Testimony of Keith Humphreys to House Judiciary

Subcommittee on Immigration and Border Security

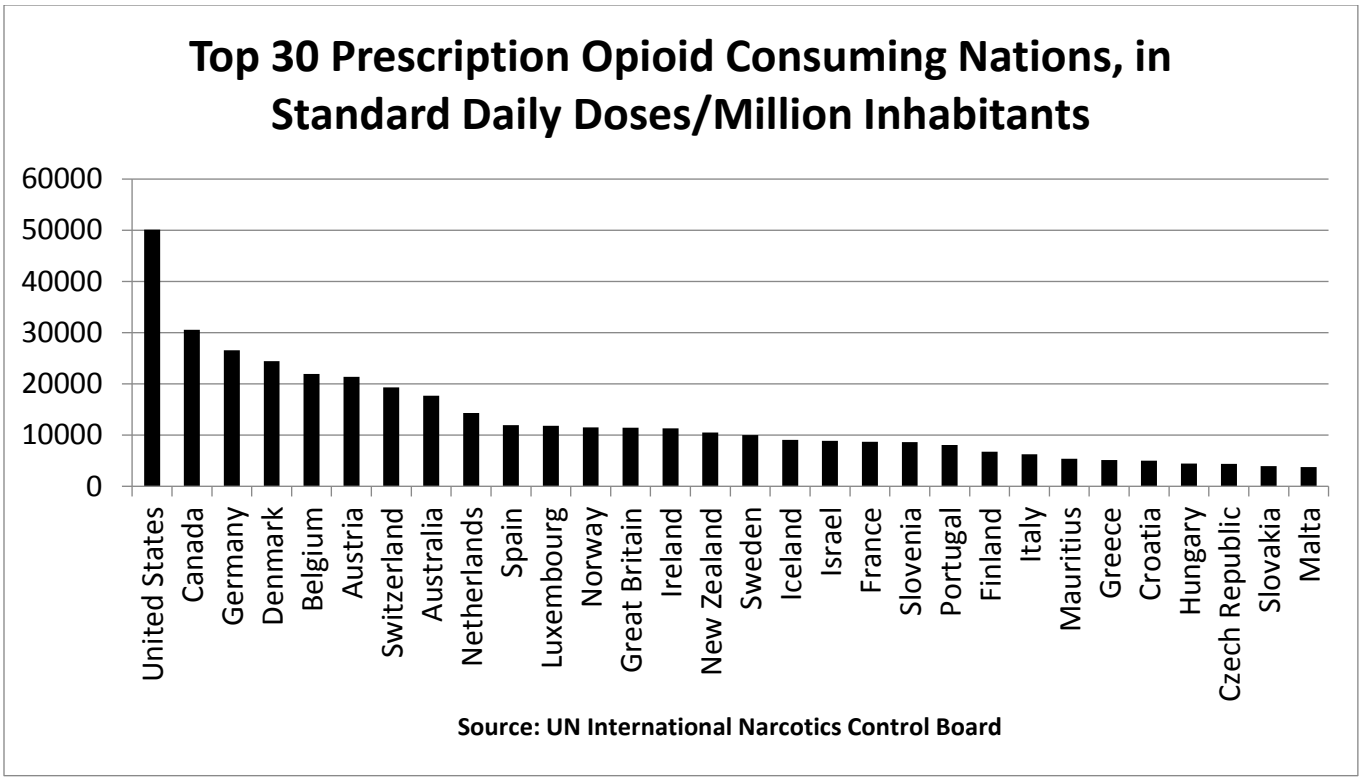
February 15, 2018 Hearing on Immigration and the Opioid Crisis

Chairman Labrador, Ranking Member Lofgren, thank you for your leadership on the opioid epidemic and for inviting me to speak with your subcommittee. My name is Keith Humphreys and I am the Esther Ting Memorial Professor at Stanford University School of Medicine. My comments today reflect my 30 years of experience as a clinician and researcher in the addiction field, as well as my service as a White House drug policy advisor in the Bush and Obama Administrations.

In the first 15 years of this century, drug overdoses claimed more Americans lives than World War I and II combined. The 2016 death toll of 64,000 – about 80% of which involved opioids – is worse than AIDS in the peak year of that terrible epidemic. To push back on this epidemic, we have to analyze it dispassionately and deploy our resources strategically. In that regard, I wish to emphasize that while there are many high-impact policies available to us, I do not think that cracking down on sanctuary cities is one of them.

I was born and raised in West Virginia, which is ground zero of this epidemic. I go back home frequently to help my state deal with the ravages of opioid addiction. West Virginia is emblematic of where this epidemic is at its most destructive – rural areas that don't have sanctuary cities and indeed generally don't have cities at all. Recent immigrants are rare, yet opioid addiction is rampant. That's because the opioid epidemic was made in America, not in Mexico, China, or any other foreign country.

Beginning in the 1990s, American companies such as Purdue Pharma convinced a generation of doctors and health care regulators to dramatically increase opioid prescribing. This campaign was extraordinarily lucrative for opioid manufacturers. According to United Nations International Narcotics Control Board data, the U.S. now dwarfs all other nations in prescription opioid consumption. We are #1 in the world and if we cut our prescribing by 40% -- we would still be #1 in the world, which is not a distinction of which to be proud. On a per capita basis, we prescribe 4 to 6 times more than other developed countries like Britain, France, Spain, Norway, and Australia.



The astonishing increase in providing opioids – which at its apex reached nearly a quarter billion prescriptions per year – is what started and still maintains our opioid epidemic. And again, prescription opioids come from American companies and are prescribed by American doctors overseen by American regulators. Immigrants have no part in our ongoing prescription opioid epidemic.

It is absolutely true that some criminals from other countries deal heroin in the U.S. But as documented in journalist Sam Quinones' excellent book *Dreamland*, those dealers came here to capitalize on the millions of Americans who were already addicted to prescription opioids. Few people spontaneously decide to use heroin, and even less so heroin laced with fentanyl. But many people get pushed to that point after first becoming addicted to prescription opioids. As addicted people become tolerant to the effects of prescription opioids, they typically increase their consumption to the point that it exceeds the amount of pills they can extract from the health care system or can purchase on the street. Because, adjusted for potency, heroin costs about one-third as much as Oxycontin on the street, many prescription opioid addicted people "trade down" to heroin, allowing them to buy three times as much opioid as they could before, which they may consume themselves, sell to other users, or both.

Arresting heroin dealers, whether they are from the U.S. or other countries, will thus never eliminate the root of our problem. Smart enforcement actions against high-level heroin traffickers can make a difference,

including producing a drought of the drug that leads some users to seek treatment. But as long as we continue putting countless Americans in "heroin prep school" each year by overprescribing opioids, the next generation of users will soon replace those who exit the heroin market.

The epidemic is thus an enormous challenge which merits a more informed and strategic national response than the Trump Administration has offered thus far. Critical agencies such as The White House Office of National Drug Control Policy, The Centers for Disease Control and Prevention, and the Drug Enforcement Administration all lack Presidentially-appointed leadership even as the opioid epidemic worsens. President Trump's budget request to spend $18 billion to begin building a wall on the Rio Grande is ill-directed when the health care system is distributing enough opioids each year for every American adult to be medicated round the clock for a month. Also, given that all the heroin imported from Mexico each year could fit in about 2,000 pieces of luggage and that the fentanyl supply is even more compact and hard to interdict than that, the billions of dollars it would take to even start building the wall would make little difference relative to what a comparable investment elsewhere could accomplish.

When the President declared that the opioid epidemic was a public health emergency in 2017, he only made available funds in the amount of $57,000 – less than a dollar for each overdose the U.S. experienced that year. His just-released budget request includes $13 billion in new funding for opioid epidemic response spread across fiscal years 2018 and 2019. This would be a significant investment on its face, but because the request is coupled with major proposed cuts to the Department of Health and Human Services and a request to repeal the Affordable Care Act, it is likely than on balance the President's budget request would cut rather than increase funding for opioid use disorder treatment if enacted.

Fortunately, Congress has recently shown the kind of leadership that the country needs by appropriating $6 billion to fight the opioid epidemic. We now have the resources to begin putting effective policies into place. Two important sources of excellent ideas are the Surgeon General's Report on Facing Addiction that was released 14 months ago and The President's Commission on Combating Addiction and the Opioid Crisis, which began offering proposals beginning last summer. Let me list a few of the promising proposals that appear in one or both of these reports:

- Enhance prescription drug monitoring programs (PDMPs). PDMPs can help prescribers identify someone who is addicted as well as people who are engaging in doctor shopping to support their drug dealing. PDMPs can also help law enforcement identify pill mills. Needed enhancements to PDMPs that the federal government could support include helping states

share data across borders, mandating that doctors check the system before prescribing opioids and other controlled substances, and providing grants to private sector companies to integrate PDMPs with existing systems for managing electronic health records.

- Require as a condition of obtaining and renewing DEA controlled substances prescribing licenses that doctors complete a training course in safe prescribing, including content on recognizing addiction and how to link people to treatment.
- Ensure that non-opioid alternatives for pain, including physical therapy, are adequately reimbursed. As a major purchaser of health care, the federal government has huge leverage to ensure that the economic incentives support health care providers giving pain patients more options than opioids, which after all, in addition to being addictive, have limited efficacy in relieving chronic pain.
- Direct the Department of Labor to actively enforce the provisions of the 2008 Mental Health Parity and Addiction Equity Act. This law, which passed Congress with an overwhelmingly bipartisan majority, mandates that insurers covering employees of large companies offer benefits for substance use disorder care at parity with those for other health conditions. But some insurers have resisted implementation, denying life-saving addiction treatment to which enrollees are legally entitled. A few individual states have successfully held the insurance industry accountable and forced them to follow the law, but for the most part, evasions of parity requirements have gone unpunished and thus demand close federal oversight.
- Rebuild the data collection capacity of the federal government regarding drugs. In the midst of this epidemic, we have very poor information on how many people use heroin and other street drugs. Overdose data are also of low quality and slow in coming in throughout much of the country. Even a small federal investment in enhancing data collection systems would pay handsome dividends in terms of better-directed, more effective and evaluable, policies.
- Get naloxone, the life-saving overdose reversal drug, into the hands of every first responder in the country. This is challenging because as demand for the medication has grown, its price has risen. As a major purchaser, the federal government should in this emergency situation waive its rule forbidding negotiation of drug prices. This would allow a massive purchase of naloxone at low cost per unit that could be distributed to hard hit areas all over the country.
- Augment Medicaid's role as a payor for addiction treatment. We have unfortunately been moving in the opposite direction with efforts to curtail Medicaid expansion, impose work requirements, and cut funds from the program. Instead, we should be increasing the number of

people covered so that opioid-addicted individuals can receive the treatment they need to restore them to health.

I hope this sampling of effective policies gives a flavor of how we can respond to an epidemic that was made in America and to which the solutions are within America as well. Thank you again for the opportunity to testify. I look forward to your questions.

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