fallen and how great a person they were.

So it is not just what we do today; it is really about what has happened. The gentleman from New Jersey talked about the Senate; and Mr. KING, from this House, from New York, moved this legislation through. It has been a pleasure to stand here today, to come here today and talk for all those who can't talk for themselves; they can't speak for themselves.

My 38 years in law enforcement was probably the best time of my life because I was actually doing something and protecting people on a regular basis. I can't think of a greater honor than to fly a flag of this Nation over this Capitol and give that to the grieving family of a fallen first responder. Mr. Speaker, knowing that this institution is behind them, so stand the American people.

Mr. Speaker, I urge my colleagues to support this legislation. I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of S. 2755, the ''Fallen Heroes Flag Act of 2016,'' which allows Members and Senators, at the request of an immediate family member of a fallen emergency responder, to have a flag flown above the United States Capitol in their memory.

As a senior member of the House Committee on Homeland Security, I am intimately aware, as are my colleagues, of the great sacrifices made by our emergency responders.

This is why I am proud that earlier this Congress the House passed H.R. 2795, the FRIENDS Act, which I introduced.

I introduced the FRIENDS Act because it embodied the important and fundamental idea that we have an obligation to ensure that the first responders who protect our loved ones in emergencies, have the peace of mind that comes from knowing that their loved ones are safe while they do their duty.

S. 2755 and the FRIENDS Act embody the spirit of bipartisanship that is needed in this Congress.

These brave men and women who risk everything by running towards danger should be honored by this Congress by streamlining the process to have a flag flown above the U.S. Capitol in their memory.

Let us not forget the 15 brave volunteer firefighters who perished in the city of West, Texas, in 2013 when a fertilizer plant exploded.

This tragedy serves as a reminder of the risks and dangers undertaken each day by our firefighters and other first responders to keep us safe.

Since 1996 in the city of Houston there have been 20 firefighters that have lost their lives protecting others.

They are District Chief Ruben Lopez, Firefighter Steven C. Mayfield, Firefighter Lewis E. Mayo III, Firefighter Kimberly A. Smith, Captain Jay Paul Jahnke, Probationary Firefighter Kevin Wayne Kulow, Captain Grady Don Burke, Assistant Chief David Louis Moore, Captain James Arthur Harlow Sr., Captain Damion Jon Hobbs, Cadet Firefighter Cohnway Matthew Johnson, Captain Thomas William Dillion, Engineer Operator Robert Ryan Bebee, Firefighter/EMT Robert Herman Garner, IV, Captain Matthew Rena Renaud, Firefighter Anne McCormick Sullivan, Firefighter Daniel D Groover, Captain Dwight ''B.B.'' W Bazile, Firefighter Richard J Cano, and Cadet Steven Whitfield II.

Since 1860, 109 Houston Police officers have fallen in the line of duty.

In 2015 officer Richard K. Martin was killed when he was intentionally struck with a car when he was laying down spike strips during a pursuit.

I have on many occasions requested that U.S. Flags be flown above the Capitol in the memory of fallen first responders and presented them to the family members.

First responders are called to serve and few outside of their ranks can understand why they do the work that they do each day placing their lives in harm's way to save a stranger.

The greatest example of the selflessness of first responders was the hundreds of fire fighters, law enforcement officers, emergency management service personnel, port authority workers, and federal officers and agents who rushed into the Twin Towers on September 11th 2001, to save lives.

On that terrible day 366 first responders sacrificed their lives so others may live.

Mr. Speaker, I support S. 2755 because this bill streamlines the process to have a flag flown in the memory of the fallen emergency responders in this country.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. NUGENT) that the House suspend the rules and pass the bill, S. 2755.

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

A motion to reconsider was laid on the table.

PROMOTING RESPONSIBLE OPIOID MANAGEMENT AND INCORPORATING SCIENTIFIC EXPERTISE ACT

Mr. MILLER of Florida. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4063) to improve the use by the Secretary of Veterans Affairs of opioids in treating veterans, to improve patient advocacy by the Secretary, and to expand the availability of complementary and integrative health, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4063

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 ''Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act'' or the ''Jason Simcakoski PROMISE Act''.

SEC. 2. IMPROVEMENT OF OPIOID SAFETY MEASURES BY DEPARTMENT OF VETERANS AFFAIRS.

(a) EXPANSION OF OPIOID SAFETY INITIATIVE.—

(1) INCLUSION OF ALL MEDICAL FACILITIES.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall expand the Opioid Safety Initiative of the Department of Veterans Affairs to include all medical facilities of the Department.

(2) GUIDANCE.—The Secretary shall establish guidance that each health care provider of the Department of Veterans Affairs, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or any subsequent tool), which shall include information from the prescription drug monitoring program of each participating State as applicable, that includes the most recent information to date relating to the patient that accessed such program to assess the risk for adverse outcomes of opioid therapy for the patient, including the concurrent use of controlled substances such as benzodiazepines, as part of the comprehensive assessment conducted by the health care provider.

(3) ENHANCED STANDARDS.—The Secretary shall establish enhanced standards with respect to the use of routine and random urine drug tests for all patients before and during opioid therapy to help prevent substance abuse, dependence, and diversion, including—

(A) that such tests occur not less frequently than once each year; and

(B) that health care providers appropriately order, interpret and respond to the results from such tests to tailor pain therapy, safeguards, and risk management strategies to each patient.

(b) PAIN MANAGEMENT EDUCATION AND TRAINING.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the Secretary shall require all employees of the Department responsible for prescribing opioids to receive education and training described in paragraph (2).

(2) EDUCATION AND TRAINING.—Education and training described in this paragraph is education and training on pain management and safe opioid prescribing practices for purposes of safely and effectively managing patients with chronic pain, including education and training on the following:

(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.

(B) The use of evidence-based pain management therapies, including cognitive-behavioral therapy, non-opioid alternatives, and non-drug methods and procedures to managing pain and related health conditions including medical devices approved or cleared by the Food and Drug Administration for the treatment of patients with chronic pain and complementary alternative medicines.

(C) Screening and identification of patients with substance use disorder, including drug-seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appropriate addiction treatment professionals if addiction is identified or strongly suspected.

(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other controlled substances.

(E) Such other education and training as the Secretary considers appropriate to ensure that veterans receive safe and high-quality pain management care from the Department.

(3) USE OF EXISTING PROGRAM.—In providing education and training described in paragraph (2), the Secretary shall use the Interdisciplinary Chronic Pain Management Training Team Program of the Department (or success program).

(c) PAIN MANAGEMENT TEAMS.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is noncancer related.

(2) ESTABLISHMENT OF PROTOCOLS.—

(A) IN GENERAL.—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department.

(B) CONSULTATION ON PRESCRIPTION OF OPIOIDS.—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

(3) REPORT.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the director of each medical facility of the Department shall submit to the Under Secretary for Health and the director of the Veterans Integrated Service Network in which the medical facility is located a report identifying the health care professionals that have been designated as members of the pain management team at the medical facility pursuant to paragraph (1).

(B) ELEMENTS.—Each report submitted under subparagraph (A) with respect to a medical facility of the Department shall include—

(i) a certification as to whether all members of the pain management team at the medical facility have completed the education and training required under subsection (b);

(ii) a plan for the management and referral of patients to such pain management team if health care providers without expertise in prescribing analgesics prescribe opioid medications to treat acute and chronic pain that is non-cancer related; and

(iii) a certification as to whether the medical facility—

(I) fully complies with the stepped-care model of pain management and other pain management policies contained in Directive 2009-053 of the Veterans Health Administration, or successor directive; or

(II) does not fully comply with such stepped-care model of pain management and other pain management policies but is carrying out a corrective plan of action to ensure such full compliance.

(d) TRACKING AND MONITORING OF OPIOID USE.—

(1) PRESCRIPTION DRUG MONITORING PROGRAMS OF STATES.—In carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool of the Department, the Secretary shall—

(A) ensure access by health care providers of the Department to information on controlled substances, including opioids and benzodiazepines, prescribed to veterans who receive care outside the Department through the prescription drug monitoring program of each State with such a program, including by seeking to enter into memoranda of understanding with States to allow shared access of such information between States and the Department;

(B) include such information in the Opioid Therapy Risk Report; and

(C) require health care providers of the Department to submit to the prescription drug monitoring program of each State information on prescriptions of controlled substances received by veterans in that State under the laws administered by the Secretary.

(2) REPORT ON TRACKING OF DATA ON OPIOID USE.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of improving the Opioid Therapy Risk Report tool of the Department to allow for more advanced real-time tracking of and access to data on—

(A) the key clinical indicators with respect to the totality of opioid use by veterans;

(B) concurrent prescribing by health care providers of the Department of opioids in different health care settings, including data on concurrent prescribing of opioids to treat mental health disorders other than opioid use disorder; and

(C) mail-order prescriptions of opioid prescribed to veterans under the laws administered by the Secretary.

(e) AVAILABILITY OF OPIOID RECEPTOR ANTAGONISTS.—

(1) INCREASED AVAILABILITY AND USE.—

(A) IN GENERAL.—The Secretary shall maximize the availability of opioid receptor antagonists approved by the Food and Drug Administration, including naloxone, to veterans.

(B) AVAILABILITY, TRAINING, AND DISTRIBUTING.—In carrying out subparagraph (A), not later than 90 days after the date of the enactment of this Act, the Secretary shall—

(i) equip each pharmacy of the Department with opioid receptor antagonists approved by the Food and Drug Administration to be dispensed to outpatients as needed; and

(ii) expand the Overdose Education and Naloxone Distribution program of the Department to ensure that all veterans in receipt of health care under laws administered by the Secretary who are at risk of opioid overdose may access such opioid receptor antagonists and training on the proper administration of such opioid receptor antagonists.

(C) VETERANS WHO ARE AT RISK.—For purposes of subparagraph (B), veterans who are at risk of opioid overdose include—

(i) veterans receiving long-term opioid therapy;

(ii) veterans receiving opioid therapy who have a history of substance use disorder or prior instances of overdose; and

(iii) veterans who are at risk as determined by a health care provider who is treating the veteran.

(2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on carrying out paragraph (1), including an assessment of any remaining steps to be carried out by the Secretary to carry out such paragraph.

(f) INCLUSION OF CERTAIN INFORMATION AND CAPABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF THE DEPARTMENT.—

(1) INFORMATION.—The Secretary shall include in the Opioid Therapy Risk Report tool of the Department—

(A) information on the most recent time the tool was accessed by a health care provider of the Department with respect to each veteran; and

(B) information on the results of the most recent urine drug test for each veteran.

(2) CAPABILITIES.—The Secretary shall include in the Opioid Therapy Risk Report tool the ability of the health care providers of the Department to determine whether a health care provider of the Department prescribed opioids to a veteran without checking the information in the tool with respect to the veteran.

(g) NOTIFICATIONS OF RISK IN COMPUTERIZED HEALTH RECORD.—The Secretary shall modify the computerized patient record system of the Department to ensure that any health care provider that accesses the record of a veteran, regardless of the reason the veteran seeks care from the health care provider, will be immediately notified whether the veteran—

(1) is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose;

(2) has a history of opioid abuse; or

(3) is at risk of becoming an opioid abuser as determined by a health care provider who is treating the veteran.

(h) DEFINITIONS.—In this section:

(1) The term ''controlled substance'' has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term ''State'' means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 3. STRENGTHENING OF JOINT WORKING GROUP ON PAIN MANAGEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the Pain Management Working Group of the Health Executive Committee of the Department of Veterans Affairs–Department of Defense Joint Executive Committee (Pain Management Working Group) established under section 320 of title 38, United States Code, includes a focus on the following:

(1) The opioid prescribing practices of health care providers of each Department.

(2) The ability of each Department to manage acute and chronic pain among individuals receiving health care from the Department, including training health care providers with respect to pain management.

(3) The use by each Department of complementary and integrative health and complementary alternative medicines in treating such individuals.

(4) The concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines.

(5) The practice by health care providers of each Department of prescribing opioids to treat mental health disorders.

(6) The coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from the Department of Defense to receiving health care from the Department of Veterans Affairs.

(7) The ability of each Department to identify and treat substance use disorders among individuals receiving health care from that Department.

(b) COORDINATION AND CONSULTATION.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a)—

(1) coordinates the activities of the working group with other relevant working groups established under section 320 of title 38, United States Code;

(2) consults with other relevant Federal agencies with respect to the activities of the working group; and

(3) consults with the Department of Veterans Affairs and the Department of Defense with respect to, reviews, and comments on the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, or any successor guideline, before any update to the guideline is released.

(c) CLINICAL PRACTICE GUIDELINES.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall issue an update to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(2) MATTERS INCLUDED.—In conducting the update under subsection (a), the Pain Management Working Group, in coordination with the Clinical Practice Guideline VA/DoD Management of Opioid Therapy for Chronic Pain Working Group, shall examine whether the Clinical Practical Guideline should include the following:

(A) Enhanced guidance with respect to—

(i) the coadministration of an opioid and other drugs, including benzodiazepines, that may result in life-limiting drug interactions;

(ii) the treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; and

(iii) the use of opioid therapy to treat mental health disorders other than opioid use disorder.

(B) Enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, such as post-traumatic stress disorder or other psychiatric disorders, or a history of substance abuse or addiction, that requires a consultation or comanagement of opioid therapy with one or more specialists in pain management, mental health, or addictions.

(C) Enhanced guidance with respect to health care providers—

(i) conducting an effective assessment for patients beginning or continuing opioid therapy, including understanding and setting realistic goals with respect to achieving and maintaining an expected level of pain relief, improved function, or a clinically appropriate combination of both; and

(ii) effectively assessing whether opioid therapy is achieving or maintaining the established treatment goals of the patient or whether the patient and health care provider should discuss adjusting, augmenting , or discontinuing the opioid therapy.

(D) Guidelines to govern the methodologies used by health care providers of the Department of Veterans Affairs and the Department of Defense to taper opioid therapy when adjusting or discontinuing the use of opioid therapy.

(E) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient health care settings, which may include the use of care transition plans.

(F) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition from receiving care during active duty to post-military health care networks.

(G) Guidelines with respect to providing options, before initiating opioid therapy, for pain management therapies without the use of opioids and options to augment opioid therapy with other clinical and complementary and integrative health services to minimize opioid dependence.

(H) Guidelines with respect to the provision of evidence-based non-opioid treatments within the Department of Veterans Affairs and the Department of Defense, including medical devices and other therapies approved or cleared by the Food and Drug Administration for the treatment of chronic pain as an alternative to or to augment opioid therapy.

SEC. 4. REVIEW, INVESTIGATION, AND REPORT ON USE OF OPIOIDS IN TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMPTROLLER GENERAL REPORT.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Opioid Safety Initiative of the Department of Veterans Affairs and the opioid prescribing practices of health care providers of the Department.

(2) ELEMENTS.—The report submitted under paragraph (1) shall include the following:

(A) Recommendations on such improvements to the Opioid Safety Initiative of the Department as the Comptroller General considers appropriate.

(B) Information with respect to—

(i) deaths resulting from sentinel events involving veterans prescribed opioids by a health care provider of the Department;

(ii) overall prescription rates and prescriptions indications of opioids to treat non-cancer, non-palliative, and non-hospice care patients;

(iii) the prescription rates and prescriptions indications of benzodiazepines and opioids concomitantly by health care providers of the Department;

(iv) the practice by health care providers of the Department of prescribing opioids to treat patients without any pain, including to treat patients with mental health disorders other than opioid use disorder; and

(v) the effectiveness of opioid therapy for patients receiving such therapy, including the effectiveness of long-term opioid therapy.

(C) An evaluation of processes of the Department in place to oversee opioid use among veterans, including procedures to identify and remedy potential over-prescribing of opioids by health care providers of the Department.

(D) An assessment of the implementation by the Secretary of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(b) QUARTERLY PROGRESS REPORT ON IMPLEMENTATION OF COMPTROLLER GENERAL RECOMMENDATIONS.—Not later than two years after the date of the enactment of this Act, and not later than 30 days after the end of each quarter thereafter, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a progress report detailing the actions by the Secretary during the period covered by the report to address any outstanding findings and recommendations by the Comptroller General of the United States under subsection (a) with respect to the Veterans Health Administration.

(c) ANNUAL REVIEW OF PRESCRIPTION RATES.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually for the following five years, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report, with respect to each medical facility of the Department of Veterans Affairs, to collect and review information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients that contains, for the one-year period preceding the submission of the report, the following:

(1) The number of patients and the percentage of the patient population of the Department who were prescribed benzodiazepines and opioids concurrently by a health care provider of the Department.

(2) The number of patients and the percentage of the patient population of the Department without any pain who were prescribed opioids by a health care provider of the Department, including those who were prescribed benzodiazepines and opioids concurrently.

(3) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were treated with opioids by a health care provider of the Department on an inpatient-basis and who also received prescription opioids by mail from the Department while being treated on an inpatient-basis.

(4) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were prescribed opioids concurrently by a health care provider of the Department and a health care provider that is not health care provider of the Department.

(5) With respect to each medical facility of the Department, information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients, including information on—

(A) the prescription rate at which each health care provider at the facility prescribed benzodiazepines and opioids concurrently to such patients and the aggregate such prescription rate for all health care providers at the facility;

(B) the prescription rate at which each health care provider at the facility prescribed benzodiazepines or opioids to such patients to treat conditions for which benzodiazepines or opioids are not approved treatment and the aggregate such prescription rate for all health care providers at the facility;

(C) the prescription rate at which each health care provider at the facility prescribed or dispensed mail-order prescriptions of opioids to such patients while such patients were being treated with opioids on an inpatient-basis and the aggregate of such prescription rate for all health care providers at the facility; and

(D) the prescription rate at which each health care provider at the facility prescribed opioids to such patients who were also concurrently prescribed opioids by a health care provider that is not a health care provider of the Department and the aggregate of such prescription rates for all health care providers at the facility.

(6) With respect to each medical facility of the Department, the number of times a pharmacist at the facility overrode a critical drug interaction warning with respect to an interaction between opioids and another medication before dispensing such medication to a veteran.

(d) INVESTIGATION OF PRESCRIPTION RATES.—If the Secretary determines that a prescription rate with respect to a health care provider or medical facility of the Department conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, the Secretary shall—

(1) immediately notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of such determination, including information relating to such determination, prescription rate, and health care provider or medical facility, as the case may be; and

(2) through the Office of the Medical Inspector of the Veterans Health Administration, conduct a full investigation of the health care provider or medical facility, as the case may be.

(e) PRESCRIPTION RATE DEFINED.—In this section, the term ''prescription rate'' means, with respect to a health care provider or medical facility of the Department, each of the following:

(1) The number of patients treated with opioids by the health care provider or at the medical facility, as the case may be, divided by the total number of pharmacy users of that health care provider or medical facility.

(2) The average number of morphine equivalents per day prescribed by the health care provider or at the medical facility, as the case may be, to patients being treated with opioids.

(3) Of the patients being treated with opioids by the health care provider or at the medical facility, as the case may be, the average number of prescriptions of opioids per patient.

SEC. 5. MANDATORY DISCLOSURE OF CERTAIN VETERAN INFORMATION TO STATE CONTROLLED SUBSTANCE MONITORING PROGRAMS.

Section 5701(l) of title 38, United States Code, is amended by striking ''may'' and inserting ''shall''.

SEC. 6. MODIFICATION TO LIMITATION ON AWARDS AND BONUSES.

Section 705 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 703 note) is amended to read as follows:

''SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

''The Secretary of Veterans Affairs shall ensure that the aggregate amount of awards and bonuses paid by the Secretary in a fiscal year under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title or title 38, United States Code, does not exceed the following amounts:

''(1) With respect to each of fiscal years 2017 through 2021, $230,000,000.

''(2) With respect to each of fiscal years 2022 through 2024, $360,000,000.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. MILLER) and the gentleman from North Carolina (Mr. BUTTERFIELD) each will control 20 minutes.

The Chair recognizes the gentleman from Florida.

GENERAL LEAVE

Mr. MILLER of Florida. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend or add any extraneous material to their remarks.

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

There was no objection.

Mr. MILLER of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 4063, as amended, the Promoting Responsible Opioid Management and Incorporating Scientific Expertise—or the Jason Simcakoski PROMISE—Act.

When our Nation's servicemembers transition from military life to civilian life, they carry with them the skills, experiences, memories, and relationships that will last a lifetime. Unfortunately, many of them also carry significant pain as a result of injuries that they incurred while in service to this great Nation.

Veterans, in general, experience chronic pain at a higher rate than their nonveteran counterparts. What is more, chronic pain is one of the most frequent conditions facing the veterans of Iraq and Afghanistan.

Effectively managing this pain, which often occurs alongside a number of other comorbid conditions, is a challenge for which the Department of Veterans Affairs has been increasingly turning to opioid-based medications to meet that challenge.

Now, while opioids, when used appropriately, can be effective in treating pain, opioid medications are extremely high risk. Unfortunately, VA's own research has found that veterans are at an increased risk for many adverse outcomes that may accompany opioid use, including substance abuse, overdose, and self-inflicted injuries.

Given that, VA's recent reliance on opioid medications to manage veteran pain is alarming. According to a CBS News report on VA data, the number of opioid prescriptions written by VA providers rose an astonishing 259 percent from 2002 to 2013. During that same time period, VA's total patient population increased only 29 percent.

The sad reality behind an overreliance on opioids became apparent at the VA Medical Center at Tomah, Wisconsin, last year. In response to a series of complaints made in 2011 and 2012, the VA Office of the Inspector General conducted a review of alleged inappropriate prescribing of controlled substances and abuse of authority at the Tomah VA Medical Center. The IG found that the number of opioids prescribed in Tomah was ''at considerable variance'' with the other VA medical facilities in that region and was a cause for ''potentially serious concerns.''

□ 1545

It is no wonder that the veterans being treated in Tomah commonly referred to it as ''Candy Land'' and to the facility chief of staff as the ''Candy Man.'' Jason Simcakoski was one veteran who was being treated by the Tomah VA Medical Center.

In August of 2014, Jason died from the combined effect of the multiple prescription medications he received as an in-patient. He put his trust in a system that ultimately failed him.

He left behind a young daughter and a grieving family, some of whom are with us today. Unfortunately, the failures in Tomah, the failures that led to Jason's death, are not isolated. There are countless others just like him in the VA across this country.

Chronic pain and the conditions that frequently accompany it are undoubtedly complex, and concerns about an overreliance on opioids are certainly not unique to the Department of Veterans Affairs.

But the VA alone has the responsibility to treat our Nation's most heroic citizens, meaning VA does have a unique responsibility to act responsibly.

The bill before us would help the Department do just that by improving and expanding opioid safety initiatives, strengthening the VA/Department of Defense joint working group on pain management, mandating that VA medical facilities disclose information to State-controlled substance monitoring programs, and requiring VA review, investigate, and report on the use of opioids among veteran patients.

The manager's amendment to H.R. 4063 would require the Department and DOD to update their joint clinical practice guidelines for the management of opioid therapy to reflect the latest medical practices.

The bill would also direct VA to ensure that every employee who prescribes opioids receives education and training on pain management and safe prescribing practices and every VA medical facility has a designated pain management team.

It would further require VA to maximize the availability of Food and Drug Administration-approved opioid receptor antagonists to ensure that veterans most at risk of opioid overdose have access to and training on potentially life-saving drugs that can counter the devastating effects of an opioid overdose.

I am grateful to the vice chairman of the full Veterans' Affairs Committee, GUS BILIRAKIS, for sponsoring this legislation. I urge all of my colleagues to join me in supporting it.

I reserve the balance of my time.

COMMITTEE ON ARMED SERVICES,
HOUSE OF REPRESENTATIVES,
Washington, DC, May 9, 2016.

Hon. JEFF MILLER,
Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: I am writing to you concerning the bill H.R. 4063, the Jason Simcakoski PROMISE Act. There are certain provisions in the legislation which fall within the Rule X jurisdiction of the Committee on Armed Services.

In the interest of permitting your committee to proceed expeditiously to floor consideration of this important bill, I am willing to waive this committee's right to sequential referral. I do so with the understanding that by waiving consideration of the bill the Committee on Armed Services does not waive any future jurisdictional claim over the subject matters contained in the bill which fall within its Rule X jurisdiction. I request that you urge the Speaker to name members of this committee to any conference committee which is named to consider such provisions.

Please place this letter into the committee report on H.R. 4063 and into the Congressional Record during consideration of the

measure on the House floor. Thank you for the cooperative spirit in which you have worked regarding this matter and others between our respective committees.

Sincerely,

WILLIAM M. ''MAC'' THORNBERRY,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, May 10, 2016.

Hon. WILLIAM M. ''MAC'' THORNBERRY,
Chairman, Committee on Armed Services,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN, Thank you for your letter regarding H.R. 4063, as amended, the Jason Simcakoski PROMISE Act.

I agree that the Committee on Armed Services has valid jurisdictional claims to certain provisions in this legislation and I appreciate your decision not to request a referral in the interest of expediting consideration of the bill.

I agree that by foregoing a sequential referral to H.R. 4063, as amended, the Committee on Armed Services is not waiving its jurisdiction.

This exchange of letters will be included in the Committee's report on H.R. 4063, as amended.

If you have any further questions or concerns, please contact Christine Hill, Staff Director for the Subcommittee on Health.

Thank you for your commitment to the well-being of our nation's veterans.

With warm personal regards, I am,

Sincerely,

JEFF MILLER,
Chairman.

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

Mr. Speaker, I rise today in support of H.R. 4063, as amended, the Jason Simcakoski PROMISE Act.

I would like to thank my friend from Florida, the vice chair of the committee, Congressman GUS BILIRAKIS, for introducing this bill and for his passionate leadership on this very important issue.

Mr. Speaker, I also would like to take a moment to thank Chairman MILLER for his extraordinary leadership on this bill and on issues that pertain to veterans generally. I thank the chairman so much for all of his work. In fact, the rumor among our colleagues is that he runs the most bipartisan committee on Capitol Hill. I thank him for his leadership.

The epidemic of opioid addiction and overdose deaths is a national problem. It is a public health crisis, Mr. Speaker, that affects constituents living in all of our districts and all of our States.

Opioid use disorder is a chronic relapsing disease of the brain. Yet, the stigma associated with opioid use disorder keeps people from seeking, accessing, or maintaining treatment.

In 2014, according to The New York Times, over 47,000 people died from a drug overdose. That is 125 Americans each day who lost their lives due to addiction or abuse. Of these, more than 61 percent involved opioids.

Across the country, Mr. Speaker, nearly 260 million prescriptions are written for opioids, enough, according to the Centers for Disease Control, for every American adult to have their own bottle of pills that can be highly, highly addictive.

In my home State of North Carolina, fatal drug overdoses have jumped 75 percent since 2002. According to an article in February from The Charlotte Observer, nearly half of the accidental drug overdose deaths in 2010 were associated with prescriptions that had been filled within 60 days of death.

It is estimated that North Carolina has spent over $582 million in healthcare costs stemming from opioid abuse. This is nearly $59 for each man, woman, and child in my home State of North Carolina. This is a healthcare problem, Mr. Speaker, that affects all levels of our society. One of the main drivers is the overprescription of opioids to manage pain.

Veterans are at an even greater risk. The statistics on veterans experiencing chronic pain are absolutely staggering. Over 50 percent of all veterans enrolled and receiving care at VA medical facilities experience chronic pain, with over half a million veterans managing pain with prescribed opioids. Compared to the general population, veterans are prescribed opioids at a much, much higher rate.

But there is a growing awareness that the long-term prescription of opioids to manage chronic pain can have severe and sometimes tragic—yes, tragic—consequences. It has been reported that veterans, our beloved veterans, are twice as likely to die from accidental overdose compared to nonveterans.

As a Member of Congress that represents the ''Nation's Most Military Friendly State''—and we like to say that all of the time—and as an Army veteran, as I am myself, I am alarmed and committed to bringing about a solution.

But addressing this crisis will not be easy. The Veterans' Affairs Committee members know that so very well. It is not going to be easy. It will take the work of all of us working together. It will take education. It will take research into more effective and less addictive ways to treat chronic pain.

It will take the combined work, Mr. Speaker, of our States and the Federal Government to address what the CDC has termed ''the worst drug addiction epidemic in the country's history,'' and the chief medical officer of my State's medical board has called it ''an unequivocal health crisis.''

This bill, Mr. Speaker, we are debating today marks a major step forward, and it will go a very long way in helping to lessen this public health emergency.

Mr. Speaker, I reserve the balance of my time.

Mr. MILLER of Florida. Mr. Speaker, I yield 5 minutes to the gentleman from Florida (Mr. BILIRAKIS) of the 12th District of Florida, the vice chairman of the full committee, somebody who has been a stalwart on this and many other veteran issues.

Mr. BILIRAKIS. Mr. Speaker, I thank the chairman and the ranking member. I appreciate it.

I rise in support of my bill, H.R. 4063, the Promoting Responsible Opioid Management and Incorporating Scientific Expertise, or the Jason Simcakoski PROMISE Act.

This important bill helps us fulfill our promise to past, current, and future veterans, our true American heroes, Mr. Speaker.

I introduced the PROMISE Act in response to the tragic death of Marine Corps Corporal Jason Simcakoski at the Tomah, Wisconsin, VA Medical Center.

Jason's death, caused by a mixed drug toxicity and the combination of various medications, was an avoidable tragedy. My colleagues and I worked with local veterans, veterans organizations, and other stakeholders to get this done right.

I am honored to discuss the need for this bill in the presence of Jason's family, who join us in the Capitol on this memorable day. We could not do it without them.

The PROMISE Act can't bring Jason and others like him back. But, like Jason's family expressed to me, this will ensure future veterans get the treatment they need for their physical and invisible wounds.

Currently, VA treatment for chronic pain is largely the prescription of opioids without consideration of a patient's personal history or preferences. Unfortunately, there is a lack of data on veteran opioid use. There are also inefficiencies in the VA identifying abuse of opioids and with patient follow-up to determine effectiveness of these drugs on a case-by-case basis.

The PROMISE Act is the congressional action needed to rectify these problems. The PROMISE Act increases safety for opioid therapy and pain management, ensures more transparency at the VA, and encourages more outreach and awareness of the patient advocacy program for veterans.

My bill also acknowledges that VA patient services do not stop at the initial consultation. It requires the VA to maintain realtime tracking of data on opioid use to help prevent overmedication and misuse or overuse of medication.

I want to thank Speaker RYAN; Representative BUTTERFIELD, of course; our great chairman, Mr. MILLER from Florida, a real good friend of mine; Representative KIND, Representative RICE, and many others who supported this bill and worked to make this happen.

I urge my colleagues to support this bill to uphold our commitment and promise to those that pay the ultimate sacrifice.

Mr. BUTTERFIELD. Mr. Speaker, I yield such time as he may consume to the gentleman from Wisconsin (Mr. KIND), and I thank Mr. KIND for coming to the floor. There is not a Member of this body who works harder than him on issues that pertain to veterans.

(Mr. KIND asked and was given permission to revise and extend his remarks.)

Mr. KIND. Mr. Speaker, I thank my good friend from North Carolina for yielding me this time.

Mr. Speaker, I rise in strong support of the Jason Simcakoski PROMISE Act.

Jason was a veteran who unfortunately saw his life end way too soon while receiving treatment at the Tomah VA Medical Center in the heart of my congressional district.

I want to thank, first of all, Subcommittee Chairman BILIRAKIS for the leadership and support that he has shown this legislation. He has been a real joy to work with.

I want to thank Chairman MILLER for the leadership he has provided the committee and for the concern and the attention that he has given to all of our veterans throughout our country.

I want to thank Representative BUTTERFIELD and the other members of the committee for the strong bipartisan support that this legislation enjoys on the floor today.

Jason was born in Stevens Point, Wisconsin, in 1978 in my congressional district. He is the son of Marvin and Linda Simcakoski. He is a graduate of Stevens Point Pacelli High School.

Shortly after his graduation, he joined the Marine Corps, where he reached the rank of corporal, receiving the Sea Service Deployment Ribbon with one star, a Certificate of Commendation, the Rifle Sharp Shooters Badge, and the Good Conduct Medal. He was honorably discharged in February of 2002. Jason loved being a marine, and he was very proud to serve his country.

He married Heather in 2010 in Stevens Point, and they had a beautiful daughter named Anaya. I am proud that many members of Jason's family came out to Washington this week to see the passage of this bill today: his mother Linda, his wife Heather, his daughter Anaya, who are in the Chamber with us today. His father, Marvin, who was also intimately involved in helping draft this legislation and see it through, was unfortunately unable to attend.

But I commend all of them because this is how legislation is meant to work, by reaching out to veterans organizations, getting direct feedback from the veterans themselves, their families, healthcare providers. We have known for some time that we have had a pain management problem not just in the VA medical system, but throughout our entire healthcare system.

This unfortunately came to light through numerous investigations at the Tomah VA Medical Center over the course of the last few years, which ultimately helped and precipitated the legislation that we have before us today.

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Jason's family's guiding star in all of this, based on the numerous conversations that I have had with them and that they have had with Chairman BILIRAKIS and even with Speaker RYAN, was to ensure that the care and the treatment that our veterans receive be enhanced so that no veteran and no family would have to go through and endure what they did.

Jason was receiving pain management and was under the opioid medication at Tomah. This legislation, I think, advances that goal. I don't think anyone can be here with absolute certitude and promise a family or future veterans that mistakes won't happen in the future; but I think what is contained in this legislation is a significant step in the right direction, with the understanding that more work is needed.

The bill would require a review and an update of the VA's Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain. It requires all opioid prescribers at the VA to have enhanced pain management and safe opioid prescribing education and training. It improves the realtime tracking of and access to data on the opioid use of veterans in order to prevent overmedication. It provides additional resources to assist the VA's ability to counter overdoses. It expands the Opioid Safety Initiative to all VA medical facilities. It updates the Joint Working Group of the VA and DOD to focus on opioid prescribing practices, the use of alternative pain therapy, and the coordination when a servicemember transitions from the DOD into the VA care setting. It also encourages the use of alternative and complementary forms of pain management. Lastly, it requires the VA to report on prescription rates so we can better assess the problem and find solutions.

This is a work in progress not just within the VA system, not just with the reforms that are currently being implemented at the Tomah VA Medical Center in my congressional district, but throughout the entire healthcare system. We as a Nation have not done a very good job of managing pain at all levels. I am glad and I am proud that this Congress sees the need to move forward on a comprehensive opioid legislation bill. Hopefully we can get that to the finish line yet this year. There is also a major VA reform bill that we are working on—excellent vehicles in order to include some of the provisions of this legislation as we move forward.

If there is any hope and promise that out of the tragedy of Jason's death good things can come of it, I think the legislation that we have before us today, the Jason Simcakoski PROMISE Act, gives us that hope and gives us that opportunity. I couldn't think of a more powerful legacy in Jason's name than this legislation.

I ask all of my colleagues to give their support of this legislation today. Again, I thank the leadership of the Committee on Veterans' Affairs for the help, the assistance, and the focus that they have provided on this important piece of legislation.

The SPEAKER pro tempore. Members are reminded that it is not in order to introduce to the House individuals present in the gallery.

Mr. MILLER of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. I thank the gentleman from Florida for yielding and for his efforts and the efforts of all of those who are involved in this legislation.

Mr. Speaker, my concern here is twofold. First of all, as a pharmacist with over 30 years of experience and practice, this is a deep concern of mine.

Secondly, I believe we have a duty to our servicemen and -women who have sacrificed their lives to serve and protect our country. Studies have shown that soldiers and veterans use opioid painkillers far more frequently than civilians because their military training and combat lead to far more injuries. In fact, a report by the American Public Health Association found that the fatal overdose rate among VA patients is nearly double the national average. Something needs to be done. The VA is doing a disservice to our veterans by prescribing too many opioids at too high quantities. That is why H.R. 4063 is so important.

H.R. 4063 directs the Department of Defense and the Department of Veterans Affairs to jointly update the VA/DOD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain so it adequately reflects the current environment we face with opioid abuse. It also directs the VA to modify and establish initiatives and protocols to better address the misuse of opioids by our veterans.

These changes, I believe, will be one step toward ensuring that the services provided to our men and women of the military will improve their overall care and will move us closer to fulfilling our duty of servicing our servicemen and -women.

I ask all of my colleagues to support this legislation.

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

It is bipartisan legislation like this that makes me proud to be a Member of the United States Congress. I want to thank each one of my colleagues for his role in making this day happen.

I thank Jason's family. I am not going to single them out except to make reference to them. I just want to thank Jason's family for making the journey to Washington today for this very important and momentous occasion.

Mr. Speaker, I yield back the balance of my time.

Mr. MILLER of Florida. Mr. Speaker, I yield myself such time as I may consume.

I wish that we did not have to discuss this tragedy today on the floor. Jake is not with us, not by his choice. His wife is a widow; his daughter is now fatherless; his parents lost a son.

Why? Why did he die of a drug overdose inside of the very hospital in which he sought protection?

Mr. Speaker, I hope that all Members will support this legislation today. It is not that it will bring Jake back, but it may prevent this from occurring to another veteran in the future.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in strong support of H.R. 4063, the ''Promise Act.''

H.R. 4063 directs the Department of Veterans Affairs (VA) and the Department of Defense (DOD) to jointly update their respective clinical practice guidelines.

The practice guideline pertains to the management of Opioid Therapy for Chronic Pain.

The guidelines spell out procedures for: (1) prescribing opioids for outpatient treatment, (2) (con-tra-in-di-ca-tions) contraindications for opioid therapy, (3) treatment of patients with post-traumatic stress disorder, (4) psychiatric disorders, or a history of substance abuse or addiction, (5) and management transitioning patients.

The guidelines also prescribe routine and random urine drug tests, as well as treatment options to augment opioid therapy designed to minimize opioid dependence.

This bill examines the VA's evidence-based therapy treatment model for treating veterans' mental health conditions.

The Department of Veterans Affairs (VA) will be expected to update safety measures for opioid therapy, expand the use of alternative medicine, and conduct audits of the VA health care system through a nongovernment entity.

The VA will be required to request documentation of medical license violations during the past 20 years and any settlement agreements for medical-related disciplinary charges from the medical board, of each state.

All VA medical facilities will implement the opioid safety initiative and train employees to effectively dispense pain management techniques through the establishment of pain management teams.

Enhancing national oversight, the VA is also expected to track and monitor opioid use and access to state program information, increase the availability of Food and Drug Administration-approved opioid receptor antagonists, and modify the computerized patient record system, as well as internal audits.

Adjusting the computerized patient record system will ensure that health care providers accessing veterans' records are notified of their use of opioid therapy.

This system also informs health care providers of substance use disorder or opioid abuse histories.

The Promise Act of 2016 institutes pilot programs within the VA to evaluate the feasibility of wellness programs complementing veteran pain management and related health care services.

I support this legislation because it will promote safety measures for opioid therapy and alternative medicine.

H.R. 4063 is a positive step in the right direction and I urge my colleagues to join me in supporting its passage.

Mrs. LAWRENCE. Mr. Speaker, I stand today in support of H.R. 4063, the Jason Simcakoski PROMISE Act. As those who defend our liberty return home from service, their fight for freedom internalizes. The homecoming of our nation's veterans often marks their entrance into a new war—a constant battle against a visceral and intangible enemy: substance abuse. As we pass this important legislation, we afford our veterans the adequate support to fight this uphill battle, thus allowing our nation's fallen soldiers to rise as they repeatedly repel attacks from addiction. We must pass the PROMISE Act, because if we do not look out for the protectors of our freedom, who will look out for us?

Through my experiences as an EOE investigator at the USPS, I saw firsthand the divisive consequences of substance abuse on addicts, their loved ones, and communities as a whole. The PROMISE Act will bring nationwide uniformity to opioid addiction prevention efforts by implementing opioid treatment and therapy guidelines, expanding VA safety initiatives, and establishing research-based committees to measure the quality of treatment methods. While some may question why we are voting today to help those who have broken our nation's laws, just consider: who were the citizens that protected our freedom and nurtured our liberty when they were called upon? Now that our soldiers are the ones in need, who are we to deny them?

Just as veterans took on the duty of defending our communities, we must come together to halt the increasing opioid addiction rate for the sake of veterans and the good of America as a whole. The PROMISE Act will serve to acknowledge veterans' selfless sacrifice by establishing a forgotten American ideal: that we as a nation will always care for those who protect and defend our freedom. While no amount of money could ever buy back that which was sacrificed in the name of liberty, the passage of this legislation will alleviate some of the hardships faced by opioid-dependent veterans. As we look to find the most effective methods for treating opioid addiction, the PROMISE Act will serve as a strong step toward reversing our nation's substance abuse epidemic.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. MILLER) that the House suspend the rules and pass the bill, H.R. 4063, as amended.

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

The title of the bill was amended so as to read: ''A bill to improve the use by the Secretary of Veterans Affairs of opioids in treating veterans, and for other purposes.''.

A motion to reconsider was laid on the table.

ARIEL RIOS FEDERAL BUILDING

Mr. CURBELO of Florida. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4957), to designate the Federal building located at 99 New York Avenue, N.E., in the District of Columbia as the ''Ariel Rios Federal Building.''

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4957

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

SECTION 1. DESIGNATION.

The Federal building located at 99 New York Avenue, N.E., in the District of Columbia shall be known and designated as the ''Ariel Rios Federal Building''.

SEC. 2. REFERENCES.

Any reference in a law, map, regulation, document, paper, or other record of the United States to the Federal building referred to in section 1 shall be deemed to be a reference to the ''Ariel Rios Federal Building''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. CURBELO) and the gentleman from Indiana (Mr. CARSON) each will control 20 minutes.

The Chair recognizes the gentleman from Florida.

GENERAL LEAVE

Mr. CURBELO of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to include extraneous material on H.R. 4957.

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

There was no objection.

Mr. CURBELO of Florida. Mr. Speaker, I yield myself such time as I may consume.

H.R. 4957 would designate the Federal building located at 99 New York Avenue, N.E., in the District of Columbia, as the Ariel Rios Federal Building.

I am pleased to be a cosponsor of this legislation, along with the chairman and ranking member of the Subcommittee on Economic Development, Public Buildings, and Emergency Management—my colleague from Pennsylvania (Mr. BARLETTA) and my colleague from Indiana (Mr. CARSON).

Special Agent Ariel Rios joined the Bureau of Alcohol, Tobacco, Firearms and Explosives in 1978, where he became one of the most effective agents who was assigned to then-Vice President George H. W. Bush's task force. Special Agent Rios worked as an undercover agent as part of the task force.

During his undercover assignment in 1982, he and another agent arranged to meet two suspects at a motel in Miami, Florida, to purchase large quantities of drugs and machine guns. A confrontation ensued and, during a struggle, Special Agent Rios was shot and was seriously wounded. He died shortly after in the hospital on December 2, 1982.

Special Agent Rios received a number of posthumous awards, including the Secretary of the Treasury's Exceptional Service Award and a Meritorious Service Award from the Dade County Chiefs of Police Association. The previous location of the ATF headquarters on Pennsylvania Avenue bore his name for 27 years. During that time, the ATF relocated to a new headquarters building, and the old building was occupied by another agency and was renamed. H.R. 4957 would appropriately name the current location of the ATF headquarters after Special Agent Rios.