thank you to our second panel for appearing here today, because you give us that critical insight into the bills that we are considering.

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Dr. Westlake, thank you for turning around and coming back in to talk to us again.

And during the previous panel, we heard of numerous concerns regarding the permanent scheduling of fentanyl-related substances.

First, on the issues of mandatory minimum requirements for fentanyl-related substances, do you feel these requirements are necessary to deter the trafficking, to deter the cartels, to deter the business model, as they continue to bring these deadly poisons into our communities?

Dr. Westlake. Yeah, I think absolutely, without question.

I think that is what makes it prevention-based, is that it stops the incentive for creating them. If you remove mandatory minimums, just like you pointed out, you have something that has less -- you know, there is less penalty with it, so that is where it is going to go, is they are going to start creating those fentanyl-related substances.

Because if it is easy -- there is a lot of literature on researching fentanyl-related substances and how to make them, and it is as easy as using just a different reagent. So, if you want to make methyl fentanyl, all you do is you use methyl instead of an ethyl group. And so it is literally just one tweak in a cookbook that is well-delineated in the literature.

That is why the language for the structure is so surgically targeted, is because it just gets rid of those known pathways.

Mr. Joyce. Dr. Westlake, do you feel that the cartels have those abilities to make those minor changes to the recipe, to cook the fentanyl-related products in just a different manner to allow them to come through and escape those sentencings?

Dr. Westlake. Absolutely. If they can make fentanyl, they can make any fentanyl-related substance. All they have to do is look at -- there is a Federal sentencing reform testimony that I put in my testimony that addresses that -- Mike Van Linn of DEA,

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Ph.D. It is absolutely easy to find in the literature.

Mr. Joyce. We have also heard substantial concerns raised over a class-wide ban and how that could potentially criminalize harmless substances.

In this case, have there been any fentanyl-related substances that have been found to be harmless?

Dr. Westlake. No, there have been zero. So there --

Mr. Joyce. Have there been any fentanyl-related products that have been found to be not addictive?

Dr. Westlake. No, there have been zero.

Mr. Joyce. Have there been any fentanyl-related products that do not bind to the opioid receptors in the brain?

Dr. Westlake. Zero. All of the substances studied by DEA, all 27 of them that have been studied, have bioactivity. Again, one of them is 7,000 times more potent than morphine.

Mr. Joyce. Dr. Westlake, do you feel that all of these fentanyl-related products are poisons?

Dr. Westlake. Absolutely.

Mr. Joyce. I think that your ability to take your clinical experience as an emergency room physician, to bring that to Congress, to take your personal ability to recognize that, as you put it, all of these fentanyl-related products are deadly poisons -- they are having that impact throughout our country, making every State a border State, something you have heard us frequently say but something that you as a physician recognize.

Would you relate personal experiences on what would make the fentanyl-related products more easily classified, more educated to those who potentially could see those?

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Dr. Westlake. So, again, I think the One Pill Can Kill idea, the education component of it, of just educating people that there is no -- I have seen marijuana that people smoke that has fentanyl in it that they die from. I have seen all kinds -- you know, fake xanax pills.

I mean, I think just the education is key to the component of how dangerous the substances are.

Mr. Joyce. Given the dangerous nature that we recognize, that just one pill can kill, if there could be only one Schedule I drug to have mandatory minimum sentences attached to it, what would that be?

Dr. Westlake. Absolutely, without a doubt, fentanyl and fentanyl-related substances. I mean, it is literally -- you know, it is literally a chemical-weapons-grade poison.

You know, it is hard to die overdosing on cocaine. It can happen, but it does. It is hard to die from heroin, actually, compared to fentanyl. Fentanyl, I mean, literally 2,000 -- I don't have my packet of sugar -- 2,000 deaths from 1 teaspoon? I mean, that is insane.

Mr. Joyce. Thank you for your concise presentation.

I thank all of the members of the panel for being here today.

And I yield the remainder of my time.

Mr. Bucshon. The gentleman yields.

I will now yield 5 minutes to myself for questions.

Dr. Loyd, Cedar Recovery specializes in outpatient care. I think it is important that we get people care in the least restrictive setting and that we get them the care early that they need. This is for substance abuse, of course.

However, we need access to all levels of care, including residential care and

inpatient care, in my opinion. Do you agree that we should have all settings available to patients?

Dr. Loyd. Thank you for the question, Vice Chairman Bucshon.

And, yes, I do. I agreed with what you said earlier, and I am glad we are getting to talk right now, because I do agree with that. We need to help people find the level of treatment that is right for them, not the level of treatment that is right for the person who is providing the treatment. And I see that all the time.

And there is a different between access to care and access to quality care. The patients that we focus on in the outpatient setting are Medicaid and Medicare as well as State opioid response patients who don't have resources otherwise.

So all levels of care need to be accessible, but we also need to look at what may hinder somebody from getting the necessary level of care. And the example I will give you is the single mom with two children. The level of care that she may need is inpatient care. And that is fine and dandy until they tell her she can't bring her kids with her and she is the sole provider for her family.

And so we have to be willing to be flexible and give patients the level of care that will keep them alive, first, and then help them find the path to recovery that is right for them.

Mr. Bucshon. So you must think -- there are some Federal barriers probably, particularly in the Medicare program, like the IMD exclusion, that maybe we should change or revisit?

Dr. Loyd. Vice Chair, there are a lot of hindrances to people trying to get care for substance use disorder, and that would be one I would like to look at.

Mr. Bucshon. Yeah, I mean, I think we have talked about that quite a bit. And I think, personally, we need to just revisit some of the things we are doing and make sure

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we are not limiting access to care in all settings.

Dr. Loyd. Yes, sir.

Mr. Bucshon. Well, Dr. Westlake, I want to ask you again about naloxone. And you say you are in favor of it going over the counter.

Dr. Westlake. I am.

Mr. Bucshon. Before we do that -- and I am not saying I am against it. But I was a practicing physician before, a cardiovascular and thoracic surgeon. So I had a lot of patients in the ICU that, you know, as you know, sometimes patients aren't waking up. And you are saying, "Well, maybe they are narcotized, so let's try some Narcan and see if it works." And it does frequently.

You know, chronic ICU patients sometimes are given pain medication even when they are not awake, just with the assumption that, you know, they are in pain. And that happens.

But then, of course, you know naloxone in that setting and in other settings is not without some risk. I mean, there are cardiovascular -- potential hypertension, tachycardia, cardiovascular ramifications. And sometimes people do awake suddenly and can be combative and have other issues.

So, once we go to over the counter, what type of public education do you think we should put in place maybe a little bit before we take that step? Or do you think we -- what do you think we should do?

Dr. Westlake. I see it as -- I mean, I think the people that are going to be using it are not going to be the ones that are at cardiovascular risk. I think you saw pretty skewed patients in the ICU that present to the ICU with advanced cardiovascular --

Mr. Bucshon. I did. That is correct.

Dr. Westlake. So what I am seeing in the E.D. is younger people, you know,

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mostly under the age of 40, and if they had access to it. Someone may have had it at home. Because when it is given, it works.

And so --

Mr. Bucshon. Absolutely.

Dr. Westlake. -- definitely education is needed with it. But I think -- and it is the same thing, I think, with buprenorphine.

Buprenorphine is -- I know that there is talk about it being abused, and I would much rather see buprenorphine abused than fentanyl or OxyContin or oxycodone. And the people that are abusing it with substance use disorder are going to be abusing something, and so that is -- it kind of falls into the same thing, almost like a harm-reduction thing.

Mr. Bucshon. I understand.

Is there any evidence out there that the availability of naloxone facilitates ongoing illicit narcotics use?

For example, I mean, I have had in some counties, rural counties, where they have gone to the same house three, four, five times. And the law enforcement, at least, tell me some of the suspicion is that the people know that this is available and, you know, the cavalry is going to show up.

I don't personally believe that, but do you think there is any evidence of that, that the availability of naloxone could facilitate further use, or no?

Dr. Westlake. No, I don't think there is.

But do you want to --

Mr. Bucshon. Whoever wants to comment on that.

Dr. Loyd. Thank you, Dr. Westlake.

I don't think there is any evidence to that either. But I would tell you this: that

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if it is my son, I hope the cavalry continues to show up.

Mr. Bucshon. And they do. But they run out. That is the problem, right? I have counties that are literally -- the county sheriffs, they run out every month before the end of the month. And then the cavalry may not come.

So, with that, I yield back -- oh, Mr. Johnson is here. I yield back. And I will now recognize the gentleman from Ohio, Mr. Johnson, for 5 minutes.

Mr. Johnson. Thank you, Mr. Chairman.

I appreciate the panel coming in.

I do have another fentanyl question. Then I will move on. So let me go quickly to Dr. Westlake.

Higher-dose pills from improperly mixed batches, known as hotspots, that lead to overdose and death in a given area are often the way the medical community and law enforcement learn that fentanyl or an analog has been introduced into a local drug market, which, in turn, would beget reactive scheduling in States.

Dr. Westlake, this helped you -- if I understood it right, this helped lead you to work to target bioactive fentanyls as a class, in order to remove the incentive that international drug traffickers had in modifying the drug molecule.

Can you discuss how fentanyl class scheduling is critical not only for law enforcement but for patient and community health as well?

Dr. Westlake. Yeah. It is critical to leave that spigot closed so that -- you know, again, right now, there are no more new fentanyl-related substances that are being created, so no one is dying from new fentanyl-related substances. They are dying, you know, a lot from illicit fentanyl but not from fentanyl-related substances.

You know, what Congress can do is to pass a law that will stop the manufacture and creation of this and remove the incentive for it. If you take away the mandatory

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minimums, the incentive is going to creep back in, and I fear that that would come back into play.

Mr. Johnson. Okay. So, should this scheduling ban expire, is it realistic to expect that we would see an increase, perhaps even a sharp increase, in overdose deaths?

Dr. Westlake. So that is a good question. So there is really not -- the fentanyl-related substances are not being created or researched in America at all. It is all from Chinese chemical labs and, you know, potentially from Indian chemical companies if they were to choose to do that. And so the key thing is to make sure that the Chinese stop, you know, creating these fentanyl-related substances.

So, yeah, I mean, it is critical to get this passed.

Mr. Johnson. Okay. All right.

And then I want to pivot to address another piece of legislation that we are considering today, this, quote, "quality-adjusted life years."

This concept is exactly what it sounds like. It is a calculation, not made by you or your loved ones, that decides how much, quote, "quality" remain in the remaining years of your life that you might have if you are diagnosed with an illness or a disability, and that then determines how much cost and coverage is going to be applied to that.

I mean, another term for that is called rationing healthcare. That is not what we do in the United States. In some countries with nationalized healthcare, like the United Kingdom, the government gets a say in this, when it is time to consider healthcare treatment options.

And some on the -- not everybody, but some on the Democratic side want to emulate health systems like those in the United Kingdom. Well, I say, no, thanks. We don't want that here. This is a dystopian future that neither the people I represent nor I

want any part of.

So, Ms. Pickard, thank you for being here and for your advocacy on this issue, because the public needs to learn more about this.

The legislation we are considering today prohibiting using quality-adjusted life years calculations in Federal programs, I fully support it. But, in addition, you mentioned other metrics and value assessments that also contribute to this type of discrimination or, as I refer to it, rationing.

Can you outline, Ms. Pickard, any other metrics or assessments here in the United States or overseas that, as policymakers, we need to watch out for and work to mitigate the damage that they may cause?

Ms. Pickard. Thank you for that question.

Yeah. I mentioned a little bit earlier that our friends in the U.K. and in Canada do heavily rely on these QALYs to determine who is worth treating and who is too expensive to treat.

I think that, when we look at this, we really want to look at what is the best for people -- in my case, the people with disabilities -- and how do we make sure that we look at alternatives.

And I think that there has been a number of alternatives and supplements proposed to replace or improve the QALY, but there is still more research that needs to be done to determine what is the best route.

Mr. Johnson. Okay. All right.

Mr. Chairman, I see that my time has expired. I yield back.

Mr. Bucshon. The gentleman yields back.

I want to make a personal privilege here, that my wife is an anesthesiologist, and I have been using the term "illicit fentanyl." Let me tell you why. Because every day in

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her job she uses fentanyl. And she is having patients -- this message is getting out, which is good, that this is a problem in our country, but it is actually a very useful anesthetic agent that we use every day legally. So I have been using the term "illicit fentanyl" rather than just saying "fentanyl," just FYI.

At this point, I ask unanimous consent to include in the record the following items on this list. It is my understanding these documents have been shared with the minority and approved by the minority.

Without objection, so ordered.

[The information follows:]

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Mr. Bucshon. Seeing there are no further members wishing to ask questions, I would like to thank all of our witnesses -- it has been a long day -- again for testifying here. Very strong testimony from all of you. Very much appreciate it.

And, at this point, the committee stands adjourned.

[Whereupon, at 3:00 p.m., the committee was adjourned.]