that children and their parents receive appropriate screenings and followup.

I want to thank Representatives CAPPS and GUTHRIE for their leadership on this issue. I thank Chairman UPTON, Ranking Member PALLONE, and Chairman PITTS for their work to advance this important legislation. I urge my colleagues to support H.R. 1344, the Early Hearing Detection and Intervention Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I have no further requests for time, and I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS), my colleague and a cosponsor of the bill.

Mrs. CAPPS. I thank my colleague for yielding.

Mr. Speaker, I rise in strong support of H.R. 1344, the Early Hearing Detection and Intervention Act, which I was so pleased to coauthor with my colleague from Kentucky, Congressman BRETT GUTHRIE.

Hearing loss in newborns is considered an invisible disability. Almost 3 out of every 1,000 children in the United States are born deaf or hard of hearing, and even more children lose their hearing later on during childhood. When hearing loss is left undetected, it can impede speech, language, and cognitive development; but we know that, when hearing loss is caught early, children have much better outcomes. In fact, early intervention can help children overcome hearing issues and get them ready to learn on par with their peers.

That is exactly what the Early Hearing Detection and Intervention Act does, pronounced ''Eddie.'' As it is commonly called, EHDI has helped families in all 50 States and the District of Columbia identify children in need of care early when interventions are most effective.

By all accounts, this program has worked. Since the implementation of the EHDI program 15 years ago, we have seen a tremendous increase in the number of newborns who are being screened for hearing loss. Back in 2000, when we first set up the EHDI program, only 44 percent of newborns in the country were being screened for hearing loss. Now we are screening newborns at a rate of over 96 percent. This is a remarkable achievement, but our work is not done.

While it is important that all babies are screened for hearing loss, it is just as important that those babies who do not pass this screening receive a diagnostic evaluation and be connected to early intervention programs. Unfortunately, according to the Centers for Disease Control, 36 percent of newborns who fail their initial hearing screenings are not receiving appropriate followup care. This reauthorization effort will focus on those children, helping to bridge the gap between screening and intervention.

My background is as a school nurse for over 20 years, and I have worked with so many students who were lagging behind their classmates due to undiagnosed or untreated hearing loss.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Mr. GENE GREEN of Texas. I yield the gentlewoman an additional 30 seconds.

Mrs. CAPPS. These children did not need to suffer. We can and must help them succeed through stronger investments in followup and interventions, such as sign language training, hearing aids, and speech-language development. Early identification and intervention are both keys to a child's well-being.

Our legislation would ensure that these programs are there for the children who need them. A vote for this bill is a vote to keep this program strong. I urge my colleagues to support our bipartisan bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I urge the support of this bill, and I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, in closing, I thank my friend from California (Mrs. CAPPS) so much for our working together to move this bipartisan bill forward. I thank our subcommittee ranking member, Mr. GREEN, and our chairman, Chairman PITTS.

I was involved in this effort in Kentucky when I was in the State Senate. I have seen the difference that it makes, and I am glad to be involved in this on a national level. Knowing that 97 percent of our babies are screened so they can get intervention and treatment very early in their lives makes a big difference. I am proud to be a part of this, and I urge my colleagues to vote for H.R. 1344.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I support H.R. 1344, the ''Early Hearing Detection and Intervention Act of 2015'' introduced by my colleagues Representatives CAPPS and GUTHRIE.

H.R. 1344, would reauthorize the Early Hearing Detection and Intervention Program. Prior to the creation of this program, less than 50 percent of all newborns were regularly screened for hearing loss. I'm proud to say that thanks to this program about 97 percent of newborns now receive a hearing screening. Through this program, children gain early access to interventions and treatments that are critical in minimizing a hearing-impaired child's risk of developmental delays, especially communication, social skills and cognition. H.R. 1344 would ensure that we continue to support this valuable public health program that has a proven track record of success.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 1344, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

## NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING REAUTHORIZATION ACT OF 2015

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1725) to amend and reauthorize the controlled substance monitoring program under section 399O of the Public Health Service Act, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1725

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''National All Schedules Prescription Electronic Reporting Reauthorization Act of 2015''.

**SEC. 2. AMENDMENT TO PURPOSE.**

Paragraph (1) of section 2 of the National All Schedules Prescription Electronic Reporting Act of 2005 (Public Law 109–60) is amended to read as follows:

''(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that—

''(A) health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

''(B) appropriate law enforcement, regulatory, and State professional licensing authorities have access to prescription history information for the purposes of investigating drug diversion and prescribing and dispensing practices of errant prescribers or pharmacists; and''.

**SEC. 3. AMENDMENTS TO CONTROLLED SUBSTANCE MONITORING PROGRAM.**

Section 399O of the Public Health Service Act (42 U.S.C. 280g–3) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''or'';

(ii) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

(iii) by adding at the end the following:

''(C) to maintain and operate an existing State-controlled substance monitoring program.''; and

(B) in paragraph (3), by inserting ''by the Secretary'' after ''Grants awarded'';

(2) by amending subsection (b) to read as follows:

''(b) MINIMUM REQUIREMENTS.—The Secretary shall maintain and, as appropriate, supplement or revise (after publishing proposed additions and revisions in the Federal Register and receiving public comments thereon) minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).'';

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in the matter preceding clause (i), by striking ''(a)(1)(B)'' and inserting ''(a)(1)(B) or (a)(1)(C)'';

(ii) in clause (i), by striking ''program to be improved'' and inserting ''program to be improved or maintained'';

(iii) by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively;

(iv) by inserting after clause (ii) the following:

''(iii) a plan to apply the latest advances in health information technology in order to incorporate prescription drug monitoring

program data directly into the workflow of prescribers and dispensers to ensure timely access to patients' controlled prescription drug history;'';

(v) in clause (iv), as redesignated, by inserting before the semicolon at the end ''and at least one health information technology system such as an electronic health records system, a health information exchange, or an e-prescribing system''; and

(vi) in clause (v), as redesignated, by striking ''public health'' and inserting ''public health or public safety'';

(B) in paragraph (3)—

(i) by striking ''If a State that submits'' and inserting the following:

''(A) IN GENERAL.—If a State that submits'';

(ii) by striking the period at the end and inserting ''and include timelines for full implementation of such interoperability. The State shall also describe the manner in which it will achieve interoperability between its monitoring program and health information technology systems, as allowable under State law, and include timelines for implementation of such interoperability.''; and

(iii) by adding at the end the following:

''(B) MONITORING OF EFFORTS.—The Secretary shall monitor State efforts to achieve interoperability, as described in subparagraph (A).''; and

(C) in paragraph (5)—

(i) by striking ''implement or improve'' and inserting ''establish, improve, or maintain''; and

(ii) by adding at the end the following: ''The Secretary shall redistribute any funds that are so returned among the remaining grantees under this section in accordance with the formula described in subsection (a)(2)(B).'';

(4) in subsection (d)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''In implementing or improving'' and all that follows through ''(a)(1)(B)'' and inserting ''In establishing, improving, or maintaining a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subparagraph (B) or (C) of subsection (a)(1)''; and

(ii) by striking ''public health'' and inserting ''public health or public safety''; and

(B) by adding at the end the following:

''(5) The State shall report to the Secretary on—

''(A) as appropriate, interoperability with the controlled substance monitoring programs of Federal departments and agencies;

''(B) as appropriate, interoperability with health information technology systems such as electronic health records systems, health information exchanges, and e-prescribing systems; and

''(C) whether or not the State provides automatic, real-time or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.'';

(5) in subsections (e), (f)(1), and (g), by striking ''implementing or improving'' each place it appears and inserting ''establishing, improving, or maintaining'';

(6) in subsection (f)—

(A) in paragraph (1)—

(i) in subparagraph (B), by striking ''misuse of a schedule II, III, or IV substance'' and inserting ''misuse of a controlled substance included in schedule II, III, or IV of section 202(c) of the Controlled Substance Act''; and

(ii) in subparagraph (D), by inserting ''a State substance abuse agency,'' after ''a State health department,''; and

(B) by adding at the end the following:

''(3) EVALUATION AND REPORTING.—Subject to subsection (g), a State receiving a grant under subsection (a) shall provide the Secretary with aggregate data and other information determined by the Secretary to be necessary to enable the Secretary—

''(A) to evaluate the success of the State's program in achieving its purposes; or

''(B) to prepare and submit the report to Congress required by subsection (l)(2).

''(4) RESEARCH BY OTHER ENTITIES.—A department, program, or administration receiving nonidentifiable information under paragraph (1)(D) may make such information available to other entities for research purposes.'';

(7) by redesignating subsections (h) through (n) as subsections (j) through (p), respectively;

(8) in subsections (c)(1)(A)(iv) and (d)(4), by striking ''subsection (h)'' each place it appears and inserting ''subsection (j)'';

(9) by inserting after subsection (g) the following:

''(h) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving a grant under subsection (a) shall take steps to—

''(1) facilitate prescriber and dispenser use of the State's controlled substance monitoring system;

''(2) educate prescribers and dispensers on the benefits of the system both to them and society; and

''(3) facilitate linkage to the State substance abuse agency and substance abuse disorder services.

''(i) CONSULTATION WITH ATTORNEY GENERAL.—In carrying out this section, the Secretary shall consult with the Attorney General of the United States and other relevant Federal officials to—

''(1) ensure maximum coordination of controlled substance monitoring programs and related activities; and

''(2) minimize duplicative efforts and funding.'';

(10) in subsection (l)(2)(A), as redesignated by paragraph (7)—

(A) in clause (ii), by inserting ''; established or strengthened initiatives to ensure linkages to substance use disorder services;'' before ''or affected patient access''; and

(B) in clause (iii), by inserting ''and between controlled substance monitoring programs and health information technology systems'' before '', including an assessment'';

(11) by striking subsection (m) (relating to preference), as redesignated by paragraph (7);

(12) by redesignating subsections (n) through (p), as redesignated by paragraph (7), as subsections (m) through (o), respectively;

(13) in subsection (m)(1), as redesignated by paragraph (12), by striking ''establishment, implementation, or improvement'' and inserting ''establishment, improvement, or maintenance'';

(14) in subsection (n), as redesignated by paragraph (12)—

(A) in paragraph (5)—

(i) by striking ''means the ability'' and inserting the following: ''means—

''(A) the ability'';

(ii) by striking the period at the end and inserting ''; or''; and

(iii) by adding at the end the following:

''(B) sharing of State controlled substance monitoring program information with a health information technology system such as an electronic health records system, a health information exchange, or an e-prescribing system.'';

(B) in paragraph (7), by striking ''pharmacy'' and inserting ''pharmacist''; and

(C) in paragraph (8), by striking ''and the District of Columbia'' and inserting '', the District of Columbia, and any commonwealth or territory of the United States''; and

(15) by amending subsection (o), as redesignated by paragraph (12), to read as follows:

''(o) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years from 2016 through 2020.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of H.R. 1725, the National All Schedules Prescription Electronic Reporting Reauthorization Act of 2015, introduced by my colleagues Mr. WHITFIELD, Mr. KENNEDY, Mr. BUCSHON, and Mr. PALLONE.

Prescription drug abuse is an epidemic in this country, and, sadly, Kentucky is impacted by high rates of prescription drug abuse. Every year, there are 15,000 overdose deaths from prescription pain relievers. For every overdose death, there are an estimated 10 addiction treatment admissions and 32 emergency department visits. One important tool we have as a nation to combat this epidemic is Prescription Drug Monitoring Programs. They prevent doctor shopping and help physicians make more informed clinical decisions.

Reauthorizing NASPER would provide grant support to States to establish Prescription Drug Monitoring Programs. Healthcare providers can access a patient's prescription history through the PDMP to help them identify patients at risk for addiction or those who are abusing prescription drugs. NASPER also helps identify best practices for new PDMPs and ways to improve existing monitoring programs.

Mr. Speaker, I urge my colleagues to support this bill, and I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of H.R. 1725, the National All Schedules Prescription Electronic Reporting Reauthorization Act. This important legislation is sponsored by Ranking Member PALLONE, Representatives JOE KENNEDY and ED WHITFIELD, and Congressman LARRY BUCSHON.

The reauthorization of NASPER is urgently needed to ensure that physicians have patient-specific information through Prescription Drug Monitoring

Programs, PDMPs, at the point of care. As its name suggests, PDMPs help physicians and other providers make appropriate prescribing decisions while ensuring that patients with legitimate pain management needs have access to necessary care. We are in the middle of an epidemic of prescription drug opioid misuse and overdose. According to the Centers for Disease Control and Prevention, in 2013, more than 16,000 Americans died from an opioid-related overdose.

PDMPs are an integral part of our Nation's effort to combat the ongoing opioid and prescription drug epidemic. They allow for the early identification of at-risk patients and timely intervention to prevent prescription drug abuse. States have recognized that PDMPs are a vital tool to address this public health crisis as demonstrated by their universal adoption amongst the States.

H.R. 1725 reauthorizes grants to States to enhance their PDMPs, and it makes further improvements to the programs. Funding for PDMPs is needed to help States utilize this effective tool, to incentivize information sharing across State lines, and to further the implementation of best practices.

I want to thank Ranking Member PALLONE and Representatives KENNEDY, WHITFIELD, and BUCSHON for their leadership. I also want to thank my colleagues on the Energy and Commerce Committee for their commitment to addressing our Nation's opioid epidemic. I urge my colleagues to support H.R. 1725.

I reserve the balance of my time.

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Mr. GUTHRIE. Mr. Speaker, I yield 4 minutes to the gentleman from Kentucky (Mr. WHITFIELD), who has worked tirelessly on these issues in the Energy and Commerce Committee and back home to try to address the prescription drug problem in our State.

Mr. WHITFIELD. Mr. Speaker, I rise today in support of H.R. 1725, the National All Schedules Prescription Electronic Reporting Reauthorization Act, as we call it, NASPER.

I introduced this legislation earlier this year with my colleagues, Congressman LARRY BUCSHON of Indiana, FRANK PALLONE of New Jersey, and JOE KENNEDY of Massachusetts.

I want to thank Chairman UPTON, Ranking Member PALLONE, as well as Subcommittee Chair PITTS, Ranking Member GREEN, and Congressman GUTHRIE for helping move this bill through the committee and subcommittee.

It has already been stated, the importance of this legislation to reauthorize NASPER. Prescription drug overdose death is reaching an epidemic proportion. Tragically, it has increased in America by fivefold since 1980, and drug overdose now kills more Americans than automobile accidents.

In my home State of Kentucky, more than 1,000 individuals die each year from prescription drug overdose, which is the third highest rate in the country.

Ten years ago NASPER was signed into law to assist States in combating prescription drug abuse through the creation and improvement of prescription drug-monitoring programs, which experts agree are one of the most promising clinical tools to address this epidemic.

So today we come to the floor to reauthorize this important legislation, and I hope that we can continue our efforts to obtain adequate funding from the Appropriations Committee for NASPER.

While there is no silver bullet to solve the problem, we do have an opportunity to make a difference by advancing this reauthorization act. I urge my colleagues to join me in supporting that effort.

Mr. GENE GREEN of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. BUCSHON), a colleague, friend, neighbor—our districts are joined on the Ohio River—who is a physician who understands these issues.

Mr. BUCSHON. Mr. Speaker, I rise today as an original coauthor of this legislation, H.R. 1725. The reauthorization of NASPER would allow SAMHSA to provide grants to States for the establishment, implementation, and improvement of prescription drug-monitoring programs, or PDMPs, offering timely access to accurate prescription information for healthcare providers.

As a physician, I understand this is critical to a provider's ability to screen and treat patients at risk for addiction.

The NASPER program also promotes greater information sharing among States by requiring grantees to facilitate these monitoring programs with at least one bordering State while simultaneously protecting against unauthorized access to patient records.

This reauthorization language would also encourage States to explore ways to incorporate access to their PDMPs into provider workflow systems, such as electronic health records and e-prescribing. Given the growing problem of prescription drug abuse, this is a commonsense measure to protect the public.

I want to thank Mr. WHITFIELD, Mr. KENNEDY, and Ranking Member PALLONE for their work on this legislation.

I urge all of my colleagues to support this important bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I have no further speakers.

I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

I appreciate Mr. WHITFIELD, Dr. BUCSHON, certainly Mr. KENNEDY, and Mr. PALLONE for bringing this forward. It is important. It is important to my State, and it is important to our neighboring States and citizens throughout this country.

I urge my colleagues to vote for H.R. 1725.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I am pleased to support H.R. 1725, the ''National All Schedules Prescription Electronic Reporting (NASPER) Reauthorization Act,'' which helps States establish and maintain prescription drug monitoring programs in order to combat prescription drug abuse, a public health crisis affecting communities across the country. I have been a long-time champion of this bill with my colleague Representative WHITFIELD and I am pleased that Representatives KENNEDY and BUCSHON joined our efforts this Congress to reauthorize the NASPER program.

Prescription drug monitoring programs help prescribers, pharmacists, and law enforcement track and prevent the misuse of prescription drugs. Forty nine states currently have laws authorizing these programs and they are playing a critical role in our efforts to combat the opioid crisis. This bill, however, once passed into law, will need funding and investment by appropriators in order to be effective. I urge Members to ensure that investment is met.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 1725, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

## PROTECTING OUR INFANTS ACT OF 2015

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1462) to combat the rise of prenatal opioid abuse and neonatal abstinence syndrome.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1462

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Protecting Our Infants Act of 2015''.

**SEC. 2. FINDINGS.**

Congress finds as follows:

(1) Opioid prescription rates have risen dramatically over the past several years. According to the Centers for Disease Control and Prevention, in some States, there are as many as 96 to 143 prescriptions for opioids per 100 adults per year.

(2) In recent years, there has been a steady rise in the number of overdose deaths involving heroin. According to the Centers for Disease Control and Prevention, the death rate for heroin overdose doubled from 2010 to 2012.

(3) At the same time, there has been an increase in cases of neonatal abstinence syndrome (referred to in this section as ''NAS''). In the United States, the incidence of NAS has risen from 1.20 per 1,000 hospital births in 2000 to 3.39 per 1,000 hospital births in 2009.

(4) NAS refers to medical issues associated with drug withdrawal in newborns due to exposure to opioids or other drugs in utero.

(5) The average cost of treatment in a hospital for NAS increased from $39,400 in 2000 to $53,400 in 2009. Most of these costs are born by the Medicaid program.

(6) Preventing opioid abuse among pregnant women and women of childbearing age is crucial.