United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 114th CONGRESS, SECOND SESSION

Vol. 162 WASHINGTON, WEDNESDAY, MAY 11, 2016 *No. 74*

House of Representatives

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Mr. FORTENBERRY).

DESIGNATION OF SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
May 11, 2016.

I hereby appoint the Honorable JEFF FORTENBERRY to act as Speaker pro tempore on this day.

PAUL D. RYAN,
Speaker of the House of Representatives.

MORNING-HOUR DEBATE

The SPEAKER pro tempore. Pursuant to the order of the House of January 5, 2016, the Chair will now recognize Members from lists submitted by the majority and minority leaders for morning-hour debate.

The Chair will alternate recognition between the parties, with each party limited to 1 hour and each Member other than the majority and minority leaders and the minority whip limited to 5 minutes, but in no event shall debate continue beyond 11:50 a.m.

THE COST OF FEDERAL REGULATIONS

The SPEAKER pro tempore. The Chair recognizes the gentlewoman from North Carolina (Ms. FOXX) for 5 minutes.

Ms. FOXX. Mr. Speaker, we talk a lot in this Chamber about the burdensome regulations that Federal agencies frequently place on the American public. Last week the Competitive Enterprise Institute released a report that puts a price tag on the rules implemented by the Federal bureaucracy, saying that Federal regulation and intervention cost American consumers and businesses nearly $2 trillion in lost economic productivity and higher prices in 2014. That is simply unacceptable.

Many of these rules hinder innovation and job creation and are costly to businesses and consumers. As a former small-business owner, I know firsthand how the government can make it more difficult for a business to be successful. I recognize the true costs of overregulation, such as lost productivity, increased expenses, and new financial and legal liabilities, which many policymakers often forget about.

Just last month, the House approved a disapproval resolution to stop the Obama administration from implementing its flawed fiduciary rule, which will significantly impact the ability of Americans to receive advice on how to save for retirement and make it more difficult for businesses—in particular, small businesses—to establish retirement plans. The rule, which contains more than 1,000 pages of new regulations, makes it cost prohibitive to offer advice or services to low- and middle-income Americans by increasing compliance costs and the risk of litigation.

The Department of Education is constantly putting obstacles in the path of innovation, and these unnecessary regulations are stifling pioneering higher education institutions at a time when forward-thinking solutions are desperately needed. More redtape and hoops to jump through are not going to promote diverse choices for students. In fact, they often add administrative costs on schools—costs that are typically passed on to students in the form of higher fees and tuition. That is why I have introduced legislation to reduce Federal intrusion and limit the costly regulatory burden on colleges and universities.

As my colleagues and constituents know, the issue of unfunded mandates has been a particular interest of mine for a long time. It is frequently overlooked in the debates about reforming our regulatory system and carrying out Federal policies. It is all too easy for Washington bureaucrats to write off concerns expressed by a handful of local governments or a small subset of private businesses. But these decisions have real costs and real effects on the individuals, families, and communities we each represent.

My legislation, the Unfunded Mandates Information and Transparency Act, does not seek to prevent the Federal Government from regulating; rather, it seeks to ensure that its regulations are deliberative and economically defensible. Asking regulators to consider thoroughly and understand the cost of a rule in addition to its benefits should not be controversial.

Republicans are often accused of opposing all regulations, but that is just not true. We are in favor of commonsense rules, and we believe it is possible to alleviate the regulatory burden on small businesses and other job creators while balancing public safety and consumer interests.

Regulation by bureaucratic fiat is not what the Founding Fathers had in mind when they created our government. I applaud Speaker RYAN for creating the Task Force on Reducing Regulatory Burdens and look forward to seeing its suggestions for a modern and transparent regulatory system that makes it easier to invest, produce, and build in America.

ISRAEL INDEPENDENCE DAY/DAY OF REMEMBRANCE

The SPEAKER pro tempore. The Chair recognizes the gentleman from Rhode Island (Mr. CICILLINE) for 5 minutes.

Mr. CICILLINE. Mr. Speaker, tomorrow is Yom Ha'atzmaut, the commemoration of the Israeli Declaration of

Printed on recycled paper.

Independence in 1948. This day of celebration is always immediately preceded by Yom Hazikaron, Israel's Memorial Day.

This timing is no accident. The people of Israel know that their freedom comes at a high price. Today I am humbled to join them in remembering more than 23,000 soldiers and victims of terrorist attacks who have paid this price, including 68 soldiers and police officers and 32 civilians over the past year alone.

The strong relationship between the United States and Israel dates back more than six decades. On May 14, 1948, just 11 minutes after the provisional government of Israel, led by Prime Minister David Ben-Gurion, proclaimed a new state, President Harry S. Truman announced: ''This government has been informed that a Jewish state has been proclaimed in Palestine, and recognition has been requested by the provisional government thereof. The United States recognizes the provisional government as the de facto authority of the new State of Israel.''

This year, Israelis will celebrate their independence as they always have, gathering for public shows, performing Israeli folk dances, singing Israeli songs, and spending the day with families at picnics or on hikes. The holiday will conclude with the awarding of the Israeli Prize to men and women who have made unique contributions to culture, science, the arts, and humanities.

For American Jews, the celebration of Israel's independence has always been a way to express solidarity with the State of Israel. In many communities, it is a special occasion for Jewish organizations and synagogues of different denominations to come together for a single, united celebration of Israel's creation and existence, both of which have defied great odds.

Just one day after President Truman recognized the new Jewish state's existence, five neighboring Arab countries amassed their armies and invaded, determined to remove the dream of Israel from the pages of history. But after months of fighting, Israel emerged stronger than it was before, with more territory under its control.

Since then, the people of Israel have lived under the threat of violence for nearly seven decades. They survived the Six-Day War in 1967, the Yom Kippur War in 1973, and insurgencies that targeted soldiers and civilians alike. Through it all, the friendship between the United States and Israel has remained strong. We stood together to oppose Soviet aggression during the cold war, and we continue to stand together today, united in the fight against terrorism and global extremism.

This friendship is rooted in much more than strategic interests. The United States and Israel have always shared common values. As the most stable and successful democracy in the Middle East, Israel is committed to the values of equality and freedom, including a free press, freedom of religion, and the right to self-determination through democratic elections.

Today, at a pivotal moment in the history of the world, it is more important than ever for the United States to stand with the people of Israel. I have been proud to work with my colleagues on both sides of the aisle on legislation to strengthen the ties between our two countries. The United States-Israel Cybersecurity Cooperation Act, which I introduced earlier this year, will establish a joint Cybersecurity Center of Excellence where the leaders from our two countries can work together on cybersecurity and the protection of critical infrastructure. In the House Foreign Affairs Committee, we have worked to advance legislation that condemns efforts to inflame anti-Semitic sentiments by the Palestinian Authority. These are critical issues we must continue to work on in the pursuit of our common objectives and our shared values.

I congratulate the State of Israel on the anniversary of its independence, and I look forward to continuing to work to strengthen the relationship between our two countries even further.

THE REPUBLIC OF GEORGIA: A DEMOCRACY IN A ROUGH NEIGHBORHOOD

The SPEAKER pro tempore. The Chair recognizes the gentleman from Texas (Mr. POE) for 5 minutes.

Mr. POE of Texas. Mr. Speaker, as the world leader in freedom and democracy, it is in our national interest to see the same freedoms we enjoy spread to people throughout the world.

The Republic of Georgia is a small and young democracy in an area that is more known for its authoritarian rule than freedom. Georgia formally declared its independence in 1918, but 4 years later, the Soviet bear invaded and declared Georgia a Soviet Socialist Republic. But the Georgian people are resilient, and with the fall of the Soviet Union in 1991, Georgia again declared its independence from Russia.

Over the past 25 years, Georgia has become the freest country in its region. It sets up a stark contrast to the dictatorship of Putin in the north. However, the Russians never gave up on their ambitions to control Georgia.

I was in Georgia in 2008 when Russian troops invaded and took one-third of Georgia. I saw the Russian tanks up on the hill. And, Mr. Speaker, the Russians still illegally occupy one-third of the nation of Georgia.

The Russians want to impose tyranny upon Georgia precisely because of Georgia's quest for democracy and liberty. Georgia has made good governance a cornerstone of its reforms, grown the economy, and made significant progress toward creating a democratic society.

The world witnessed Georgia's first peaceful democratic transition of power from one party to another in 2013, and it has improved media freedom for 4 consecutive years, according to Reporters Without Borders. In fact, Freedom House ranks Georgia number one in the region for its freedom of the press.

Georgia has also made significant strides when it comes to corruption. It even ranks higher than some European Union countries and other U.S. allies according to Transparency International.

When it comes to business and free markets, Georgia makes it to the top of the pack. The World Bank ranked Georgia among the top 25 countries easiest to do business in.

The fact is that the Georgian people and their government share our Western values. A recent poll found that more than three-quarters of the Georgian people support their government's goal to join the European Union. Nearly 70 percent of Georgians also support Georgia's joining NATO. The United States should be vocal and support Georgia's quest to be in NATO.

For the past 25 years of independence, Georgia has been a valuable ally of the United States. Due to Georgia's free market system, low corruption, and simplified tax system, many American companies have invested in Georgia, especially in the energy sector.

The U.S. should negotiate a free trade agreement with Georgia to add jobs to both of our economies and send a message that Georgia is an important friend of the United States.

Georgia is also a vital partner in the battle against international terrorism. It has provided more troops to the effort in Afghanistan than any other non-NATO member. Thirty-three Georgian troops have fought and died on the battlefield with American troops, and 900 Georgian troops still remain in Afghanistan.

The Georgians are now preparing to hold elections in October. To ensure that these parliamentary elections are free and fair, the Georgians have invited international, independent election observers to monitor those elections in October.

The United States and our NATO allies must remain firm in our support for Georgia. Georgia is a sovereign country whose boundaries should be respected—even by Putin. Russia knows Georgia is a symbol of democracy in the region. That is why Putin continues to rattle his sabres in the entire neighborhood. Dictator Putin knows if Georgia is a successful democracy, then Georgia's neighbors are going to want to follow that lead and become more democratic. It is in our national interest to support Georgia and their democratic aspirations in their journey for liberty.

Fifty years ago, our President John F. Kennedy talked about liberty. He stated what the American policy is regarding liberty. I hope and believe it is still our policy today. Here is what he said, Mr. Speaker: ''Let every nation

know, whether it wishes us well or ill, that we shall pay any price, bear any burden, meet any hardship, support any friend, oppose any foe to assure the survival and the success of liberty.''

That applies to Georgia, Mr. Speaker. And that is just the way it is.

EPIDEMIC OF OVERDOSE DEATHS

The SPEAKER pro tempore. The Chair recognizes the gentleman from Connecticut (Mr. COURTNEY) for 5 minutes.

Mr. COURTNEY. Mr. Speaker, next to me is a map of the United States which shows the sickening increase in overdose deaths in this country due to heroin and opioid use over the last decade or so.

The first map is a map from the Centers for Disease Control statistics in 2004, when roughly 7,000 Americans lost their lives to opioid overdose. Again, the red color shows the intensity of regions where deaths occurred in excess of 20 per 100,000. The blue is 10 per 100,000 or less.

□ 1015

In 2014, over 28,000 Americans lost their lives to heroin and opioid overdose deaths. As you can see, the red portions of the country are increasing at an alarming rate. We have not gotten the 2015 statistics yet from the Centers for Disease Control, but by all indication from State numbers that are coming out, this map is actually going to get worse for the 2015 numbers.

Mr. Speaker, we have an epidemic in this country which far surpasses any challenge that is presented by any natural disaster. If we had an attack on the homeland that took the number of lives that these maps represent, this Congress would be on fire in terms of trying to move resources and help to communities all across the country.

Again, it is indiscriminate. It hits rural America, it hits suburban America, it hits urban America, and it hits age groups and ethnic groups across the board.

Today we are going to be taking up some legislation, H.R. 4641 and H.R. 5046. The first bill has 2 cosponsors; the second has 10 cosponsors. The first provides for establishment of an interagency task force to talk about pain medication, and the second is to authorize, not appropriate, different programs for heroin and opioid reduction. They are benign bills. It would be impossible for anyone to object to them.

But to be very clear, there is not a penny in either of these measures to help law enforcement. The police and fire who are responding to these crises day in and day out back home in eastern Connecticut are burning out because of the frequency of these calls. There is not a penny in these measures for treatment beds, for detox, or for long-term care treatment. In the State of Connecticut, it takes 4 to 6 months to get treatment.

These are addicts who are at points in their lives where to talk about a 4- to 6-month time span is to talk about an eternity. If you talk to the families who are dealing with their loved ones who are ensnared in these addictions, 4 to 6 months is really basically being told that there is no treatment available.

There is not a penny for prevention and education. If we go upstream, that is how we solve this problem in terms of better practices for opioid and heroin prescription.

It is not a coincidence that the White House last night issued a statement on this legislation, which basically points out the fact that they ''do little to help the thousands of Americans struggling with addiction.''

The statement goes on to say that these alarming trends which are represented on this map ''will not change by simply authorizing new grant programs, studies and reports. Congressional action is needed to fund the tools communities need to confront this epidemic and accelerate important policies like training health care providers on appropriate opioid prescribing, an essential component of this effort.''

The President submitted a budget with $1 billion of new funding paid for offset for 2017 that would put money into those three buckets: prevention and education, law enforcement, and treatment, again, no action by the majority in terms of dealing with actual funding to help people out there desperate for help.

There is a bill also to provide emergency supplemental funding of $600 million for this year to get that help out now. We presented it to the Rules Committee last night, and it was rejected.

If we had a hurricane or a tornado or a forest fire that was ravaging parts of this country or an attack on the homeland, this place would not hesitate about getting resources out there to help the folks that would respond to that type of a crisis; yet, somehow we have turned a blind eye to the thousands of Americans who are suffering from addiction and to the thousands of law enforcement fire and police who are responding to these calls literally as we are sitting here today.

There are hundreds of people per day who are dying because of this problem, and we, again, are providing no resources about better opioid prescription practices and getting better education, particularly to our young people, that clearly this map shows we must do if we are going to get our arms around this conflict and this problem.

Today there will be votes. There will be a lot of self-congratulatory rhetoric about the fact that we are moving on this. But, remember, there is not a penny for law enforcement, for treatment, or for prevention and education. Until we do that, we are kidding ourselves that we are going to turn this alarming, disturbing trend around.

SOUTH DADE VETERANS AFFAIRS CLINIC

The SPEAKER pro tempore. The Chair recognizes the gentlewoman from Florida (Ms. ROS-LEHTINEN) for 5 minutes.

Ms. ROS-LEHTINEN. Mr. Speaker, I rise today in strong support of the long-overdue south Dade Veterans Affairs clinic adjacent to Homestead Air Reserve Base, part of my congressional district.

Community-based outpatient clinic facilities in Homestead and Key Largo are extremely limited in the amount of services that they provide. This project, therefore, can no longer be ignored, Mr. Speaker. Currently, these local military personnel, retired servicemembers, and veterans are not getting the proper support that they have so rightfully earned.

As the wife of a Vietnam veteran and a stepmother of two marine aviators, I am passionate about safeguarding our Nation's military members and their families and fighting for the services they need in order for them to live healthy and fulfilling lives. Our military does not quit on us, Mr. Speaker, and I certainly will continue fighting for them.

It is estimated that there are more than 22,500 veterans, Active-Duty military, and recently deployed reservists eligible for VA medical services within a 20-mile radius of Homestead Air Reserve Base. Currently, those living in Homestead who require more than the limited services offered at Homestead Outpatient Clinic must travel about 70 miles roundtrip to the VA Medical Center in order to get the proper care that they desperately need. Veterans living in the Upper Keys have to travel even further, oftentimes more than 160 miles roundtrip.

This is completely unacceptable. It is a huge burden for our servicemen and -women and their families who have already sacrificed so much for us and our Nation. This new clinic would not only improve access to care for veterans in Homestead and the Upper Keys, but it would also enhance the quality of care throughout the region by reducing pressure on the Miami VA Medical Center.

Mr. Speaker, the south Dade VA clinic is a project that has a great deal of support throughout my district, including the Department of Defense personnel at Homestead Air Reserve Base and the Military Affairs Committee of the south Dade Chamber of Commerce.

I have also received thousands of constituent support cards, many of which I have here with me today. Here is a bunch, and here is a bunch. There are just thousands, Mr. Speaker.

Once again I would like to express my strong support for the long-overdue south Dade Veterans Affairs clinic adjacent to the Homestead Air Reserve Base. These local veterans have waited too long already, and they deserve nothing less than the successful completion of a new facility as soon as possible.

CONGRATULATING ISRAEL ON ITS 68TH INDEPENDENCE DAY

Ms. ROS-LEHTINEN. Mr. Speaker, I rise today to congratulate the democratic Jewish State of Israel as it marks its Independence Day.

Though the Jewish people have historical ties to Israel that date back millennia, in just 68 years of statehood, look at all that Israel has accomplished. Israel is a world leader in education, in technology, and in innovation. It is a vibrant and open democracy with a robust economy that thrives despite the constant threats that it faces daily.

The United States can have no greater friend than Israel not only because we share the same interests, but because we also share the same values and beliefs, such as democracy and the rule of law. That is why it is imperative that our two nations sign a new memorandum of understanding to ensure that Israel has the capability and the capacity to defend herself and her citizens from all threats and be a shining example of democracy for the entire region.

Mr. Speaker, I look forward to continuing to work to strengthen the already-strong relationship between the U.S. and Israel. I congratulate the Jewish state and her citizens on its 68th Independence Day.

WAR ON DRUGS

The SPEAKER pro tempore. The Chair recognizes the gentleman from Oregon (Mr. BLUMENAUER) for 5 minutes.

Mr. BLUMENAUER. Mr. Speaker, there is a major front on the war on drugs that is only now getting the attention it deserves. We will be discussing it later today on the floor dealing with opioid addiction.

Instead of arresting or citing over 600,000 people for marijuana last year, which had zero overdose deaths and which a majority of Americans think should be legal, we should redouble our efforts to fight the abuse of opioid prescription painkillers and the epidemic of opioid deaths.

Because of reckless marketing and lax oversight, there is an overdose death every 19 minutes; 78 people a day die, 20,000 last year. This is directly related to many heroin addicts. Deaths on heroin are increasing because the addict's drug of choice when their supply of opioids is interrupted shifts to heroin.

2.1 million suffer from substance abuse and 1,000 people a day are admitted to emergency rooms for opoid related causes. We have a challenge that needs to be addressed. There is plenty of blame to go around: the drug company's marketing practices, pill mills and unscrupulous doctors whose government regulators were asleep at the switch; and the DEA, which cannot get its priorities or its story straight.

I am hopeful that today's action on the floor will be the first step. As my friend and colleague from Connecticut pointed out, today's legislation really doesn't speak meaningfully to what we are going to have to do: prevention and treatment, which ultimately can help disrupt this cycle of abuse.

There is one simple step that I think would make a profound difference. We are introducing legislation today to deal with disposal of prescription drugs. We are issuing approximately one prescription per adult in the United States, 260 million this year.

There are tens of millions of these pills floating around and left over. And what do people do? Many of them just flush them down the toilet or leave them in the medicine cabinets.

Well, flushing them into the sewer system is not a good idea because we are slowly medicating millions of Americans who are having traces of these drugs showing up in their system from drinking water. They are expensive to remove. Leaving it in the medicine cabinet is how many people find drugs to abuse. Teenagers steal unused medicines out of medicine cabinets in homes that they visit or from family members.

We are proposing a safe drug disposal tax credit, which would offer qualified entities such as retail pharmacies, narcotics treatment programs, and long-term care facilities a tax credit to be able to deal with disposal of these prescription drugs on site.

Locating safe drug disposal and take-back programs at pharmacies and other healthcare sites will increase access to this safe medicine disposal and will remove millions of these highly dangerous drugs from the hands of people who shouldn't have them.

By all means, let's have the debate today. Let's start moving forward. A look at the broader challenges of treatment and prevention is long overdue. Hopefully, the DEA gets its priorities straight in the future.

But, in the meantime, providing a tax credit for safe disposal is a small step, which should have bipartisan support and will make a difference in every community across America to end this epidemic of prescription overdose deaths.

CONGRATULATING BROCKWAY'S GRACE PRESTON

The SPEAKER pro tempore. The Chair recognizes the gentleman from Pennsylvania (Mr. THOMPSON) for 5 minutes.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I rise to recognize the efforts of Grace Preston, a sixth grader from Pennsylvania's Fifth Congressional District.

Grace visited Washington, D.C., last week to accept the Prudential Spirit of Community Award, a ceremony at the Smithsonian Museum of Natural History. Grace was one of only two students in Pennsylvania to be honored with this award, which recognizes outstanding acts of volunteerism.

Grace has raised more than $4,000 in the past 3 years to improve the lives of animals in her community through the sale of homemade dog treats, cat toys, and flee and tick repellent.

□ 1030

She became interested in helping animals after her family adopted a pet from a local shelter.

Through her efforts, Grace has raised enough money to enable the local Humane Society to purchase a storage shed, as well as other supplies, such as rabies gloves. She has also provided animal oxygen mask kits to a local fire department for pets that have been caught in fires; has helped pay for a shelter dog's surgery; and has collected animal food for the pets of needy families.

Grace's work is an example that students all across the Nation should look toward. I know she has made her school and her community proud.

LEADERSHIP FOR CLEAN WATER

Mr. THOMPSON of Pennsylvania. Mr. Speaker, last week was National Drinking Water Week. This designation is to highlight the importance of drinking water across our Nation and the need to reinvest in the infrastructure that brings tap water into our homes.

Quality water has been credited with vastly extending the life expectancy here in the United States by eliminating the sickness from diseases that are spread through drinking water, such as typhoid fever. While we have made great progress in improving water across our Nation, there is always more work to be done.

In Congress, since 1996, the Drinking Water State Revolving Fund has helped to fund public water systems and infrastructure projects in order to meet public health goals and to comply with Federal regulations. Last year alone, Congress provided $2.3 billion to the EPA for local drinking water and sewer construction projects through the Clean Water and Drinking Water State Revolving Loan Funds.

Good water is not only vital for good health, but it is also essential for our State's number one industry: agriculture. The Commonwealth of Pennsylvania continues to provide substantial food, fiber, and energy for residents across our Nation. With this in mind, promoting and sustaining healthy waters and soil is essential.

As chairman of the Agriculture Subcommittee on Conservation and Forestry, with jurisdiction over Federal conservation programs that are administered by the Natural Resources Conservation Service, the U.S. Forest Service and forestry practices, we work to provide leadership and resources to promote the health of our watersheds, soils, and forests.

To help meet those needs, I was proud to work on the 2014 farm bill, which provides many positive tools for farmers and landowners. From on-farm operations to estuary management, the United States Department of Agriculture plays an important role in

managing and in improving both water and soil quality. The farm bill is the guiding authorization for the Department. Programs such as the Conservation Reserve Program, or the CRP, the Environmental Quality Incentives Program, or the EQIP, and the Regional Conservation Partnership Program, or the RCPP, are a few of the critical ones that directly impact soil and water quality in our country and certainly in Pennsylvania.

As we have seen so many times in Pennsylvania and around the country, once a watershed or water source is harmed, it often takes generations to recover. History shows us just how important clean water is. It also demonstrates how hard it is to fix a water source once it has been contaminated.

I remain committed in Washington and certainly in my home State of Pennsylvania to helping our professionals, volunteers, business community, nonprofits, such as Trout Unlimited and Watershed Associations, as well as academic and research institutions, such as Penn State, in their efforts to preserve our State's water and our country's water for future generations.

MR. SCOTT'S VISIT TO OREGON

The SPEAKER pro tempore. The Chair recognizes the gentlewoman from Oregon (Ms. BONAMICI) for 5 minutes.

Ms. BONAMICI. Mr. Speaker, when I travel around northwest Oregon, I often hear from parents who struggle to afford child care, which in Oregon can cost as much as a year of college tuition. I hear from people who can't find work because their skills don't match up with the jobs that are available in their areas, and I hear from students who are overwhelmed by the cost of their college educations.

These are not problems without solutions. As policymakers, we should be addressing the challenges our families face. It is possible to give every child the opportunity to succeed, to close the achievement gap, to make college accessible and affordable, to expand family-friendly workplace policies, and to make sure we have a 21st century workforce. In fact, we can't afford to let these problems continue to hold us back.

This week, I welcomed to Oregon Mr. SCOTT of Virginia, the ranking member of the Committee on Education and the Workforce. Together we saw and discussed some of the struggles our working families face. We had a whirlwind day that included substantive discussions about how to give children, young people, and working families the support they need to succeed. We talked about how to open the doors of opportunity that are closed for too many.

I invited Mr. SCOTT to Oregon because he has a remarkable record of standing up for working families. On the Education and the Workforce Committee, we worked together on the Every Student Succeeds Act to strengthen our public schools, and on the Older Americans Act to support our growing population of older adults.

He has also been a leader for working families by his standing up to attacks on the National Labor Relations Board and by his protecting retirees through his support for the Department of Labor's rule to ban conflicts of interest in retirement advice. During his visit this week, I showed Mr. SCOTT the innovative and collaborative nature that sets Oregon apart.

Oregon is a leader in addressing barriers that are faced by working families. Last year our State legislature raised the State's minimum wage and passed legislation to provide workers with paid sick days to care for themselves or their families.

At our forum on early childhood development, we discussed how this country's workplace policies have not kept up with our changing workforce. Andrea Paluso from Family Forward Oregon told us that even the iconic image of the Cleaver family does not accurately reflect the diversity of American families.

In fact, Barbara Billingsley, the actress who played June Cleaver on ''Leave It to Beaver,'' was in real life a single, working mom.

We heard from others about how food insecurity and hunger interfere with the ability of too many children to focus in school and about how early childhood education correlates to positive health outcomes and academic achievement later in life.

I am proud of Oregon for taking so many positive steps to protect working families, but these changes shouldn't be happening just for some. We should be having these conversations and discussions in Congress as well. Our economy will be stronger and our families will be healthier when we acknowledge that families need policies that work for them, not against them. We need equal pay for women, good wages, paid leave, and affordable child care to support families in Oregon and across the country.

Looking toward our future, I want students today to have the same opportunities I had. I worked my way through community college, college, and law school, and I graduated with a very manageable amount of student debt. Unfortunately, that opportunity is out of reach for too many of today's families.

Again, Oregon is a national leader. Oregon Promise, our State's free community college plan, will help put education within reach for thousands of students. Oregon's leaders have recognized that the future of our economy relies on an educated and innovative workforce to create and fill the jobs of the 21st century.

During our visit, I introduced Mr. SCOTT to Fernando, who participates in the Portland Community College's very successful Future Connect Program. This program connects low-income, first-generation college students with financial aid resources, personalized academic advising, internships and job training, and an intensive summer orientation, all of which help them to succeed in college. This program is critical to Fernando, who is a DACA student, and to other first-generation college students. Fernando told us that Future Connect made a difference, it made him feel at home in college. Oregon knows it is not enough just to get students to college, but that it is important that they stay there and finish their degrees. Now Fernando is off to a 4-year university and is pursuing his plans to become a dentist.

I am incredibly proud of the State I represent. Congress can learn a lot from the Oregon spirit of innovation and collaboration. I was glad to show Mr. SCOTT the progress we have made in Oregon, and I look forward to working with my colleagues on both sides of the aisle to remove the many obstacles that are holding back working families and that are keeping young people from achieving their full potential, because when we open the doors of opportunity to everyone, we all succeed.

A STRONGER AMERICA OR A PATH TO ECONOMIC DISASTER

The SPEAKER pro tempore. The Chair recognizes the gentleman from Ohio (Mr. GIBBS) for 5 minutes.

Mr. GIBBS. Mr. Speaker, in 2009 and 2010, when the other side of the aisle had complete control of Congress and the White House, the American people saw what liberals would pass when given free rein and a blank check.

With Dodd-Frank, Democrats deemed it necessary to punish small community banks with burdensome regulations they cannot afford to comply with. Dodd-Frank created a new, unaccountable bureaucracy called the CFPB, which is funded in a way that obscures its transparency and prevents Congress' direct oversight of the agency. The lack of accountability like that seen with the CFPB and the heavy hand of agencies like the EPA and the IRS have become hallmarks of this administration.

With the stimulus bill, Democrats gave handouts to their union and so-called green energy friends. Taxpayers were on the hook for loan guarantees to companies like Solyndra, which used its political connections in the White House to push through irresponsible loan approvals. When Solyndra went bankrupt, it was at the cost of the American people. Many other smaller boondoggles came out of the stimulus: silly studies on ducks, over $1 million on road signs that promote the stimulus, and over $3 million for a tunnel for turtles in Florida.

This leaves ObamaCare. Too many Americans have felt the negative consequences of what boils down to a government takeover of the healthcare industry. The President claimed this law would decrease premiums by $2,500 per

year. Instead, they have risen since ObamaCare has been enacted. To go with the increase in cost, many Americans have seen a sharp decrease in their choices. There are fewer plans available, restricting the ability of hardworking families to choose coverage that is appropriate for their circumstances.

Taken together, this trio of liberal policies is adding layers of bureaucratic red tape, forcing Americans to pay more for health care and putting taxpayers on the hook.

In 2009, Democrats used the blank check to add $1.5 trillion in discretionary spending. When Republicans gained control of the House of Representatives in 2011, we put discretionary spending on a downward trend. Discretionary spending funds our Federal agencies such as the EPA and the IRS, as well as the Department of Defense. We have made real cuts in spending, not slowdowns in growth and not projected cuts down the road—honest-to-God cuts in spending. Since I took office in 2011, discretionary spending has been cut significantly by $434 billion.

But this does not address mandatory spending, which is the real driver of our national debt. This includes programs like food assistance, welfare, Medicare, Medicaid, Social Security, and interest on our debt. Reforms are needed to ensure these programs work efficiently and are sustainable. Because of the way ObamaCare was written and enacted, mandatory spending also includes large portions of ObamaCare funding. Mandatory spending is on autopilot and will continue with or without Congress' annual appropriations process.

The fact is we have to change the law. That means both Chambers of Congress have to pass reforms and the President has to sign them or we have to override a veto. Mandatory spending accounts for three-quarters of all money spent by the Federal Government. This is a 180-degree change from when I was a teenager, when in 1970, mandatory spending was only about a third of government spending.

Realistically, there is only one path to a balanced budget and shrinking our national debt. That path is to pass a budget and use a process called reconciliation. A budget facilitates reconciliation, which only requires a 51-vote majority in the United States Senate and avoids a filibuster by liberals who want to continue running up America's credit card. Not doing a budget forfeits the opportunity to do reconciliation. Reconciliation with mandatory spending program reforms, coupled with real tax and regulatory reforms, will send a strong signal to our entrepreneurs and businesses, which will unleash innovation and the American spirit and will, thus, grow our economy and provide for our national defense. A vibrant economy will provide for our national security and priorities without raising taxes.

We have an opportunity with a new President next year to send two reconciliation bills to his desk—one for this fiscal year and another for the next fiscal year. Elections do matter, and this one has historic implications—one being a path to a stronger America and opportunity for every American or a path on a downward spiral of economic disaster, risking our personal and economic freedoms. God help us.

AMERICA IS SADDLED WITH BAD TRADE DEALS

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. SHERMAN) for 5 minutes.

Mr. SHERMAN. Mr. Speaker, how does America get saddled with these bad trade deals?

If we look at our free trade agreements, we see a 425 percent increase in our trade deficit with those FTA countries. You get that statistic if you include NAFTA, which, of course, is the granddaddy of all of our free trade deals, and that doesn't even count our worst deal, which was granting most favored nation status to China.

So how do we end up with such bad deals?

First, the elites convince themselves that it is good for the country. They do this because they love the theory of the economic textbook and don't feel comfortable looking at the practice of how business actually works.

Second, the elites benefit from these deals. These deals help economists and Wall Street and attorneys, so they convince themselves that they are good for the country as a whole and create a subcultural echo chamber in which it is a subcultural norm that all smart people realize that these are good trade deals. In having convinced themselves to support these deals, they use a combination of condescension, false appeals to patriotism, and sneaky tactics to saddle the American people with these trade deals.

□ 1045

Take a look at the effect on working families. America needs a raise. To get it, we need a severe labor shortage. We would have millions of additional jobs, a desperate labor shortage, if only we had balanced trade with the world.

Let's look at TPP and its inclusion of Vietnam. We were told that the Trans-Pacific Partnership will give us free access to the Vietnamese market. There is only one problem: in Vietnam, there is no freedom and there is no market. In fact, we will not have access except as the Communist Party of Vietnam decides to grant it on the basis of crony capitalism, but our workers are going to have to compete against 40-cent-an-hour Vietnamese labor.

Now, we are told that in Vietnam, under this deal, it won't be illegal to organize a union. They won't put you in jail for organizing a union. What they will do is they will plant drugs on every union activist and arrest them for that. You are not going to see free unions in Vietnam, and that will hurt working families in the U.S.

So how do they sell it? They claim that it may take jobs away, but it is a necessary sacrifice because we have to contain China. As the ranking member of the Asia and the Pacific Subcommittee, I am here to tell you the TPP is great for China.

First, we are told, well, we get to write the rules. No. These are Wall Street's rules. They are not the rules of the American working family.

Second, TPP enshrines the idea that currency manipulation is just fine. So China gets the single most important change in the rules of international trade.

Finally and most obscurely, there are the rules of origin. Now we know that, under this deal, goods that are made in Vietnam or Japan come right in to the United States with no tariffs. What you don't know is the goods that are 50, 60 percent, 70 percent made in China then go to Vietnam or Japan where they can put a made-in-Japan sticker on it and send it to the United States—that is when they admit that it is 50 or 60 percent made in China.

As a CPA, I will tell you, if you are in a position to admit that your goods are 60 percent made in China, that means they can be 90 percent made in China. So China gets to fast-track their goods into the United States, no tariffs, and we get no access to the Chinese markets. So it is a really bad deal.

How do you pass it? You use sneaky tactics. They don't have the votes to pass it now. The American people would rise in opposition to try to pass it now. So they are going to wait for the lame duck and then have a group of retiring Members of this body shaft the American people with the TPP.

We do have a solution. We need to get all three remaining Presidential candidates to declare, if sneaky tactics and lame duck sessions are used to impose TPP on America, that they will, in their first month in office, pull us back out of TPP. Unless we hear that clearly from the three Presidential candidates, all of whom oppose TPP, that they not only oppose it, but they will erase anything that happens in a lame duck session, then the elites will prevail. We will lose jobs again. Our workers will have to compete with 40-cent-an-hour labor. Chinese goods will be fast-tracked into the United States with ''Made in Japan'' and ''Made in Vietnam'' stickers on them.

It is time for the Presidential candidates to go beyond saying they are against it. They have to declare that they will make sure that any lame duck approval of TPP that happens in December will be erased the following January.

HEROIN OPIOID CRISIS

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York (Mr. ZELDIN) for 5 minutes.

Mr. ZELDIN. Mr. Speaker, the growing heroin and opioid crisis has especially hit home in my district in Suffolk County, New York. There was a 2015 report issued in New York State that showed that, out of all 62 counties in New York, it was my home county that was hit the hardest by the rise of heroin and opioid abuse. We had the highest number of heroin-related overdose deaths of any county in New York.

As a member of the Bipartisan Task Force to Combat the Heroin Epidemic, I have spoken with affected families directly. Addiction is a truly devastating disease that shatters lives, families, and communities. It is a disease that only continues to spread at rapid rates, and more can and must be done to counteract the damage it has done and prevent its rapid advancement.

Working closely with my local community, I have been pursuing a more localized solution to address this crisis. Hosting multiple drug task force roundtables in Suffolk County, I have been able to bring together local elected officials, law enforcement, health professionals, community groups, parents, concerned residents, and those in recovery to discuss various ways that we can work together to combat this epidemic. Over the past year, working with both local residents and my colleagues in Congress, I have been pushing to advance legislation in the House that would help provide us with the resources we need to end the growing epidemic crisis on Long Island.

Just last week, joined by my local community, I was proud to announce that there has been progress made to pass several important bills this week aimed at improving and increasing access to treatment, enforcement, and education. The House is now passing many of these critically important measures over the course of the next few days.

While I have been dedicating the most amount of my time advocating for the passage of the Comprehensive Addiction and Recovery Act, CARA, H.R. 593, many other important proposals are also moving forward.

One other bill that I cosponsor is H.R. 4641, which will be passing today, which would improve the guidelines for prescribing opioids and pain medication by creating a Federal interagency and stakeholder task force that would review, modify, and update best practices for pain management in prescribing pain medication. While there are many legitimate reasons and needs for some to be treated with pain medication, those highly addictive pills pose a serious risk. This critical bill would help ensure that all parties, from prescribers to patients, have access to the most up-to-date information so that lawful prescription use does not become addicting.

Just a few of the other bills include the Examining Opioid Treatment Infrastructure Act of 2016, H.R. 4982, which would require Congress receive a report on substance abuse treatment availability and infrastructure needs in the U.S., and legislation that would task a Federal agency to create a plan on how to deal with the opioid and heroin epidemic, H.R. 4976.

Legislation is passing to help stop the flow of illegal narcotics into our country, to keep drugs out of our communities and off our streets, such as legislation to help law enforcement officials identify and target drug traffickers, H.R. 3380, and to allow for easier prosecution of these criminals, H.R. 4985.

There is not one piece of legislation that will completely solve this overwhelming crisis, but finally Congress is taking a big step forward in the fight against drug abuse. We must always do everything in our power to provide our local communities with the resources necessary to help stop and prevent drug abuse through treatment, enforcement, and education, which is why I will continue pushing these efforts in the House.

I have spoken to parents of those recovering, parents of those who are unfortunately lost. It is impacting lives. It is devastating families.

Have a conversation in each of our districts, all 435 congressional districts, and we all hear the story all too often. It is not any race, gender, or socioeconomic status. It is not one particular school district. It is impacting all of our children.

As the father of two 9-year-old girls, I visited their class last week. I think of their generation, and it is important that this generation in Congress today does everything in our power this week and beyond to combat this epidemic.

WALLACE COMMUNITY COLLEGE SELMA

The SPEAKER pro tempore. The Chair recognizes the gentlewoman from Alabama (Ms. SEWELL) for 5 minutes.

Ms. SEWELL of Alabama. Mr. Speaker, today I rise to pay tribute to a hidden jewel in Alabama's Seventh Congressional District: Wallace Community College Selma. Wallace Community College Selma is a stellar 2-year institution that provides incredible educational opportunities to the students of Dallas County and across the Black Belt of Alabama.

Now, more than ever, America needs greater innovation in our educational system to meet the demanding needs of tomorrow. Outstanding higher education institutes in the State of Alabama are producing some of our State's and our Nation's best and brightest who will lead us into the next era of American innovation.

Wallace Community College Selma is leading that charge in my district through its dual enrollment program, which allows high school students to complete college courses and graduate with a high school diploma as well as an associate degree from this junior college.

In 2008, Wallace Community College Selma graduated 31 students from the Selma Early College High School, which was the first of its kind on a college campus in the State of Alabama. The 2016 graduating class will include 22 dual enrollment students, including 20 students that participated in a special partnership with Tuskegee University.

The Howard Hughes Medical Institute program with Tuskegee allowed Wallace Community College Selma to increase the participation of underrepresented minority students from Alabama's Black Belt counties in the important fields of science and research. This dual enrollment program with Tuskegee offers high school students an opportunity to take classes at Wallace Community College Selma as well as Tuskegee, and to graduate with their high school diploma as well as an associate degree in science.

Mr. Speaker, the dual enrollment program at Wallace Community College Selma is accomplishing what it set out to do: to give Dallas County high school students a head start in college. The benefits of this important opportunity are immeasurable: cutting the cost and the time spent in college while providing high school students significant exposure to the types of classes and fields of interest that will give them an important advantage and jump start on their peers.

Collaborations like these are so critically important to our youth gaining important and invaluable educational experience while obtaining college credit through dual enrollment. America must encourage more of these types of programs as we seek to lead the world in educating our people and attracting new generations of high-tech and high-paying jobs.

As a Member of Congress for the Seventh Congressional District, I take great pride in working to offer solutions that will help lay the foundation for creating better paying jobs and for our educational system to thrive in the future. I am so proud to acknowledge today the tremendous efforts and the outstanding programs offered at Wallace Community College Selma which exemplify the invaluable role our 2-year colleges play in our communities.

This college's leadership and innovation in creating a 21st century learning environment is to be commended—what a jewel to have serving the students of the Black Belt of Alabama. I am proud to represent them in my district and also to help encourage more students to participate in the dual enrollment program and Wallace Community College Selma.

Mr. Speaker, I want to commend Dr. James Mitchell for his tremendous leadership as president of Wallace Community College Selma. I want to commend the faculty, administrators, and students of Wallace Community College Selma for being truly outstanding.

This Friday, May 13, 2016, is graduation day at Wallace Community College Selma. I want to congratulate the entire class of 2016 and especially acknowledge the academic achievement of the 22 dual enrollment students who will receive a special congressional commendation on Friday. The names of these students will be listed in this CONGRESSIONAL RECORD.

I would also like to acknowledge the tremendous efforts and the tremendous achievements of the Wallace students who participated in Alabama Skills USA:

Alabama Skill USA winner Jonniece Collins won first place in masonry and, as such, was the first woman in the State of Alabama to win this honor.

Other winners included Roderick Perkins, who won second place in masonry; Terrence Campbell, who won third place in masonry; and Francis Phillips, who won second place in cosmetology in the men's hair design competition.

I want to also pay special tribute to the outstanding athletic achievements of Ki'Onna Likely, who was the 2015–2016 Alabama Community College Conference Player of the Year as well as NJCAA Second Team All-American.

Mr. Speaker, I ask my colleagues to join me in honoring all of the accomplishments of the outstanding students and graduates of Wallace Community College Selma and to praise the leadership of Dr. James Mitchell and the hardworking staff and faculty of Wallace Community College.

Congratulations to the graduating class of 2016. I wish you all the very best in all of your future endeavors. We are counting on you to make a difference.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until noon today.

Accordingly (at 11 a.m.), the House stood in recess.

□ 1200

AFTER RECESS

The recess having expired, the House was called to order by the Speaker at noon.

PRAYER

The Chaplain, the Reverend Patrick J. Conroy, offered the following prayer:

Merciful God of the universe, we give You thanks for giving us another day.

Send Your spirit upon the Members of this people's House. Enlighten their hearts, and give them the light and strength to know Your will and make it their own.

Guide them by Your wisdom, and support them with Your power. For You desire justice for all, and we ask You to enable them to uphold the rights of all.

May they be not misled by ignorance nor corrupted by fear or favor, but rather faithful to all that is true. As they work through this day and these weeks, may they temper justice with love, and may all their deliberations be pleasing to You.

May all that is done within these hallowed halls be for Your greater honor and glory.

Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Illinois (Mr. LAHOOD) come forward and lead the House in the Pledge of Allegiance.

Mr. LAHOOD led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain up to 15 requests for 1-minute speeches on each side of the aisle.

REMEMBERING FIREFIGHTER RICHARD SHELTRA

(Mr. PITTENGER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PITTENGER. Mr. Speaker, I rise today in memory of Firefighter Richard Sheltra of the Pineville Volunteer Fire Department.

Firefighter Sheltra died a hero while battling a fire on April 30, but he was a hero long before he volunteered to step into that burning building.

Firefighter Sheltra had service in his blood. He had great examples because his parents were also volunteer firefighters, all dedicated Christians attending Forest Hill Church.

Whenever the call went out, Firefighter Sheltra dropped whatever he was doing to go help. So strong was his commitment to serve and protect the families involved that he was often first on the scene.

Firefighter Sheltra was Pineville's Rookie of the Year in 2015. He was in the process of applying to the Charlotte Fire Department when he died at the age of 20.

While Mr. Sheltra was an excellent firefighter, he was an even greater servant of God. Please join me in praying for Firefighter Sheltra's family and the Pineville Volunteer Fire Department during this time of immense grief and, also, asking God to protect all of the brave men and women who serve our communities each and every day.

UNITED STATES' RELATIONSHIP WITH ISRAEL IS MORE IMPORTANT THAN EVER

(Mr. QUIGLEY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. QUIGLEY. Mr. Speaker, last week I had the honor and privilege of traveling to Israel for the fourth time. Congressman SCHIFF and I joined the U.S. Ambassador to Israel, Dan Shapiro, at Yad Vashem in Jerusalem for Holocaust Remembrance Day.

We watched six survivors, each representing 1 million innocent civilians killed, light the torch and share their stories of loss and survival. It was a powerful, moving, and emotional moment.

I am not sure one can begin to understand the devastation of the Holocaust until you have stood in Dachau or Auschwitz or heard stories from survivors themselves that seem too horrific to be real.

The United States' relationship with Israel is more important than ever. No matter what other threats we face, the United States and Israel must remain the closest of friends and continue to work together to ensure the security of our trusted ally.

HONORING KANE COUNTY OFFICER OF THE YEAR DEAN TUCKER

(Mr. HULTGREN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HULTGREN. Mr. Speaker, I rise today to congratulate Officer Dean Tucker on being named Kane County's Officer of the Year for saving the life of a 7-year-old girl.

Last June Officer Tucker responded to reports of an early-morning two-car collision. Upon arrival, witnesses alerted him to an SUV believed to be submerged at the bottom of a retention pond. Surveying the scene from the shoreline, Tucker spotted 7-year-old Monserrat Alanis Ramirez 40 yards away, flailing on the surface.

Acting decisively, Officer Tucker quickly removed his gear, dove into the water, and wrapped his arms around the girl to keep her afloat. Fatigue quickly set in and Tucker called out to a fellow Aurora police officer, David Bliss, and a passerby for help. The passerby provided support, swimming alongside Tucker, while Officer Bliss waded in and pulled Tucker and the girl to safety.

Tragically, Monserrat's mother and brother did not survive. However, the brave actions of Officer Tucker prevented further loss of life. We salute his selfless courage.

BREAKING ADDICTION TO OPIOIDS

(Mr. HIGGINS asked and was given permission to address the House for 1 minute.)

Mr. HIGGINS. Mr. Speaker, I rise in support of H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act.

Like the TREAT Act, which I introduced, this bill would allow qualified physician assistants and nurse practitioners to prescribe the medical treatment patients need to break their addiction to opioids. Utilizing these healthcare professionals is crucial to combat this epidemic, especially in medically underserved areas.

The bill would also increase the number of patients that physicians can prescribe Suboxone to from 100 to 250 per year. This is a step in the right direction. But there is no cap on the prescription of opioids, and it is counterproductive to cap treatment for opioid addiction.

The TREAT Act would eliminate this cap. The Senate Committee on Health, Education, Labor & Pensions has reported out a version with an annual cap of 500 patients. I urge my colleagues to support the Senate position so that more Americans can access this lifesaving treatment.

I thank the sponsors of this bill, Mr. BUCSHON and Mr. TONKO, and the Senate sponsor of the TREAT Act, ED MARKEY, for their work on this important initiative.

NATIONAL POLICE WEEK

(Mr. LAHOOD asked and was given permission to address the House for 1 minute.)

Mr. LAHOOD. Mr. Speaker, I rise today in recognition of National Police Week, a week we set aside to thank the 780,000 police officers who put on a badge nationwide and risk their lives to protect our communities.

We thank them for their brave service. Our police officers play an essential role in our community, working to keep us safe, upholding the rule of law, and responding to emergencies. The 18th District of Illinois is home to many upstanding, honorable, courageous, and self-sacrificing police officers.

Mr. Speaker, we also take time this week to mourn the loss of our fallen officers whose lives were lost in the line of duty. On average, one law enforcement officer is killed in the line of duty somewhere in the United States every 61 hours.

That is why I am proud to support a measure on the floor this week to extend the Bulletproof Vest Partnership Grant Program through fiscal year 2020. We need to ensure our officers have the necessary equipment to keep them safe.

Just this winter South Jacksonville, Illinois, in my district grieved the loss of one of its very own police officers in the line of duty.

I also want to take this time to thank the support network that supports our police officers, their parents, wives, husbands, and children, for the sacrifices they make when their loved ones serve as police officers.

Let us show our men and women who wear the badge how much we value their crucial work.

OPIOID AND HEROIN EPIDEMIC

(Ms. KUSTER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. KUSTER. Mr. Speaker, today I rise to highlight the crucial importance of addressing the heroin epidemic that is sweeping across this Nation.

I have been holding a series of regional briefings in my home State of New Hampshire to hear firsthand from communities working to fight this crisis. I have heard from far too many families who have lost loved ones to this epidemic because no treatment options were available.

In the fall of 2014, a high school French teacher in one of my towns who was beloved by her students died of an overdose, in part, because she could not get access to the treatment she needed.

And my good friend, Kriss Blevens, lost her stepdaughter, Amber, to addiction when no treatment beds were available.

This is simply unacceptable. We need to take action now to fight back against this epidemic and arm our communities with the resources to help individuals struggling to overcome the devastating pull of addiction.

I am a cofounder of the Bipartisan Task Force to Combat the Heroin Epidemic. We recently announced a package of 15 bills. I urge my fellow members to pass these bills this week. Let's help American families.

WHITE HOUSE DECEPTION ON IRAN ARMS DEAL

(Mr. LAMALFA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LAMALFA. Mr. Speaker, over the weekend The New York Times published a disturbing story about the Obama administration's efforts to manipulate press coverage of the Iran deal.

When the deal was signed last year, many of my colleagues and I warned that Iran could not be trusted to follow these temporary restrictions on their nuclear weapons program, but key staffers in the White House worked to create an echo chamber for their false claims about the Iran deal.

The Obama administration spun a concocted story about a moderate regime coming to power in Iran that was suddenly willing to change their approach to their pursuit of nuclear weapons and their relationship with the rest of the world.

As it turns out, the administration had already begun talks with Iran well before new President Rouhani took office. Iran already knew how desperate President Obama was to sign this or any deal which allowed them to extract several key concessions. The deal only provides temporary restrictions on Iran's nuclear weapons program while giving Iran permanent relief from sanctions.

Meanwhile, Iran will continue to support terrorism and further destabilize the region as well as violate the missile test program in the agreement.

The Obama administration's misleading campaign to convince the American people to support the Iran deal has dangerous consequences for us deceiving the public and their trust in government as well as putting our allies around the world, such as Israel, in danger and that trust as well.

LEAD CONTAMINATION

(Mr. PAYNE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PAYNE. Mr. Speaker, it is not a new problem. Lead in school drinking water has been a problem in communities across this Nation for years. So why isn't there more outrage and talk about it among my colleagues?

Even Chris Christie has ordered lead testing in New Jersey public schools. When New Jersey's Governor starts to admit that there is a problem that demands government action, you know the situation must be dire.

No child takes a drink from a water fountain in school and thinks about whether the water is contaminated or not. It is our job to protect our children, and that means ensuring the safety of school drinking water.

Congress should pass and the President should sign my TEST for Lead Act. The bill requires States to help schools establish programs to test for lead in the drinking water if those States receive Federal funding for safe water programs. It would ensure transparency by requiring disclosure of high levels of lead in schools. Most importantly, it would help keep our children safe.

OPIOID OVERDOSES

(Mr. STEWART asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STEWART. Mr. Speaker, like many of my colleagues, I am concerned by the great opioid epidemic that is sweeping our Nation.

Every day more than 78 Americans die from opioid overdoses—78 Americans. Think about that. That is more than three every hour. Nearly 2 million Americans are addicted to or abuse opiate-based painkillers.

Unfortunately and, frankly, very sadly, my home State of Utah is all too

familiar with these statistics, as we are fifth in the Nation in the most opioid-related deaths.

These drug addictions are destroying opportunities and are devastating families and communities all across the country. We simply must take steps to help alleviate this suffering.

I am proud to be supporting a number of bills that the House will be debating and voting on this week to combat opioid abuse, legislation that will lead to updated best practices for prescribers of pain medication, legislation that will improve drug abuse programs, and legislation that will give States and local communities more flexibility to attack this problem and the problems that are unique to those communities.

I urge support from my colleagues on both sides of the aisle, and am pleased to see that there is bipartisan support of these much-needed reforms.

□ 1215

OPIOID ADDICTION IS A NATIONAL EMERGENCY

(Mr. HIMES asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HIMES. Mr. Speaker, I rise this morning to tell the story of Alex Recupido, a troubled high school graduate of 2010, an accomplished pianist, a kid who was known for his creativity. He had gotten his nursing license and had moved to Florida when prescription drugs led to a heroin addiction and Alex died in 2014.

Sadly, Alex is not alone as 723 people died last year in my small State of Connecticut, and roughly 30,000 Americans will die this year of opioid addiction. By any standard, this is a national emergency.

At great long last, this House is acting this week on a series of bills to improve the training, the awareness, and the treatment that we offer to people who are caught in this cycle. I am concerned, though, Mr. Speaker, that the total funds called for by all of these bills—about $100 million—is completely inadequate for a national emergency.

At the end of the day, it is the resources, not the words, that we must offer. I believe we can do better. Our citizens are worth it. For people out there like Alex Recupido, it is a matter of life and death.

FACEBOOK SHOULD SHARE CONSERVATIVE NEWS

(Mr. SMITH of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Texas. Mr. Speaker, a recent story from the tech blog Gizmodo details Facebook's alleged efforts to suppress conservative views in its popular trending news section.

Former curators of the trending news section said they were routinely told to ignore news stories of interest to conservative readers. Censoring stories from popular conservative news sites to fit a liberal political agenda does a severe disservice to the American people.

A recent Pew Research Center study found that two-thirds of American adults use Facebook to get news. Facebook has an obligation and a public responsibility not to silence conservative voices. Facebook should give the American people an honest appraisal of the news when it comes to deciding what is trending on its Web site. Anything less is intentionally trying to manipulate public opinion to promote a liberal agenda.

SECURE GUNS AND PROTECT OUR KIDS

(Mr. DEUTCH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DEUTCH. Mr. Speaker, last week we read a powerful story under the headline: ''One Week in April, Four Toddlers Shot and Killed Themselves.''

Last year, toddlers shot someone with unsecured guns at a rate of one per week, and we are outpacing that horrific rate this year.

I stand here over and over, begging for Congress to act on gun violence, but today I plead for gun owners to be smart about the guns in their homes.

The groups Moms Demand Action and Everytown for Gun Safety are educating Americans and are encouraging gun owners to secure guns in their homes and vehicles, to model responsible behavior, to ask about unsecured guns in other homes, to recognize the risks of teen suicides, and to tell their peers to be smart by sharing these simple steps to stop heartbreaking violence. Our society is saturated with guns. There are 357 million guns and there are 317 million people—the highest concentration in the world.

As The New York Times noted, if owners do not secure these guns, they will continue to end up in the hands of ''shooters who need help tying their shoelaces, too young sometimes to even say the word 'gun,' killed by their own curiosity.''

Mr. Speaker, on this gun issue, let's come together, all of us, to secure guns and to protect our kids.

LUPUS AWARENESS MONTH

(Ms. ROS-LEHTINEN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. ROS-LEHTINEN. Mr. Speaker, I rise to recognize May as Lupus Awareness Month.

According to the Lupus Foundation of America, as many as 2 million Americans, including my lovely stepdaughter, Katharine Lehtinen, are living with lupus, and another 16,000 new cases are reported across our Nation each year; but new research and collaborative projects offer hope that we are getting closer to safer and more effective treatments.

The Lupus Research Institute, in particular, has funded over 150 Novel Research Grants. These funds are aimed at forging scientific breakthroughs to better understand the disease and to help patients who are living with lupus. Because of the advancing science, 2016 may very well mark a new and exciting year in the long fight against this mysterious autoimmune disease.

Mr. Speaker, as this poster reads, ''For a future with no lupus, we must know lupus.''

NATIONAL NURSES WEEK

(Mr. CICILLINE asked and was given permission to address the House for 1 minute.)

Mr. CICILLINE. Mr. Speaker, this week is National Nurses Week. It is an opportunity to honor the 3.1 million registered nurses who are primary providers of hospital patient care.

Right now at hospitals and health centers across America, nurses are offering essential, lifesaving treatment for patients. Every day nurses encounter and overcome challenges that most of us will never face. Honoring the work of nurses is especially important for me on a personal level as my grandmother, Lucy Cicilline, was a proud nurse at Saint Joseph's Hospital in Providence, Rhode Island, for many years.

Let's honor the work of nurses by passing H.R. 2083, the bipartisan Registered Nurse Safe Staffing Act, which is a bill that I am proud to cosponsor that will require hospitals to create staffing plans for nurses, establish new whistleblower protections, improve nurse retention, and make hospitals safer both for nurses and their patients.

I am honored to recognize National Nurses Week, and I thank all of America's great nurses for all that they do.

HONORING THE LEGACY OF HARRY WU

(Mr. ROTHFUS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ROTHFUS. Mr. Speaker, 2 weeks ago, on April 26, the world lost an extraordinary man.

As a political prisoner in China for 19 years, from 1960 to 1979, Harry Wu endured torture, forced labor, and severe hunger. It was not until 3 years after Mao Zedong's death that Harry Wu was released.

His alleged crime?

As a 23-year-old student, Wu had criticized the Soviet invasion of Hungary and was given, according to Wu, a life sentence of labor, torture, and the teachings of Mao. After being freed, he devoted his life to exposing the horrors

of the so-called reform through labor camps.

After moving to the United States in 1985, Wu began returning to China to secretly document the labor camps, known as laogai. His work was showcased both on CBS and on the BBC in the early 1990s and continued through his Laogai Research Foundation and museum in Washington. He testified before Congress on China's unfulfilled promises of reform, forced abortions and sterilizations, Internet censorship, and religious repression.

We can honor his tremendous work by ensuring the truths he revealed are not forgotten and by continuing to defend human rights in China and across the world.

DR. CASTRO AND THE CONSUL OF MEXICO AWARD

(Mr. COSTA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COSTA. Mr. Speaker, I rise to recognize Dr. Joseph Castro, the president of Fresno State University. Dr. Castro is the president of one of the finest universities in the Western United States. It also happens to be my alma mater.

Since Dr. Castro has been president, it has been clear that he wants to make a positive difference in the lives of all students, especially of those who are from California's San Joaquin Valley. Over 60 percent of the students are the first in their families to attend a university, and it has over 25,000 students today.

This is one of the many reasons the Consul General of Mexico honored Dr. Castro with the Ohtli Award, which is the highest award given to exceptional leaders who improve the lives of the Hispanic community abroad.

Dr. Castro is truly deserving of this award. He understands the immigrant communities throughout the valley and throughout the region and my home, which we are also proud to represent. It is a special place. It is where he was from originally, from California, and he is the first Hispanic president to be appointed at Fresno State.

Please join me in honoring Dr. Joseph Castro and the entire Fresno State faculty and staff for all they do for the students to ensure that they have access to a high quality, affordable college education, because they are the future of America.

NATIONAL WOMEN'S HEALTH WEEK

(Ms. LORETTA SANCHEZ of California asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I rise in honor of National Women's Health Week.

Our goal this week is to empower women to prioritize and to take charge of their health. Thanks to the Affordable Care Act, women can access preventative care for little or no cost, but there still are concerning gaps in women's health.

One out of four women reports not visiting a doctor because of the cost, and nearly two out of three women in America die from chronic diseases like diabetes, heart disease, cancer, which is why women need quality, affordable, and accessible health care.

Protecting and improving the health of American women is one of my top priorities in Congress. I fought to insert language in the annual defense bill to ensure that our brave servicewomen and female veterans have access to adequate health services that fully address their specific medical needs, including preventative care and infertility treatments.

We have seen increasing attacks on women's health in Congress. So it is important, more than ever, that we ensure women's access to contraception and to their constitutionally protected right to choose.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore (Mr. JOLLY) laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, May 11, 2016.

Hon. PAUL D. RYAN,
The Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on May 11, 2016 at 9:12 a.m.:

That the Senate passed without amendment H.R. 4923.

That the Senate passed S. 1352.

That the Senate passed with amendments H.R. 4336.

With best wishes, I am
Sincerely,

KAREN L. HAAS.

APPOINTMENT OF MEMBER TO BOARD OF VISITORS TO THE UNITED STATES MILITARY ACADEMY

The SPEAKER pro tempore. The Chair announces the Speaker's appointment, pursuant to 10 U.S.C. 4355(a), clause 10 of rule I, and the order of the House of January 6, 2015, of the following Member on the part of the House to the Board of Visitors to the United States Military Academy to fill the existing vacancy thereon:

Mr. SEAN PATRICK MALONEY of New York

PROVIDING FOR CONSIDERATION OF H.R. 4641, ESTABLISHING PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE, AND PROVIDING FOR CONSIDERATION OF H.R. 5046, COMPREHENSIVE OPIOID ABUSE REDUCTION ACT OF 2016

Mr. COLLINS of Georgia. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 720 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 720

Resolved, That at any time after adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 4641) to provide for the establishment of an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Energy and Commerce now printed in the bill. The committee amendment in the nature of a substitute shall be considered as read. All points of order against the committee amendment in the nature of a substitute are waived. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in part A of the report of the Committee on Rules accompanying this resolution. Each such amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against such amendments are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the committee amendment in the nature of a substitute. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

SEC. 2. At any time after adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 5046) to amend the Omnibus Crime Control and Safe Streets Act of 1968 to authorize the Attorney General to make grants to assist State and local governments in addressing the national epidemic of opioid abuse, and for other purposes. The first reading of the bill shall be

dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on the Judiciary. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule an amendment in the nature of a substitute consisting of the text of Rules Committee Print 114–52. That amendment in the nature of a substitute shall be considered as read. All points of order against that amendment in the nature of a substitute are waived. No amendment to that amendment in the nature of a substitute shall be in order except those printed in part B of the report of the Committee on Rules accompanying this resolution. Each such amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against such amendments are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the amendment in the nature of a substitute made in order as original text. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from Georgia is recognized for 1 hour.

Mr. COLLINS of Georgia. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

□ 1230

GENERAL LEAVE

Mr. COLLINS of Georgia. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and to include any extraneous material on House Resolution 720, currently under consideration.

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

There was no objection.

Mr. COLLINS of Georgia. Mr. Speaker, I am pleased to bring this rule forward today on behalf of the Rules Committee.

The rule provides for consideration of H.R. 5046, the Comprehensive Opioid Abuse Reduction Act of 2016, and H.R. 4641, a bill to establish an interagency task force to review, modify, and update best practices for pain management and for prescribing pain medication.

For H.R. 5046, the rule provides for 1 hour of debate, equally divided and controlled by the chairman and ranking member of the Judiciary Committee.

And for H.R. 4641, the rule provides for 1 hour of debate, equally divided and controlled by the chairman and ranking member of the Energy and Commerce Committee.

Both rules are structured rules that make in order numerous amendments.

Yesterday the Rules Committee received testimony from members of the Judiciary Committee, the Energy and Commerce Committee, and multiple other Members on their amendments. H.R. 5046 was marked up by the Judiciary Committee, and H.R. 4641 was reported by the Energy and Commerce Committee. Both bills have broad bipartisan support.

These bills are part of the House's effort to combat our Nation's growing opioid epidemic. They reflect a commitment to address this devastating problem in a constructive and meaningful way.

Opioid abuse hits communities all across this country, rich and poor, rural, suburban, and urban, and it takes a major toll. In 2012, an estimated 2.1 million in the United States were suffering from substance abuse disorders related to prescription opioid pain relievers. An estimated 467,000 people were addicted to heroin.

In the same year, in Georgia, the Georgia Bureau of Investigation found that prescription drugs played a role in 592 deaths in 152 of 159 counties for which autopsies were performed.

Mr. Speaker, just the other day I was having coffee with a dear friend of mine who I have known for 20 years. As we were talking and I mentioned what we were doing here, he brought forth that just in the last little bit in his own family life he has seen relatives that have been touched by this epidemic of painkillers and substance abuse issues. This is something that can affect anyone in any family, and this is why we are here today.

The bills before us today take steps to combat the opioid epidemic and drug addiction.

H.R. 5046, introduced by Mr. SENSENBRENNER from Wisconsin, establishes a comprehensive opioid abuse grant program. The program encompasses new and existing Department of Justice programs, including training for first responders, law enforcement, drug courts, residential substance abuse treatment, and criminal investigations for the unlawful distribution of opioids.

Importantly, this bill provides flexibility for the States to use the funds where they are needed most. It does so by establishing one grant program that has numerous allowable uses. The bill also ensures that there isn't duplication and eliminates redundancy.

I was proud to support this bill at the Judiciary Committee.

H.R. 4641, introduced by Congresswoman SUSAN BROOKS of Indiana, establishes a pain management best practices interagency task force. This task force will include representatives from Federal agencies, state medical boards, healthcare professionals, experts from addiction recovery communities, and others knowledgeable in the field.

The task force will be responsible for reviewing and updating best practices for acute and chronic pain management in an evidence-based manner. It will also be responsible for sharing the information found with healthcare professionals. This bill recognizes that responses to the opioid epidemic need to be coordinated and thoughtful.

Addiction is happening far too often with devastating consequences. Further, it is shown that prescription opioid abuse often leads to heroin abuse—and the sheriffs in my part of my State can attest to this every day—compounding this problem.

In fact, according to the Centers for Disease Control, 45 percent of people who used heroin were addicted to prescription opioid painkillers.

Heroin has frequently been thought of as an inner-city problem, but we are starting to see it more and more outside of cities and spreading to rural areas, too. This problem is a problem for America. This problem has exploded.

According to the Georgia Bureau of Investigation, heroin deaths have increased in Georgia by 300 percent. That is an astonishing and very tragic statistic.

CDC statistics on opioid abuse show 18,893 overdose deaths related to prescription pain relievers and 10,574 overdose deaths related to heroin in 2014. Those are staggering numbers.

The opioid epidemic affects everyone, and I believe that most people could tell you of a family member or friend who has suffered in some way because of this problem.

Also, Mr. Speaker, it affects babies who are born addicted to opioids and other drugs. These children, through no fault of their own, are born with a serious and heartbreaking problem. They then go through dangerous withdrawals and can be left with lasting health consequences. We have to find a way to stop this.

The opioid epidemic affects veterans, whose battle scars are treated by a VA whose answer too often is to prescribe high quantities of opioids with little thought to the consequences.

I am a chaplain in the United States Air Force Reserve. I served in Iraq. I saw firsthand the scars that the battlefield can leave, both physical and mental. We need a support system for our veterans. We need to address their pain. We need to ensure that they have an avenue to get the help they need.

I believe that the bills that this rule provides for will take the steps to make that happen. Our veterans deserve our very best.

Addiction issues are often related to other co-occurring disorders, including mental health issues. Addiction claims victims, and addiction is a disease.

We must not turn a blind eye to those in need. We must work to halt the opioid epidemic, and we must act to prevent more deaths and to stop the growth and spread of the problem. Today's bills are a step toward doing that, and I am glad that we have the opportunity to discuss those in an open manner.

These bills are brought forward due to the hard work of many Members. In particular, I thank Chairmen GOODLATTE and UPTON, Ranking Members CONYERS and PALLONE, Congresswoman BROOKS, Congressman SENSENBRENNER, and their staffs for their work in bringing these important reforms together. These reforms are a step in the right direction.

I reserve the balance of my time.

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

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

Mr. MCGOVERN. Mr. Speaker, I thank the gentleman from Georgia (Mr. COLLINS) for the customary 30 minutes.

I rise to speak on the rule for consideration of H.R. 5046, the Comprehensive Opioid Abuse Reduction Act, and H.R. 4641, a bill to provide for the establishment of an interagency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes.

By the end of this week, the House will have taken up a total of 17 bipartisan opiate-related bills, each a critical measure to help us tackle the opioid crisis in a variety of ways as we work to end this scourge hurting so many communities across our country and costing the lives of so many all across this country.

I am pleased that the House will be considering this critical bipartisan legislation this week. But in all honesty, I am also very concerned that Republicans are not proposing the new funding that is necessary to meaningfully address the opioid crisis.

So, in addition to passing the bipartisan legislation on the floor this week, which authorizes a new grant program, we must also provide real, new resources in the form of appropriations to ensure that the initiatives in this legislation can be fully implemented.

If we don't do that, all the speeches that we will give this week will amount to empty rhetoric. We need to make sure we fund these priorities. This is an emergency.

Opiate addiction is inflicting a savage daily toll in neighborhoods across America. According to the CDC, 78 Americans die from an opiate overdose every day, and many of them are young people. In 2013, the number of heroin users was 681,000, an increase of more than 250,000 users since 2002. This crisis is affecting every region across the country and every demographic group.

I have long said that Congress must provide the meaningful resources that are needed to make a difference and save lives. Today I am pleased that we are coming together and taking action to attempt to do just that. These are important first steps.

In New England, we know all too well the terrible toll of the opiate epidemic. Having seen the damage it has done to the communities that I represent in central and western Massachusetts, tackling the opiate epidemic has long been a top priority for me.

Across Massachusetts, the number of opiate overdose deaths climbed by nearly 10 percent, up from 1,228 in 2014 to 1,379 in 2015. Once all cases are finalized by the medical officials in Massachusetts, it is estimated that there will be an additional 63 to 85 deaths for 2014 and 118 to 179 deaths in 2015.

In Worcester County alone, home to the second largest city in New England, opiate-related deaths jumped from 163 in 2014 to 177 in 2015. Looking back at the last 16 years, we can see an even bigger increase. In 2000, there were 59 opiate-related overdose deaths in Worcester County, a small fraction of the 1,289 deaths in 2015.

Most of last year's victims were between the ages of 25 and 44, in the prime of their lives with so much to live for. Many left behind families heartbroken and devastated by these senseless deaths. These families included husbands, wives, children, and so many more who loved them and desperately wanted them to get the help that they needed and to be able to live.

The opiate epidemic is even harder to cope with for those who have seen young people lose their lives to addiction. In Shrewsbury, Massachusetts, one high school principal said that, in the 11 years he has been principal, he has known of 33 students who have been active heroin addicts and 7 of them died. And in a recent forum, he learned that there had been even more that he had not known about.

Part of the problem is the stigma associated with heroin use. I think a lot of us think we know what heroin use and addiction looks like, but the reality is it can take hold of anyone, including our neighbors, our friends, and even our own family members.

However, instead of giving in to despair, communities in Massachusetts and across the country are responding to the opiate epidemic with strength and with courage. They are helping to lead grassroots State and national coalitions to raise awareness and educate people about the crisis and provide resources to help those ensnared by the addiction.

The Central Massachusetts Opiate Task Force, chaired by Worcester County District Attorney Joe Early, is a great example of this. They are working to bring greater awareness of the problem to residents. Members of the task force attend many of the coalition forums and also go into schools to talk to students directly.

The opiate task force serving Franklin County and the North Quabbin Region in Massachusetts is another example. It is co-chaired by John Merrigan, Franklin County Register of Probate; Chris Donelan, the Franklin County Sheriff; and David Sullivan, the Northwestern District Attorney.

I am so thankful for these and other task forces and coalitions in Massachusetts and across the country for coming together quickly to address this public health crisis and for their tenacity in fighting for individuals and families struggling with addiction.

Just this week I had the opportunity to join community leaders at North Brookfield High School in central Massachusetts for an event with Chris Herren, a former constituent of mine from Fall River and a former Boston Celtics player who now travels in New England and across the country to speak about his own recovery from addiction and the need for young people to stay drug free.

I am also grateful to my fellow members of the Massachusetts congressional delegation for being strong partners in this fight. JOE KENNEDY is a member of the Energy and Commerce Committee and has been a leader on this issue. He is the lead Democratic sponsor of H.R. 4641. A number of amendments sponsored by Massachusetts Members were made in order last night, including several from KATHERINE CLARK, as well as amendments from SETH MOULTON, BILL KEATING, and STEPHEN LYNCH.

□ 1245

I also want to commend the leadership of the gentlewoman from New Hampshire (Ms. KUSTER). She has been out front on this issue for a long, long time, and we appreciate her leadership.

The simple truth is that we are not going to arrest our way out of this problem. Prevention and treatment must be at the heart of our approach to tackling this epidemic. As part of the comprehensive approach called for, we must equip our young people with the skills necessary to identify constructive ways to deal with problems so that turning to drugs is never an option.

We must make every effort to ensure that treatment is available to those who seek it because it takes courage and strength to admit that you need help. I am pleased that this legislation that we are considering this week would do just that.

Mr. Speaker, I strongly support the legislation this rule makes in order, H.R. 5046. The Comprehensive Opioid Abuse Reduction Act would establish the Comprehensive Opioid Abuse Grant Program. With $103 million provided annually over 5 years, this program would help provide vital assistance to States and local agencies to fund treatment alternatives to incarceration, opioid abuse prevention, training, and education.

The program's grants could be used to train first responders in carrying and administering opioid overdose reversal drugs, support prescription drug

monitoring programs, strengthen collaborations between criminal justice agencies and substance abuse systems, or for programs targeted toward juvenile opioid abuse programs.

This legislation, I think, is a commonsense, bipartisan step that goes a long way toward providing the critical help that Americans across this country need to combat our opioid epidemic.

I also support H.R. 4641, a bill that would provide for the establishment of an interagency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes. Creating this task force is another key step to help strengthen our national response to the opioid crisis and increase interagency collaboration as we marshal all our resources in this fight.

I want to thank my colleagues on both sides of the aisle who worked very hard to bring this additional bipartisan legislation to the floor this week so we could begin to tackle this opioid crisis. These bills take important steps to cut the risk of opioid addiction among veterans managing chronic pain, take on international drug traffickers, improve the treatment and care of babies who are born addicted to opioids, help reduce opioid use among young people, and strengthen access to opioid overdose reversal medication.

There are many issues that Democrats and Republicans do not see eye to eye on, but I am pleased that both parties seem to be coming together, at least on this first step, to tackle the opioid crisis. For families and communities across the country who have already lost so much and so many to this epidemic, there has never been a more important time for us to take action.

I want to thank the leaders of both parties for helping to bring these bipartisan bills to the House floor. I do believe that we can end the opioid crisis once and for all.

But again, in conclusion—and I have to stress this—we need to provide the funding to our communities that are struggling to deal with this opioid and heroin crisis. This is an emergency. That is how you have to classify this and look at it. This is an emergency. People are dying. Without providing the additional resources needed, we will not be part of the solution.

The ideas that we have compiled today that will be debated this week are all good ideas, but they won't be real ideas unless they are funded. I worry that this Congress might not be up to the challenge. We have emergencies in Flint, Michigan, with the water crisis, and we have not done what we need to do to provide emergency funding to that community. We have a growing emergency with the Zika virus, and we can't get an emergency appropriations bill to the floor here today. I think that we need to understand that this crisis has risen to the level of an emergency. We need to do what is right. We need to not only pass these bills, but we need to commit in a bipartisan way that we are going to provide the necessary funding. I hope we can do that.

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

Mr. COLLINS of Georgia. Mr. Speaker, I am honored to yield 5 minutes to the gentleman from New Hampshire (Mr. GUINTA).

Mr. GUINTA. Mr. Speaker, I am proud to rise in support of H.R. 5046, the Comprehensive Opioid Abuse Reduction Act, and H.R. 4641, which will establish an interagency task force to review, modify, and update best practices for pain management and prescription pain medication.

Overprescription of opioids is leading to addiction, shattering lives, and creating death around our country. In my home State of New Hampshire, deadly overdoses following the abuse of heroin and opioids claimed the lives of over 430 people last year alone. That is about 1 in every 3,000 people from my State falling victim to an epidemic, succumbing to a preventable problem. According to the CDC, overdose deaths have tripled over the last 10 years.

Desperate families, too long, are crying out for help. I commend my colleagues for rising to the occasion in this legislative response, tackling this issue in a bipartisan way, and making the proper commitment to fund an adequate response to help those who are in need.

These two pieces of legislation are designed to assist those battling the epidemic on the front lines, from law enforcement officers to underfunded recovery systems and personnel, and everyone in between. I am moved time and time again by the painful stories of the victims and courageous individuals coming to their aid, and I urge the House to offer its support in this struggle.

I was pleased that just last night the Committee on Rules accepted my amendment, allowing prevention and recovery programs to accept grant money authorized by the Comprehensive Opioid Abuse Reduction Act, and I urge my colleagues to support this amendment when it comes to the House floor tomorrow.

As the House response to the Senate-passed Comprehensive Addiction and Recovery Act, these bills are a joint step toward progress and safety. I am a proud sponsor of many of these bills coming to the floor this week, and I hope for their swift and timely passage as urgent relief for those who are suffering around our Nation.

We must provide a thorough and wide-ranging plan to meet the enormity of this terrible epidemic, which invades every corner of the United States, takes lives across traditional divides, and manifests itself in ways to which we are not accustomed.

My colleagues and I are committed to seeing the House of Representatives answer this challenge by passing the most vigorous and inclusive plan possible. I am confident we will do all that we can to pass this plan this week, go to conference with the Senate, and put a bill on the President's desk before June.

Our plan is urgently needed. Almost 130 people die every day from opioid overdoses. Eighty percent of the opioids prescribed worldwide are prescribed here in the United States. In my district and around the country, I hear from families and friends who know someone coping with substance use disorder.

We will only make a dent in this great challenge by listening to its victims. We need to listen to fathers like Doug Griffin of Newton, New Hampshire. His daughter Courtney fell victim to heroin abuse at 20 years old.

Doug remembers Courtney as a vivacious girl, funny, passionate, and charming. She loved music and s'mores and told Doug she planned to become a marine, a beautiful young woman prepared to sacrifice for her country in one of its greatest and most honorable services. That was Courtney.

But 3 years later, she was lost on the streets, overwhelmed by the sorrow and confusion this epidemic instills, moving from rehab facility to rehab facility. Prescription pills, fentanyl, and street heroin ensnared Courtney in a fatal web of addiction, and she lost the will to live. Courtney was a 20-year-old girl—20 years old—a neighbor, a friend, a daughter. How can we begin to comprehend the depth of that kind of tragedy?

Because Courtney's pain was so great and because she had so few options for treatment, Doug says he and his family hid the truth from the outside world. To help others, they are speaking out now; and by speaking out and listening, we start to understand this tragedy. Doug is courageously telling everyone he knows the warning signs of heroin abuse and the deficiencies in our public response. Millions of Americans share Courtney's story and Doug's anguish. It is only by speaking out and sharing grief that we will remove the stigma preventing far too many from seeking help.

This week, during Heroin and Opioid Abuse Awareness Week, we have an opportunity to hear, learn, share, and fight back. We can hear the stories of grieving and resolute families, the stories of resilient victims. We can learn of the intensity of their experiences and glean from them the lessons we need to fight back. We can share their lessons and bring them to bear in our discourse and through our legislation, and we can start to turn the tide.

As the House considers this vital legislation, I encourage my colleagues to listen to their constituents, hear their stories, share their struggles, and help them fight back.

Mr. MCGOVERN. I yield myself such time as I may consume.

Mr. Speaker, again, I think that every Member of this House should support the underlying legislation.

There will be some good amendments offered. Unfortunately, there were a lot of good amendments that were not made in order by the Committee on Rules last night. There will be some suspensions that will come to the floor that I think deserve our support. And I am anxious to go to conference with the Senate, anxious to put a bill on the President's desk.

I don't want to spoil this bipartisan moment, but none of this means anything if we don't fund it. These aren't appropriations bills that we are dealing with. I know my colleagues on the other side of the aisle said, well, we will deal with that in the appropriations process. Well, because of the dysfunction of this place, we are not going to deal with the appropriations bills in any real way until after the election. I don't think we can wait. I think we need an emergency supplemental appropriations bill to deal right now with this crisis that has already claimed so many lives.

Let's all come together and pass these authorizing bills, but we need to do more than that. The President has requested $1.1 billion, I think, to try to help provide resources to communities to deal with this crisis. We haven't funded that. So bills that set up grant programs that we all support, initiatives that we all think are important, that is good; but if the money is not there to actually fund these and implement these programs, then we are not doing our job. I would just argue that we have waited too long. It is an emergency. We ought to do this, and we ought to have an emergency supplemental appropriations bill on the floor immediately and get relief to our communities today.

Mr. Speaker, I support all these measures that the House will consider this week; however, as I said, they can't be the final word. We have to approve additional funding to develop a comprehensive response to this epidemic, which is an emergency. I am going to ask my colleagues to defeat the previous question. If we defeat the previous question, I will offer an amendment to the rule to bring up legislation that provides $600 million in funding to address the opioid epidemic.

Mr. Speaker, I ask unanimous consent to insert the text of the amendment in the RECORD along with extraneous material immediately prior to the vote on the previous question.

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

There was no objection.

Mr. MCGOVERN. Mr. Speaker, I yield 4 minutes to the distinguished gentlewoman from New Hampshire (Ms. KUSTER), a leader on this issue, to discuss our proposal.

Ms. KUSTER. Mr. Speaker, I thank all my colleagues for the bipartisan work that is happening this week.

I am proud to be a co-chair with the gentleman from New Hampshire (Mr. GUINTA) of the Bipartisan Taskforce to Combat the Heroin Epidemic, Members of Congress from all across the country coming together to address this crisis.

I rise, however, to oppose the rule and, as Mr. MCGOVERN has said, we intend to move the previous question. I am bringing to the House floor a Democratic substitute opioids package to include $600 million in critical funding to address this opioid epidemic.

We have an emergency. People are dying, as Mr. GUINTA said—in my own State, our State of New Hampshire, over 420 people in 1 year. We have a better chance in New Hampshire of dying from an opioid epidemic death from fentanyl, from heroin, from drugs off the street, than we do of dying in a car accident. This is an emergency, and it is a crisis.

My substitute bill will provide vital funding for all of the bills that we are discussing, for bills that will provide the grants the Committee on the Judiciary has brought forth in H.R. 5046, introduced by Mr. SENSENBRENNER, for law enforcement, for drug courts.

I have just this week been to the graduation of a drug court. We can turn lives around, but we need funding for drug courts to spread all across our country, for the good work that my colleagues, the gentlewoman from Indiana (Mrs. BROOKS) and the gentleman from Massachusetts (Mr. KENNEDY), put into the Energy and Commerce bill, H.R. 4641, to create the task force.

Mr. GUINTA and I had an original bill, the STOP ABUSE Act, that created a task force, and we are so pleased that that task force will move forward. We need to bring together the experts to determine why now, what is happening in our society that opioid overdoses are leading people, leading this addiction, this substance use disorder that is a disease, leading people to go from prescribed medication from their physician into heroin off the streets and, in our State, is now being laced with fentanyl, which is a lethal combination.

□ 1300

The substitute will provide a total of $600 million in vital new resources to address this epidemic, and my understanding is that we have not included this funding in these underlying bills. We want to support the underlying bills, but it is critical to have the funding.

New Hampshire has now gone from number 24 in the Nation in deaths per population to number 3, seemingly overnight. I have traveled around my district bringing together stakeholders, law enforcement, treatment providers, long-term recovery, which is a critical aspect of this, physicians, hospitals, police, everyone to the table. In Keene, in Nashua, in Concord, in the north country of our State, we now have mayors' committees. We have the Governor having a major summit this week. Here is the answer: we have solutions.

I serve on the Committee on Veterans' Affairs, and I was so proud to bring to one of our congressional task force hearings Dr. Julie Franklin from the VA in White River Junction, Vermont, who is doing critical frontline research with people, veterans who are experiencing chronic pain. This is lifelong pain. She has worked with them with acupuncture, with mental health treatment, with physical therapy, with all different kinds of wellness and yoga, and she has decreased the use of opiate medication by 50 percent. We can do this, but we need funding.

I urge you to vote ''no'' on the rule. I ask my colleagues to please support the substitute package that will include a critical $600 million in funding.

Mr. COLLINS of Georgia. Mr. Speaker, I yield 2 minutes to the gentleman from Augusta, Georgia (Mr. ALLEN), my good friend and someone who has spent a great deal of time looking into these issues. I appreciate his willingness to come speak on it today.

Mr. ALLEN. Mr. Speaker, I thank the gentleman from Georgia for yielding to me to speak on this important threat to our country, our State, and our communities.

Our Founders made a promise of life, liberty, and the pursuit of happiness. In America today, in every State, in too many families, there is a palpable undercurrent of pain, loss, and suffering that is caused by this horrendous opioid crisis.

Sadly, nearly one in five Americans knows someone who has been addicted to opioids. Nearly every 12 minutes, someone in the U.S. dies of a drug overdose; every 25 minutes, a baby is born suffering from opioid withdrawal.

A recent CDC study found that, in 2009, more Americans died from prescription drugs than motor vehicle accidents, marking the first time drug-related deaths have outnumbered motor vehicle-related deaths since 1979, when the government started tracking drug-related deaths.

Unfortunately, my home State of Georgia is not immune to this growing epidemic. According to the Georgia Bureau of Investigation, in 2012, prescription drugs played a role in 592 deaths in 152 of the 159 counties in Georgia for which it performs autopsies.

These heartbreaking numbers are far too high and tragic. We must take action to combat this crisis so that those addicted and their loved ones may start the road to healing. This week my colleagues and I in the House of Representatives are bringing opioid addiction out of the shadows to stop this devastating crisis.

I am proud of the tireless work of my colleagues in the Judiciary Committee, the Energy and Commerce Committee, and the Education and the Workforce Committee, on which I serve, to prevent, treat, and streamline access to care for those addicted to opioids.

My colleagues and I have worked to advance bipartisan solutions that address this crisis, from helping newborns who are born into addiction to creating an interagency task force to update

best practices for prescribing opioid painkillers.

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

Mr. COLLINS of Georgia. Mr. Speaker, I yield the gentleman an additional 1 minute.

Mr. ALLEN. This is only the start of our work in the United States Congress on this important subject. The road to recovery will be long and hard fought, but the American spirit is as strong as ever and will prevail.

Together we will help our brothers and sisters in Christ become whole again. The very soul of this country is at stake. I am pleased the people's House is taking proactive steps to fight this epidemic.

I urge my colleagues to support the rule and support the numerous bills coming before the House this week.

Mr. MCGOVERN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I think we all agree that this is a crisis and that we need to come up with solutions and we need to do something rather than just talk about it.

I support—and I think I speak for the Democrats—and we all support the bipartisan legislation that is being brought to the floor, not only the bills that are going to be considered under this rule, but many of the suspension bills that will be brought to the floor this week. I expect that they will be passed nearly unanimously.

But I think what I do have a problem with is the fact that we have funded none of these things. I have a problem with the fact that some are content to wait until the appropriations process kind of works its way through this House, which, as we all know, is not going to be probably until December.

We have already been informed that we will probably deal with an omnibus package sometime after the election. Because there is infighting within the Republican ranks here in the House in trying to come to an agreement before the election, it is just too difficult. I regret that very, very much because I don't think that we can wait until December before we actually fund some of these priorities that are in this bill.

The reason why I hope my colleagues will support the Democratic substitute is because it actually funds. It is an appropriation. It funds these priorities. It puts our money where our rhetoric is. It makes the money available now, and we know it is there and communities will know that they can depend on it.

So I think we really want to be effective in our battle against this scourge of opioids and heroin addiction that has touched every district in this country.

We have all been to too many funerals. We have all seen the heartbreak up close and personal. But if we want to do something about it, we have to not only come up with the ideas, we have to fund these ideas.

That is why I am urging that Members vote ''no'' on the previous question. It is so that we can bring a funding component to this. Let's not wait until December. This is an emergency. We should have had an emergency supplemental bill. That is not coming.

So this is a chance to put some money behind these priorities and actually fund all these great ideas that we all, in a bipartisan way, say we support.

I urge my colleagues to support all the underlying bills, but to vote ''no'' on the previous question so we can bring this appropriations bill up to actually fund them. So I urge my colleagues to vote ''no'' on the previous question and to also vote ''no'' on the rule.

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

Mr. COLLINS of Georgia. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, as you have heard—and we have spent the last almost 40 minutes talking about it—the opioid epidemic is out of control, but we have the opportunity today to start addressing that problem in a meaningful way.

The rule provides for consideration of legislation that will enact measures to address this problem through multiple avenues to ensure that we are taking a comprehensive approach to stopping this scourge.

It takes important steps to address the serious and growing threat of opioid abuse. It keeps a promise that we won't sit idly by while people continue the battle of addiction and die.

For that reason, I urge my colleague to support the rule and both H.R. 5046 and H.R. 4641.

The material previously referred to by Mr. MCGOVERN is as follows:

AN AMENDMENT TO H. RES. 720 OFFERED BY MR. MCGOVERN

At the end of the resolution, add the following new sections:

SEC. 3. Immediately upon adoption of this resolution the Speaker shall, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 5189) to address the opioid abuse crisis. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided among and controlled by the respective chairs and ranking minority members of the Committees on Energy and Commerce and the Judiciary. After general debate the bill shall be considered for amendment under the five-minute rule. All points of order against provisions in the bill are waived. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of rule XIV, resolve into the Committee of the Whole for further consideration of the bill.

SEC. 4. Clause 1(c) of rule XIX shall not apply to the consideration of H.R. 5189.

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Republican majority agenda and a vote to allow the Democratic minority to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives (VI, 308–311), describes the vote on the previous question on the rule as ''a motion to direct or control the consideration of the subject before the House being made by the Member in charge.'' To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that ''the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition'' in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R-Illinois) said: ''The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition.''

The Republican majority may say ''the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever.'' But that is not what they have always said. Listen to the Republican Leadership Manual on the Legislative Process in the United States House of Representatives, (6th edition, page 135). Here's how the Republicans describe the previous question vote in their own manual: ''Although it is generally not possible to amend the rule because the majority Member controlling the time will not yield for the purpose of offering an amendment, the same result may be achieved by voting down the previous question on the rule. . . . When the motion for the previous question is defeated, control of the time passes to the Member who led the opposition to ordering the previous question. That Member, because he then controls the time, may offer an amendment to the rule, or yield for the purpose of amendment.''

In Deschler's Procedure in the U.S. House of Representatives, the subchapter titled ''Amending Special Rules'' states: ''a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate.'' (Chapter 21, section 21.2) Section 21.3 continues: ''Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon.''

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Republican majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

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

and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. POE of Texas). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. MCGOVERN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of adoption of the resolution.

The vote was taken by electronic device, and there were—yeas 215, nays 173, not voting 45, as follows:

[Roll No. 182]

YEAS—215

Abraham
Aderholt
Allen
Amash
Amodei
Babin
Barletta
Barton
Benishek
Bilirakis
Bishop (MI)
Blackburn
Blum
Bost
Boustany
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Buchanan
Buck
Bucshon
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Chaffetz
Clawson (FL)
Coffman
Cole
Collins (GA)
Collins (NY)
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Crenshaw
Culberson
Curbelo (FL)
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Dold
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Ellmers (NC)
Emmer (MN)
Farenthold
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Garrett
Gibbs
Gibson
Gohmert
Goodlatte
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guinta
Guthrie
Hanna
Hardy
Harper
Harris
Hartzler
Hensarling
Hice, Jody B.
Hill
Holding
Hudson
Huizenga (MI)
Hultgren
Hunter
Hurd (TX)
Hurt (VA)
Issa
Jenkins (KS)
Johnson (OH)
Johnson, Sam
Jolly
Jones
Jordan
Katko
Kelly (MS)
King (IA)
King (NY)
Kinzinger (IL)
Kline
Knight
Labrador
LaHood
Lamborn
Lance
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
Lummis
MacArthur
Marchant
Marino
Massie
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Mooney (WV)
Mullin
Mulvaney
Murphy (PA)
Neugebauer
Newhouse
Noem
Nugent
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Pitts
Poe (TX)
Poliquin
Pompeo
Posey
Ratcliffe
Reed
Ribble
Roby
Roe (TN)
Rogers (KY)
Rohrabacher
Rooney (FL)
Ros-Lehtinen
Ross
Rothfus
Rouzer
Royce
Salmon
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NJ)
Smith (TX)
Stefanik
Stewart
Stivers
Stutzman
Thompson (PA)
Thornberry
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Young (IN)
Zeldin
Zinke

NAYS—173

Adams
Aguilar
Ashford
Bass
Beatty
Becerra
Beyer
Bishop (GA)
Blumenauer
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (FL)
Brownley (CA)
Bustos
Butterfield
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Courtney
Crowley
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Duckworth
Edwards
Ellison
Engel
Eshoo
Esty
Farr
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Graham
Grayson
Green, Al
Green, Gene
Gutiérrez
Hahn
Heck (WA)
Higgins
Himes
Hinojosa
Honda
Hoyer
Huffman
Israel
Jackson Lee
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Kildee
Kilmer
Kind
Kirkpatrick
Kuster
Larsen (WA)
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham (NM)
Lynch
Maloney, Carolyn
Maloney, Sean
Matsui
McCollum
McDermott
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Murphy (FL)
Nadler
Napolitano
Neal
Nolan
Norcross
O'Rourke
Pallone
Pascrell
Payne
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Rangel
Rice (NY)
Richmond
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Sherman
Sinema
Sires
Speier
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Tsongas
Van Hollen
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Wilson (FL)
Yarmuth

NOT VOTING—45

Barr
Bera
Bishop (UT)
Black
Brady (TX)
Cartwright
Castor (FL)
Costa
Fattah
Fincher
Gosar
Grijalva
Hastings
Heck (NV)
Herrera Beutler
Huelskamp
Jenkins (WV)
Joyce
Kelly (PA)
LaMalfa
Langevin
Larson (CT)
Latta
Luján, Ben Ray (NM)
Meehan
Price, Tom
Reichert
Renacci
Rice (SC)
Rigell
Rogers (AL)
Rokita
Roskam
Russell
Slaughter
Smith (NE)
Smith (WA)
Takai
Tiberi
Vargas
Walberg
Webster (FL)
Welch
Westmoreland
Whitfield

□ 1328

Ms. LINDA T. SÁNCHEZ of California and Mr. BRADY of Pennsylvania changed their vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

Stated for:

Mr. KELLY of Pennsylvania. Mr. Speaker, on rollcall No. 182, I was at a hearing and not able to vote. Had I been present, I would have voted "yes."

Mr. SMITH of Nebraska. Mr. Speaker, on rollcall No. 182, I was unavoidably detained. Had I been present, I would have voted "yea."

Mr. MEEHAN. Mr. Speaker, on rollcall No. 182, I was unavoidably detained at a Ways and Means Committee Hearing. Had I been present, I would have voted "yes."

Mr. BARR. Mr. Speaker, on rollcall No. 182, I was unavoidably detained. Had I been present, I would have voted "yes."

Mr. RENACCI. Mr. Speaker, on rollcall No. 182, I was at a Ways and Means hearing and was not able to make it to the floor in time. Had I been present, I would have voted "yes."

Mr. ROKITA. Mr. Speaker, on rollcall No. 182, I was unavoidably detained. Had I been present, I would have voted "yes."

Ms. SLAUGHTER. Mr. Speaker, I was unavoidably detained and missed rollcall vote No. 182. Had I been present, I would have voted "nay."

Stated against:

Mr. LANGEVIN. Mr. Speaker, on rollcall vote No. 182, I was unavoidably detained. Had I been present, I would have voted "no."

Mr. BERA. Mr. Speaker, I was unavoidably detained for one rollcall vote Wednesday, May 11, 2016. Had I been present I would have voted "no" on rollcall No. 182.

Mr. SMITH of Washington. Mr. Speaker, today, Wednesday, May 11, 2016, I missed the first vote in a series of votes because I was at a medical appointment. Had I been present, I would have voted ''no'' on rollcall vote No. 182 (on ordering the previous question on H. Res. 720).

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MCGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 255, noes 163, not voting 15, as follows:

[Roll No. 183]

AYES—255

Abraham
Aderholt
Allen
Amash
Amodei
Babin
Barletta
Barr
Barton
Benishek
Bilirakis
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Bost
Boustany
Brady (TX)
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Buchanan
Buck
Bucshon
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Chaffetz
Clawson (FL)
Coffman
Cole
Collins (GA)
Collins (NY)
Comstock
Conaway
Cook
Cooper
Costa
Costello (PA)
Cramer
Crawford
Crenshaw
Cuellar
Culberson
Curbelo (FL)
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Dold
Donovan
Duckworth
Duffy
Duncan (SC)
Duncan (TN)
Ellison
Ellmers (NC)
Emmer (MN)
Farenthold
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Garrett
Gibbs
Gibson
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guinta
Guthrie
Hanna
Hardy
Harper

Harris
Hartzler
Heck (NV)
Hensarling
Hice, Jody B.
Higgins
Hill
Himes
Holding
Hudson
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurd (TX)
Hurt (VA)
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (OH)
Johnson, Sam
Jolly
Jones
Jordan
Kaptur
Katko
Keating
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger (IL)
Kline
Knight
Labrador
LaHood
LaMalfa
Lamborn
Lance
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
Lummis
Lynch
MacArthur
Marchant
Marino
Massie
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Mooney (WV)
Moulton
Mullin
Mulvaney
Murphy (FL)
Murphy (PA)
Neugebauer
Newhouse
Noem
Nugent
Nunes
Olson
Palazzo
Palmer
Pascrell
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Pompeo
Posey
Price, Tom
Ratcliffe
Reed
Reichert
Renacci
Ribble
Rice (SC)
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney (FL)
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce
Ruppersberger
Russell
Salmon
Sanford
Scalise
Schiff
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Sinema
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Stefanik
Stewart
Stivers
Stutzman
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Westmoreland
Williams
Wilson (SC)
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Young (IN)
Zeldin
Zinke

NOES—163

Adams
Aguilar
Ashford
Bass
Beatty
Becerra
Bera
Beyer
Bishop (GA)
Blumenauer
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (FL)
Brownley (CA)
Bustos
Butterfield
Capuano
Cárdenas
Carney
Carson (IN)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Courtney
Crowley
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Edwards
Engel
Eshoo
Esty
Farr
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Graham
Grayson
Green, Al
Green, Gene
Gutiérrez
Hahn
Heck (WA)
Honda
Hoyer
Huffman
Israel
Jackson Lee
Jeffries
Johnson (GA)
Johnson, E. B.
Kelly (IL)
Kennedy
Kildee
Kilmer
Kind
Kirkpatrick
Kuster
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Maloney, Carolyn
Maloney, Sean
Matsui
McCollum
McDermott
McGovern
McNerney
Meeks
Meng
Moore
Nadler
Napolitano
Neal
Nolan
Norcross
O'Rourke
Pallone
Payne
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Rangel
Rice (NY)
Richmond
Roybal-Allard
Ruiz
Rush
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Sherman
Sires
Slaughter
Smith (WA)
Speier
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Tsongas
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NOT VOTING—15

Capps
Cartwright
Castor (FL)
Fattah
Fincher
Grijalva
Hastings
Herrera Beutler
Hinojosa
Joyce
Latta
Pitts
Takai
Whitfield
Wittman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1335

Messrs. BRADY of Pennsylvania and AL GREEN of Texas changed their vote from ''aye'' to ''no.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. WITTMAN. Mr. Speaker, on rollcall No. 183, I was unavoidably detained. Had I been present, I would have voted "yes."

Stated against:

Mrs. CAPPS. Mr. Speaker, I was unavoidably detained. Had I been present, I would have voted "nay" on rollcall No. 183.

ESTABLISHING PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE

GENERAL LEAVE

Mrs. BROOKS of Indiana. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on the bill, H.R. 4641.

The SPEAKER pro tempore (Mr. RODNEY DAVIS of Illinois). Is there objection to the request of the gentlewoman from Indiana?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 720 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 4641.

The Chair appoints the gentleman from Texas (Mr. POE) to preside over the Committee of the Whole.

□ 1340

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 4641) to provide for the establishment of an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes, with Mr. POE of Texas in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentlewoman from Indiana (Mrs. BROOKS) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes.

The Chair recognizes the gentlewoman from Indiana.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this week we have and will continue to hear harrowing and personal stories on the House floor about how opioid addiction is devastating local communities and families across the country. Just last night, my colleagues shared some of their stories. The gentleman from Pennsylvania (Mr. MEEHAN) shared a story about a promising collegiate athlete whose star was extinguished when a minor injury led to an addiction and his eventual overdose and death. Ms. KUSTER from New Hampshire told of a constituent named Amber who tragically died of an overdose after a treatment bed was unavailable for her after leaving incarceration.

We are going to hear many more stories today about this epidemic that has touched every community in every State of our country, an epidemic that has exploded in recent years to the point where every 12 minutes someone is dying of a drug overdose in this country. By the end of this debate, there may be over five people who have died of an overdose.

The Energy and Commerce Committee has meticulously investigated this epidemic over the past year with multiple hearings and expert witnesses. The result is a thoughtful package of solutions focused on prevention and treatment that will help those facing addictions and their families deal with this opioid and, subsequently, heroin crisis. The statistics couldn't be more stark.

The United States only represents 5 percent of the world's population, yet we consume 80 percent of the world's pain medication. Yet 80 percent of heroin users started with a prescription to legal pain medication. Nearly 260 million opioid prescriptions were written in the United States in 2012, outpacing the number of American adults by 20 million.

As we debate this crisis, this is not just about statistics, because we are actually talking about husbands, wives, brothers, sisters, parents, and, sadly, our children. A parent who has inspired me is a woman named Justin Phillips from Indianapolis, a Hoosier mom who lost her son, Aaron, to a heroin overdose at the age of 20.

Out of her heartbreak, she found a calling to keep local and national attention on the issue of heroin and opioid abuse, she said, ''until the dying stops.'' She became a leading voice for families facing addiction in Indiana, and she founded Overdose Lifeline, a nonprofit organization devoted to purchasing those lifesaving drugs, those

reversal drugs, for Hoosier first responders. But she didn't stop there.

She helped pass a bill at our statehouse, called Aaron's Law, to provide access to overdose reversal drugs for others beyond first responders. Justin is just like so many other moms and dads. She needs our help to prevent more kids like Aaron from being lost to heroin and opioid abuse.

Her story made me realize that solving this public health crisis, this epidemic, must be a top priority for Congress and for the Federal Government, and inspired me to work with my colleague from across the aisle, Congressman KENNEDY of Massachusetts, to lead these efforts in the House to combat the heroin opioid crisis.

This week we are taking up a series of bills that are going to make a real difference—we hope. They must make a real difference in turning back this scourge.

□ 1345

Now, I have cited the number of opioid prescriptions written in 2012, which outpaces the number of American adults. But the fact is that our prescribers—our doctors, our nurse practitioners, our dentists, and others—are often unaware that, in many cases, their efforts to properly treat their patients' pain can inadvertently create longer term addiction issues.

While there are certainly legitimate medical needs for pain medication opioids, many prescribers are unaware that, in many cases, their efforts to properly treat their patients' pain can inadvertently create these long-term addiction issues.

In an effort to address this, the CDC recently developed guidelines for prescribing opioids for chronic pain. In order to improve the way opioids are prescribed to patients with severe and chronic pain, these guidelines seek to reduce their overuse and their abuse.

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

The task force will be comprised of representatives from the Federal relevant agencies as well as those who deal with this problem day in and day out: physicians, dentists, pharmacists, hospitals, overdose reversal specialists, and pain and addiction researchers.

This task force will also include representatives from State medical boards, pain advocacy groups, medical professional associations, mental health and addiction treatment communities.

The scope and breadth of this group will ensure that the practices are thoughtfully reviewed, modified, and updated. They will take into account the different types of opioids, opioids within and between different classes, the availability of deterrent technology as well as nonpharmacological and medical device alternatives to opioids. It is important that the task force consider the broadest scope of pain management options.

It is also important that this isn't just going to be another bureaucratic report that is compiled and sits on a shelf that is reviewed by congressional researchers and congressional staff. They must report out to Congress, lay out best practices, and provide a strategy for disseminating these best practices for pain management and recommendations at medical facilities.

We have to do more in this country. Failure to address a major part of this epidemic from the outset will perpetuate the cycle of addiction in our communities. This is but one important step. There are many, many bills that the House is considering.

I reserve the balance of my time.

Mr. PALLONE. Mr. Chairman, I yield myself such time as I may consume.

I rise in support of H.R. 4641, a bill to create an interagency task force on pain management. This legislation passed the committee with unanimous support.

In 2014, pharmacies in the United States dispensed approximately 245 million prescriptions for opioids. This is enough to provide a script to every adult in our entire Nation.

At the same time, we know that over 5 million Americans use prescription pain relievers either recreationally or to satisfy an opioid addiction.

This combination has produced tragic results. 2014 produced the highest number of drug overdose deaths than any previous year on record, with opioids and heroin driving the recent surge.

Unfortunately, our Nation's doctors and healthcare providers have not been provided the tools and education necessary to safely prescribe these medications in the midst of an opioid epidemic.

Recently, an article in the New England Journal of Medicine examined this topic and found that ''many physicians admit that they are not confident about how to prescribe opioids safely, how to detect abuse or emerging addiction, or even how to discuss these issues with their patients.''

As a result, we have created a patchwork of prescribing practices with tremendous variation both geographically as well as even within the same field.

This bill would create an interagency task force on pain management to review, modify, and update best practices on management and development of a strategy to disseminate those best practices to prescribers, pharmacists, and other stakeholders.

Those best practices will increase the tools available to providers who prescribe opioids more safely and be able to detect and intervene earlier in instances of substance use disorders.

I urge my colleagues to support this important legislation, which is part of the opioid epidemic package that we are moving on the floor today on suspension.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I yield 3 minutes to the gentleman from Michigan (Mr. UPTON), our chairman.

Mr. UPTON. Mr. Chairman, every 12 minutes someone in the U.S. dies of a drug overdose. Abuse of prescription painkillers and heroin has impacted every single community. It is an epidemic. It doesn't have boundaries and doesn't discriminate.

We have lost a lot of good kids and a lot of good people in my State and every State. As I travel back and forth to Michigan virtually every week, I meet a family member who has lost somebody with this very tragic story.

This last week it was a mother and a wife of a fellow who had committed suicide in Mattawan, Michigan. It breaks your heart.

Yes, we know the numbers. They are staggering. The CDC reports that nearly 260 million opioid prescriptions were written in 2012. That is one for every single U.S. adult, as my friend Mr. PALLONE said, with another 20 million to spare.

A recent study from the Kaiser Family Foundation found that one in five Americans say they have a family member who has been addicted to prescription painkillers.

The epidemic is unique to the U.S., as Americans consume 80 percent of the world's opioid prescriptions. It is not unique. It is a frightening reality, but we have to face the epidemic head-on. That is why today is an important step.

In the Energy and Commerce Committee, we have held a number of hearings over the last year with testimony from so many experts on the front lines. What we learned is eye-opening.

Federal policies toward opioid addiction in the past year have often overemphasized a one-size-fits-all law enforcement approach. It is clear through our listening sessions that it is a public health crisis and that our strategy should reflect the complex dynamic between public health and criminal activity. We know that we cannot simply incarcerate our way out of this epidemic.

The bills that we are considering today touch on a spectrum of issues driving the opioid crisis. While there is no one solution, these bills represent good steps in addressing a problem that has rapidly grown.

I want to thank all of my colleagues on the Energy and Commerce Committee and off for working to adhere in a bipartisan way these important bills that will really make a difference in every one of our communities.

The House leadership deserves recognition on both sides for their swift consideration of these bills. I want to thank, in particular, my good friend,

Mr. PALLONE, for working with us to get these bills across the finish line, through the committee process, and now on the floor.

Our work is going to continue. We owe this effort to the past, present, and, sadly, future victims of this epidemic: our neighbors, friends, and families across every part of the country, every demographic group. We owe it to the families and we owe it to the communities who are suffering from this addiction.

Mr. PALLONE. Mr. Chairman, I yield such time as he may consume to the gentleman from Massachusetts (Mr. KENNEDY), who is the Democratic sponsor of this bill and has worked a lot on the opioid epidemic problem.

Mr. KENNEDY. Mr. Chairman, I want to thank Mr. PALLONE for yielding, for his leadership on this issue throughout his time on Energy and Commerce, particularly over the last several months since I have been on the committee trying to galvanize support from all of our colleagues to recognize the impact that this is having every single day.

Mr. Chairman, I want to thank you for including H.R. 4641 in this package of bipartisan opioid-related bills.

None of our districts has been spared the heartbreaking headlines about lives lost to the opioid crisis. We have heard from each of our constituents who have attended funerals for friends, neighbors, classmates, colleagues, and family members. The bills we are considering this week are a promising step forward as we find ways to respond to this crisis.

To my colleague, Congresswoman BROOKS, thank you for your partnership on this issue and on so many others. We have both seen firsthand how lack of access to treatment can lead those suffering from addiction to our courts. With this bill, we are trying to change the course of their path to stop addiction before it even begins.

Mr. Chairman, last week the Boston Globe wrote a series of articles about the opioid crisis in my home State of Massachusetts. The statistics are devastating. Nationally, heroin overdose rates have tripled in the last 5 years. At home, our State faces a heroin overdose rate that is twice the national average.

Last year alone, nearly 1,400 Massachusetts families lost loved ones to opioid overdoses. Between 2013 and 2014, prescription opioid overdoses nearly doubled. During that same time, the number of people in Massachusetts who overdosed on a combination of heroin and prescription opioids rose by almost 500 percent.

The Globe also noted that there has been a noticeable shift from opioids to heroin with one exception, Bristol County, where many of my constituents live. In trying to explain that exception, the reporter included a haunting line that has stayed with me ever since.

He wrote that, in Bristol County, ''prescription opioids remain a dominant killer, though it's not clear whether that's because this area is somehow less susceptible to heroin or if it's merely a matter of time.''

Mr. Chairman, we cannot accept a reality with a rise in heroin overdoses as ''merely a matter of time.'' We have all said it over 100 times. When it comes to a Federal response, there is no silver bullet.

But H.R. 4641 tries to focus on what I believe offers us one of the very best opportunities for combating this problem: stopping addiction before it ever starts.

The bill will create a new task force dedicated to the job of reviewing, modifying, and updating best practices for the management of pain and the prescription of pain medication.

Voices from HHS, the VA, FDA, DEA, NIH, and other agencies will join prescribers, substance use disorder professionals, patients suffering from chronic pain, and patients who have lived through the heartbreaking reality of becoming addicted to prescription pills.

These advocates and experts are on the front lines of this fight every single day. Under their guidance, this task force will ensure we implement the policies that balance responsible pain management with the urgency that our opioid crisis requires.

Again, I am encouraged by the bipartisan progress we are making on this issue; yet, our work is just beginning.

I urge my colleagues to support this bill and look forward to working with each of them to build on this momentum.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield 3 minutes to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN. Mr. Chairman, I think, as you can see, Members on both sides of the aisle know of people in our districts, our States, and across our country that have been tragically affected by opioid abuse and overdose.

I want to thank my colleagues on both sides of the aisle for their work on this legislation, especially my friend from Indiana, Mrs. BROOKS.

I rise in strong support of H.R. 4641. This is a very important bipartisan step forward to combat opioid abuse. This issue hits close to home, all of our homes.

The State of Oregon ranked near the top or at the top for nonmedical use of prescription pain relievers in the Nation. With opioid prescriptions serving as a gateway to heroin, it is no surprise that deaths from drug overdoses have surpassed those of car accidents in my State.

Last week, in Medford, Bend, and Hermiston, I hosted roundtables with community leaders and affected families to talk about what they are seeing on the front lines.

Physicians, first responders, members of law enforcement, and families all were there sharing their stories, talking about how important the work we are doing here today is to them and our communities. All of them are on the ground combating this problem every day. We had excellent discussions.

H.R. 4641, in addition to the 17 other bipartisan bills we are voting on this week, will help combat this epidemic. This bill will help prevent lawful prescription use from spiraling into abuse by developing best practices for the treatment of pain.

In Medford, I heard from a father who had seen the impacts of addiction on his own family. His sister, who was a nurse, died of an overdose after years of suffering from addiction and bouncing between pharmacies, passing off forged prescriptions.

□ 1400

He spoke about how better tracking and treatment could have helped catch his sister's problem earlier and, perhaps, made counseling more effective. As it was, she was only caught because two pharmacies in a small town happened to check with each other. You see, by then, it was too late.

Today, this man is working to help his son with an addiction that started with a prescription for a high school sports injury that drifted into a heroin addiction. He spoke to the importance of counseling, support, and trying to avoid addiction through better prescribing practices.

Echoing those sentiments, a therapist I spoke to in Hermiston experienced 10 years of addiction of opioids after she was prescribed painkillers for a broken foot. Then when she tried to overcome this addiction, she could not find any help. So she traveled more than 5 hours, from Milton-Freewater, Oregon, to Marysville, Washington, because she could not find a physician in her region to prescribe Suboxone, an important medicine to help people break free from opioids.

Addiction is an equal opportunities destroyer. It crosses all segments and regions of our country, and often the disease shows no symptoms.

One emergency room physician relayed a story about a recent patient he had no reason to believe had an addiction problem until he saw in the database that the patient just received 60 pills the week before.

Opioids are highly effective at providing relief and improving the quality of life for those in debilitating pain. But if we don't know how to appropriately prescribe them, it's no wonder we got to this place. We need to increase access to counseling, medication-assisted therapy and treatment for those battling addiction. Echoing what I heard from health practitioners across my district, opioid addiction is a biopsychosocial disease—it's as complicated as diabetes and requires a multi-pronged approach.

That's why it is so important that we pass H.R. 4641 and all of these bills this week to give health providers, first responders, law enforcement, and those battling addiction the tools they need to overcome the epidemic of opioid abuse.

Mr. PALLONE. Mr. Chairman, I yield 3 minutes to the gentlewoman from

New Mexico (Ms. MICHELLE LUJAN GRISHAM).

Ms. MICHELLE LUJAN GRISHAM of New Mexico. I thank my colleague for yielding time.

Mr. Chairman, opioid abuse has become, as we have heard today, a critical national issue as 78 Americans are killed by heroin and prescription drug overdoses each day, and drug overdoses are now the leading cause of injury-related deaths in the United States.

The number of unintentional overdose deaths from prescription painkillers almost quadrupled between 1999 and 2013; but as bad as the opioid epidemic is across the country, it is much more severe in my home State of New Mexico, which has had one of the highest rates of overdose deaths in the country for several years. Unfortunately, it is getting worse. From 2013 to 2014, the death rate from drug overdoses in New Mexico increased 21 percent. Rio Arriba County, New Mexico, has the highest overdose death rate in the Nation—one in 500 people dies from overdose—which is about six times the national average.

The over-prescription of opioids for pain management is part of the problem, and an increasing number of patients is becoming dependent on these powerfully addictive medications. In fact, 259 million opioid prescriptions were written in 2012—more than one for every adult in the United States. Once addicted to these prescription opioids, many then turn to heroin and to synthetic opioids due to their increased availability, lower prices, and higher purity.

We must act to respond to this public health crisis, but we need to do it in a balanced way. We need to be mindful of the millions of Americans who suffer from chronic pain. We need to ensure that patients and providers continue to have access to the best, most medically appropriate course of treatment while cutting off access to those who abuse the system.

This is why I strongly support H.R. 4641, which would establish an interagency task force to review and update medical best practices for pain management and prescribing pain medication; but we can't stop here. We have to do more than just study the problem, because only 11 percent of Americans who need treatment for substance abuse are receiving it. Many of those who remain find themselves in our criminal justice system. Our prisons have become de facto treatment centers. More than 65 percent of our prison population has a substance abuse problem.

We have to provide the funds necessary to fully invest in opioid prevention, rehabilitation, and treatment programs. We have to support the placement of substance abuse treatment providers in the communities that are most in need, like Rio Arriba County. We have to improve access to the overdose reversal drug, naloxone, which can help save countless lives every year.

I urge my colleagues to support this legislation, which will address this disease that has destroyed the lives of so many.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I rise in support of H.R. 4641.

Prescription drug abuse, particularly with opioids, has become a national epidemic. It affects all of our communities. The bill before us today will authorize an important task force to determine and disseminate best practices for pain management.

The need for best practice guidelines was highlighted last week during a substance abuse panel I hosted in my district with Office of National Drug Control Policy Director Botticelli. One woman shared her story of addiction and struggle to receive help following a surgery she had had as a 15-year-old gymnast. We must give people like her the tools they need for prevention and treatment in order to stop the spread of this epidemic.

I thank the gentlewoman for sponsoring this bill. Please support this great bill.

Mr. PALLONE. Mr. Chairman, I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield 2 minutes to the gentleman from North Dakota (Mr. CRAMER).

Mr. CRAMER. I thank Mrs. BROOKS for her leadership on this—Mr. KENNEDY's as well—and for bringing this important legislation to our committee and to the floor.

Mr. Chairman, I rise to support H.R. 4641.

With heroin addiction now being three times greater than it was a decade ago, we know it doesn't matter where you come from. Whether you are on an Indian reservation, on a farm, in the middle of a city, in a suburb, in a small town, or whether you are in a Fargo high school, at the University of North Dakota in Grand Forks, or at Bismarck State College, it doesn't matter what your lot is in life. It doesn't matter what your income level is. It doesn't matter what your social status is. This opioid abuse crisis affects people from all walks of life, and it is about time we acknowledged it and tried to deal with it at this level.

This bill is pretty basic, but is pretty profound as well because it takes advantage of the collective opportunity of the collective talents, experiences, and backgrounds of the people on the ground who are dealing with it every day. It brings it all together and facilitates it at every level of government in every community and in every State whether it is North Dakota or Indiana or Massachusetts. It is the beginning, I believe, of a profound solution.

Just as much as anything, I applaud the efforts of the leadership who brought this to us, and I grieve with so many parents as we have heard their stories. This year, in the Fargo, North Dakota, area alone, there have been a minimum of 10 fatal overdoses because of this crisis.

I will stand shoulder to shoulder with anybody and everybody in this Chamber, as well as in the Chamber on the other side of the Capitol, to help solve this problem.

Mr. PALLONE. Mr. Chairman, I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Chairman, I rise in support of H.R. 4641 so we can continue to involve the practices of pain management and the prescribing of pain medication to fight the opioid abuse epidemic in this country.

As a lifelong pharmacist, I have provided prescription medications to Americans for over 30 years. In that time, I have personally witnessed the struggles that both medical professionals and patients face with prescription drug abuse.

There are many steps that must be taken to address this epidemic. One priority should be to involve practices related to pain management and the prescribing of pain medication. This bill does just that. This bill creates an interagency task force to continually review, modify, and update best practices for pain management and prescribing pain medication. Through the new task force, experts in fields related to prescription drug abuse and pain management will be able to involve best industry practices that will give clarity to our fight against this epidemic.

I commend Representative BROOKS and the Committee on Energy and Commerce for their work on this bill, and I encourage all of my colleagues to support this measure.

Mr. PALLONE. Mr. Chairman, I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield myself the balance of my time.

I thank all of my colleagues. I thank particularly the leadership of the Committee on Energy and Commerce. There have also been other committees—the Judiciary Committee, the Committee on Education and the Workforce—that have been working on bills. This is not something that any one Member of this body has truly been a leader on. So many different Members have been leading on this because it has affected our communities, our families, our neighborhoods.

I urge my colleagues to vote ''yes'' on this important bill because, as the gentleman from North Dakota said, the Federal Government has not done enough yet. This will be an opportunity for us to bring together all of the Federal agencies that are involved in this problem, which have been part of the problem, and try to change the way our prescribers throughout the country work on the pain management issues the country faces, which, hopefully, will yield a much lower overdose

rate—a rate which now exceeds the motor traffic fatalities in this country and which is the leading cause of calls to our poison centers. More importantly, it has devastated so many parents and friends who have found their friends who have overdosed from either heroin or opioids.

I am so pleased that we are finally beginning to recognize that we cannot arrest our way out of this problem. It is a disease. It is something that so many people cannot stop on their own. They need help. With all of these experts coming together on this task force to provide the best practices for the country, I hope we can turn the tide and save many lives.

I urge the bill's passage by my colleagues.

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

Mr. PALLONE. Mr. Chairman, I yield myself such time as I may consume.

I ask all of my colleagues to support this bill. As I said, this interagency task force is an important part of this larger opioid package that we produced in the Committee on Energy and Commerce on a bipartisan basis. I know the rest of those bills are going to come up on suspension—or most of them—this afternoon. I can't emphasize enough the importance of this package, as well as this bill, as being part of it.

I yield back the balance of my time.

The CHAIR. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule.

It shall be in order to consider as an original bill for the purpose of amendment under the 5-minute rule the amendment in the nature of a substitute, recommended by the Committee on Energy and Commerce, printed in the bill. The committee amendment in the nature of a substitute shall be considered as read.

The text of the committee amendment in the nature of a substitute is as follows:

H.R. 4641

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

SECTION 1. DEVELOPMENT OF BEST PRACTICES FOR THE USE OF PRESCRIPTION OPIOIDS.

(a) DEFINITIONS.—In this section—

(1) the term ''Secretary'' means the Secretary of Health and Human Services; and

(2) the term ''task force'' means the Pain Management Best Practices Inter-Agency Task Force convened under subsection (b).

(b) INTER-AGENCY TASK FORCE.—Not later than December 14, 2018, the Secretary, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administrator of the Drug Enforcement Administration, shall convene a Pain Management Best Practices Inter-Agency Task Force to review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication.

(c) MEMBERSHIP.—The task force shall be comprised of—

(1) representatives of—

(A) the Department of Health and Human Services;

(B) the Department of Veterans Affairs;

(C) the Food and Drug Administration;

(D) the Department of Defense;

(E) the Drug Enforcement Administration;

(F) the Centers for Disease Control and Prevention;

(G) the Health Resources and Services Administration;

(H) the Indian Health Service;

(I) the National Academy of Medicine;

(J) the National Institutes of Health;

(K) the Office of National Drug Control Policy; and

(L) the Substance Abuse and Mental Health Services Administration;

(2) State medical boards;

(3) physicians, dentists, and nonphysician prescribers;

(4) hospitals;

(5) pharmacists and pharmacies;

(6) experts in the fields of pain research and addiction research;

(7) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment and recovery community;

(D) pain advocacy groups; and

(E) groups with expertise on overdose reversal;

(8) a person in recovery from addiction to medication for chronic pain;

(9) a person with chronic pain; and

(10) other stakeholders, as the Secretary determines appropriate.

(d) DUTIES.—The task force shall—

(1) not later than 180 days after the date on which the task force is convened under subsection (b), review, modify, and update, as appropriate, best practices for pain management (including chronic and acute pain) and prescribing pain medication, taking into consideration—

(A) existing pain management research;

(B) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(C) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of differences within and between classes of opioids, the availability of opioids with abuse deterrent technology, and pharmacological, nonpharmacological, and medical device alternatives to opioids to reduce opioid monotherapy in appropriate cases;

(D) the management of high-risk populations, other than populations who suffer pain, who—

(i) may use or be prescribed benzodiazepines, alcohol, and diverted opioids; or

(ii) receive opioids in the course of medical care; and

(E) the 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention;

(2) solicit and take into consideration public comment on the practices developed under paragraph (1), amending such best practices if appropriate; and

(3) develop a strategy for disseminating information about the best practices developed under paragraphs (1) and (2) to prescribers, pharmacists, State medical boards, educational institutions that educate prescribers and pharmacists, and other parties, as the Secretary determines appropriate.

(e) LIMITATION.—The task force shall not have rulemaking authority.

(f) REPORT.—Not later than 270 days after the date on which the task force is convened under subsection (b), the task force shall submit to Congress a report that includes—

(1) the strategy for disseminating best practices for pain management (including chronic and acute pain) and prescribing pain medication, as developed under subsection (d);

(2) the results of a feasibility study on linking the best practices described in paragraph (1) to receiving and renewing registrations under section 303(f) of the Controlled Substances Act (21 U.S.C. 823(f)); and

(3) recommendations for effectively applying the best practices described in paragraph (1) to improve prescribing practices at medical facilities, including medical facilities of the Veterans Health Administration and Indian Health Service.

The CHAIR. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in part A of House Report 114–551. Each such amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered read, shall be debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

AMENDMENT NO. 1 OFFERED BY MS. BROWNLEY OF CALIFORNIA

The CHAIR. It is now in order to consider amendment No. 1 printed in part A of House Report 114–551.

Ms. BROWNLEY of California. Mr. Chairman, I have an amendment at the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, line 11, strike ''and''.

Page 4, line 13, insert ''and'' after the semicolon.

Page 4, after line 13, insert the following:

(M) the Office of Women's Health;

The CHAIR. Pursuant to House Resolution 720, the gentlewoman from California (Ms. BROWNLEY) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman.

Ms. BROWNLEY of California. Mr. Chairman, I rise to offer a very straightforward amendment to H.R. 4641.

The amendment would include the Office of Women's Health in the interagency task force created under the bill.

As we all know, the underlying bill includes a list of Federal agency representatives to be included in the interagency task force, which will review, modify, and update best practices for pain management and prescribing pain medication.

However, the bill does not currently include the Office of Women's Health. The Office of Women's Health, within the U.S. Department of Health and Human Services, was established in 1991 to improve the health of women by advancing and coordinating a comprehensive women's health agenda to address healthcare prevention and service delivery.

The Office of Women's Health works with numerous government agencies, nonprofit organizations, consumer groups, and associations of healthcare professionals to coordinate and advance policies and programs that best meet the unique healthcare needs of women.

□ 1415

As a national leader in the health of women and girls, the Office of Women's Health has critical specialized expertise that will help the interagency pain management task force address the unique pain management needs of women who may be pregnant or who may be nursing.

This expertise is desperately needed because opioid abuse among women has increased substantially in recent years. In fact, according to the Centers for Disease Control and Prevention, the number of women who fall victim to an opioid-related fatality increased an alarming 400 percent from 1999 to 2010, totalling 48,000 women who have died during that span of time.

During this decade, opioid abuse among women increased more than abuse of any other drug, including cocaine and heroin. Shockingly, the CDC reports that in 2010, 18 women per day died of a prescription painkiller overdose, accounting for nearly 7,000 women in total.

It is critically important that we include experts on women's health in the opioid task force. Women who are pregnant or who may be nursing have specialized healthcare needs, and the Office of Women's Health is uniquely qualified to ensure that the interagency task force takes the needs of women and girls into account as it examines best practices for pain management in prescribing pain medication.

I urge my colleagues to support this commonsense amendment.

I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support the amendment.

The CHAIR. Without objection, the gentlewoman from Indiana is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. At this time, I thank the gentlewoman from California for the amendment. I think it strengthens the bill. I think it is very important that the Office of Women's Health is added to the task force. So many of us have had the opportunity to visit NICUs in hospitals and have seen drug-addicted babies. So I do believe that having the perspective of the Office of Women's Health would be critically important.

So often women's health has not been given the proper attention that it deserves, and I would ask for support of the amendment.

I yield back the balance of my time.

Ms. BROWNLEY of California. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Chairman, I want to urge all my colleagues on this side of the aisle to support the bill as well.

Ms. BROWNLEY of California. Mr. Chairman, I thank the gentleman from New Jersey and the gentlewoman from Indiana. I think we all realize the importance of ensuring that this interagency task force is effective and works, and I think the eyes on specific healthcare needs of women and girls is most important.

I yield back the balance of my time.

The CHAIR. The question is on the amendment offered by the gentlewoman from California (Ms. BROWNLEY).

The amendment was agreed to.

AMENDMENT NO. 2 OFFERED BY MRS. BROOKS OF INDIANA

The CHAIR. It is now in order to consider amendment No. 2 printed in part A of House Report 114–551.

Mrs. BROOKS of Indiana. Mr. Chairman, as the designee of the gentleman from Georgia (Mr. CARTER), I offer amendment No. 2.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, line 15, strike ''physicians'' and insert ''subject to subsection (d), physicians''.

Page 4, line 18, strike ''pharmacists'' and insert ''subject to subsection (d), pharmacists''.

Page 5, after line 10, insert the following:

(d) CONDITION ON PARTICIPATION ON TASK FORCE.—An individual representing a profession or entity described in paragraph (3) or (5) of subsection (c) may not serve as a member of the task force unless such individual—

(1) is currently licensed in a State in which such individual is practicing (as defined by such State) such profession (or, in the case of an individual representing an entity, a State in which the entity is engaged in business); and

(2) is currently practicing (as defined by such State) such profession (or, in the case of an individual representing an entity, the entity is in operation).

Page 5, line 11, strike ''(d)'' and insert ''(e)''.

Page 7, line 1, strike ''(e)'' and insert ''(f)''.

Page 7, line 3, strike ''(f)'' and insert ''(g)''.

The CHAIR. Pursuant to House Resolution 720, the gentlewoman from Indiana (Mrs. BROOKS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Indiana.

Mrs. BROOKS of Indiana. Mr. Chairman, this amendment simply would require that any of the individuals who are appointed to the task force under H.R. 4641, whether they be a physician, a dentist, a nonphysician prescriber, or pharmacist who is eventually appointed by the lead of Health and Human Services, that that individual shall be a licensed prescriber and practicing in their appropriate State or that they, at a minimum, should have an active license and that they should be a practicing prescriber in that State.

I urge my colleagues to adopt this amendment.

I reserve the balance of my time.

Mr. PALLONE. Mr. Chairman, I claim the time in opposition, but I support the amendment.

The CHAIR. Without objection, the gentleman from New Jersey is recognized for 5 minutes.

There was no objection.

Mr. PALLONE. Mr. Chairman, I urge my colleagues to support the amendment.

I yield back the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I yield back the balance of my time.

The CHAIR. The question is on the amendment offered by the gentlewoman from Indiana (Mrs. BROOKS).

The amendment was agreed to.

AMENDMENT NO. 3 OFFERED BY MR. GRAYSON

The CHAIR. It is now in order to consider amendment No. 3 printed in part A of House Report 114–551.

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

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, after line 18, insert the following (and redesignate the subsequent paragraphs accordingly):

(6) first responders;

The CHAIR. Pursuant to House Resolution 720, the gentleman from Florida (Mr. GRAYSON) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Florida.

Mr. GRAYSON. Mr. Chairman, my amendment would ensure that first responders are included for membership on the Pain Management Best Practices Interagency Task Force. This is a commonsense amendment.

First responders, like police officers and other emergency room staff, are the first on the scene when a person overdoses. And they are the first to administer emergency treatments and resuscitation programs. These are the people who have the first contact with victims of opioid overdose.

It would make sense that if we are putting together a task force to address the terrible opioid problem—and specifically pain management best practices—we should include the views and opinions of those who are first on the scene and in the best position to save lives.

Being first on the scene to overdose emergencies, first responders often interact with patients in pain. Yet, most first responders, especially EMS responders, have no pain management standards as part of their accreditation.

The Commission on Accreditation of Ambulance Services does not include a pain management standard as part of its clinical assessment, nor is pain management a major part of EMS education. As a result, first responder attitudes vary. According to a 2012 Yale study, there is a widespread reluctance within the EMS community to administer opioids to those who legitimately need it out of a fear—perhaps unfounded—that patients could be addicts seeking drugs.

First responders certainly do encounter people who are not prescription painkiller dependent. However, it is often not possible for paramedics to know with certainty if a patient is an addict or even whether the addict is also experiencing legitimate pain.

This level of uncertainty and varying degrees of attitudes within the first responder community, along with the

unique experience and insight into the opioid epidemic, warrants the inclusion of first responders to the Pain Management Best Practices Interagency Task Force membership.

Mr. Chairman, this is very simple, we are putting together a Pain Management Best Practices Interagency Task Force. We should include police officers. We should include paramedics. We should include people who are on the front lines of fighting this battle every day that is a battle of life and death.

I urge the support of my amendment.

I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition.

The CHAIR. The gentlewoman from Indiana is recognized for 5 minutes.

Mrs. BROOKS of Indiana. Mr. Chairman, for the record, I support the amendment.

I yield back the balance of my time.

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

The CHAIR. The question is on the amendment offered by the gentleman from Florida (Mr. GRAYSON).

The amendment was agreed to.

AMENDMENT NO. 4 OFFERED BY MS. CLARK OF MASSACHUSETTS

The CHAIR. It is now in order to consider amendment No. 4 printed in part A of House Report 114–551.

Ms. CLARK of Massachusetts. Mr. Chairman, I have an amendment at the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 4, after line 20, insert the following:

(7) experts in the fields of adolescent and young adult addiction research;

Page 4, line 21, strike ''(7)'' and insert ''(8)''.

Page 5, line 6, strike ''(8)'' and insert ''(9)''.

Page 5, after line 7, insert the following:

(10) a person in recovery from addiction to medication for chronic pain, whose addiction began in adolescence or young adulthood;

Page 5, line 8, strike ''(9)'' and insert ''(11)''.

Page 5, line 9, strike ''(10)'' and insert ''(12)''.

Page 6, line 13, strike ''and''.

Page 6, after line 13, insert the following:

(E) the distinct needs of adolescents and young adults with respect to pain management, pain medication, substance use disorder, and medication-assisted treatment; and

Page 6, line 14, strike ''(E)'' and insert ''(F)''.

The CHAIR. Pursuant to House Resolution 720, the gentlewoman from Massachusetts (Ms. CLARK) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Massachusetts.

Ms. CLARK of Massachusetts. Mr. Chairman, a special thanks to Congresswoman BROOKS, Congressman KENNEDY, and Congressman PALLONE for introducing this important bipartisan bill to address a devastating public health crisis.

The opioid epidemic is a scourge on this country. In my district alone, 400 people have died in the last 4 years as a direct result. As we all know, there is no silver bullet to fix this problem. But what we can do and what we must do is find every possible way to help those people already affected and stop it from reaching more victims.

When substance use disorder starts in adolescence, it affects key development and societal changes in young people's lives. It can interfere with the brain's ability to mature properly and have potentially lifelong consequences.

We know that a large majority of adults in substance abuse treatment start using prior to the age of 18, and we need to make sure that the voices of adolescents and young adults are heard in this conversation.

The underlying bill establishes a pain management task force that will include many different stakeholders and experts. This amendment would add an expert in adolescent and young adult addiction and a person in recovery from addiction to medication for chronic pain that began in adolescence or young adulthood to the bill's list of experts.

This amendment would also call on the task force to consider the distinct needs of adolescents and young adults as it develops best practices for pain management and medication.

Mr. Chairman, this is a commonsense amendment to help our young people dealing with this epidemic. I urge its passage.

I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I do support the amendment.

The CHAIR. Without objection, the gentlewoman from Indiana is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I very much want to thank the gentlewoman from Massachusetts (Ms. CLARK). I believe that this does strengthen the task force. I appreciate and welcome the attention and focus on adolescents.

We had the opportunity to travel to the NIH and to learn so much about the research that is being done there. I believe in having an expert in adolescent and young adult addiction because we do know that that is where it so very often begins. So I appreciate and thank the gentlewoman for strengthening the bill.

I yield back the balance of my time.

Ms. CLARK of Massachusetts. Mr. Chairman, I yield back the balance of my time.

The CHAIR. The question is on the amendment offered by the gentlewoman from Massachusetts (Ms. CLARK).

The amendment was agreed to.

AMENDMENT NO. 5 OFFERED BY MR. PALLONE

The CHAIR. It is now in order to consider amendment No. 5 printed in part A of House Report 114–551.

Mr. PALLONE. Mr. Chairman, I rise as the designee of the gentleman from Massachusetts (Mr. MOULTON) to offer amendment No. 5.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 5, line 3, strike ''and''.

Page 5, after line 3, insert the following:

(E) veteran service organizations; and

Page 5, line 4, strike ''(E)'' and insert ''(F)''.

The CHAIR. Pursuant to House Resolution 720, the gentleman from New Jersey (Mr. PALLONE) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from New Jersey.

□ 1430

Mr. PALLONE. Mr. Chairman, this amendment by the gentleman from Massachusetts (Mr. MOULTON) would basically add representatives of veterans service organizations to the Pain Management Best Practices Inter-Agency Task Force that we have discussed and that we support on a bipartisan basis. I urge support for Mr. MOULTON's amendment.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support this amendment.

The CHAIR. Without objection, the gentlewoman from Indiana is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, while the task force was designed with the Veterans Administration as a key member of the task force, I do believe that this bill would strengthen the task force in that representatives from veterans service organizations often speak on behalf of and are the first line of defense and advocates for veterans.

Obviously, as we know, veterans seek their medical treatment often from VA hospitals and VA facilities. We know that there has been a significant problem with overprescribing at some of our VA facilities. I believe that this amendment will strengthen the task force and the bill. I urge passage or adoption of the amendment.

I yield back the balance of my time.

Mr. PALLONE. Mr. Chairman, I yield such time as he may consume to the gentleman from Massachusetts (Mr. MOULTON), the sponsor of the amendment.

Mr. MOULTON. Mr. Chairman, the addiction epidemic has touched every community and demographic in America, but our veterans have been hit particularly hard. Veterans suffer from chronic pain at a higher rate than the civilian population, often due to injuries they sustained during their service. This puts our veterans at high risk of developing addiction and presents unique challenges as they search for ways to cope with the pain caused by the wounds of war.

The results of veteran addiction are tragic. Approximately 68,000 veterans struggle with opioid use. Veterans are also almost twice as likely to die from accidental opioid overdoses than non-veterans.

We need to do more to ensure that we are not losing veterans to the disease of addiction, while also ensuring that

they get the absolute best care possible when they return home. That is why it is imperative that the veteran community has a seat at the table as we begin the process of reviewing and updating our pain management best practices.

By adding a representative of a veterans service organization to the interagency task force created by this bill, my amendment will ensure that the unique challenges our veterans face are part of the conversation.

In closing, I would like to thank my colleagues, the gentleman from New York (Mr. ZELDIN) and the gentleman from Minnesota (Mr. WALZ), for their bipartisan cosponsorship and the Iraq and Afghanistan Veterans of America, Vietnam Veterans of America, American Legion, Paralyzed Veterans of America, and Boston Scientific for their support of this amendment.

I urge my colleagues to support this amendment.

Mr. PALLONE. Mr. Chairman, I urge support for the amendment.

I yield back the balance of my time.

The CHAIR. The question is on the amendment offered by the gentleman from New Jersey (Mr. PALLONE).

The amendment was agreed to.

AMENDMENT NO. 6 OFFERED BY MR. NOLAN

The CHAIR. It is now in order to consider amendment No. 6 printed in part A of House Report 114–551.

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

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 5, line 8, strike ''and''.

Page 5, after line 8, insert the following:

(10) an expert on active duty military, armed forces personnel, and veteran health and prescription opioid addiction;

Page 5, line 9, strike ''(10)'' and insert ''(11)''.

The CHAIR. Pursuant to House Resolution 720, the gentleman from Minnesota (Mr. NOLAN) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Minnesota.

Mr. NOLAN. Mr. Chairman, Members of the House, my amendment simply would ensure that the concerns and the interests of Active-Duty members of our Armed Forces and veterans have their interests and concerns taken into consideration by the interagency task force.

The simple truth is that there is a greater need and use of opioids among Active Duty and veterans of our Armed Forces simply because of the many serious accidents and injuries that they incur in combat and in training.

Over half of the Iraq and Afghanistan veterans have had to use opioids as painkillers from the accidents and the injuries that they have suffered. That is well over half a million of our finest and bravest citizens here in this country, and an 80 percent increase in its use over the last decade.

I would be remiss if I didn't point out as well that overdose from opioids is twice the rate among our Active-Duty servicemembers and veterans of that of the general population. Also, I would be remiss if I didn't point out that, because of problems that we have been seeing in the Veterans Administration with veterans having a difficult time sometimes getting appointments to get their prescriptions filled, they have been tragically forced to go to alternative street measures, including heroin, with disastrous consequences for our soldiers and our veterans. Our veterans, our men and women of the Armed Forces, deserve better.

This is a growing problem, a growing concern, and my amendment would simply require that they be represented on this interagency task force so that their interests, their concerns can be properly reflected and reported in the findings and results of this interagency task force.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support the amendment as well.

The CHAIR. Without objection, the gentlewoman from Indiana is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I want to thank the gentleman from Minnesota, again, for strengthening the representation on the task force. While I do feel that the VSOs are a strong voice for veterans and will continue to be, I believe the addition specifically of Active-Duty military is something that would be a very strong voice. While DOD is represented on the task force, I think actually having specific Active-Duty military personnel and those who are currently serving and are currently dealing with their pain as a result of their service would be an important addition.

I thank the gentleman, and I urge passage of the amendment.

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

Mr. NOLAN. Mr. Chairman, I want to thank the gentlewoman from Indiana (Mrs. BROOKS) for her leadership on this important issue and her support for this important amendment, most importantly the great work she is doing here on behalf of our veterans and our men and women in the Armed Forces.

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

The CHAIR. The question is on the amendment offered by the gentleman from Minnesota (Mr. NOLAN).

The amendment was agreed to.

AMENDMENT NO. 7 OFFERED BY MRS. WATSON COLEMAN

The CHAIR. It is now in order to consider amendment No. 7 printed in part A of House Report 114–551.

Mrs. WATSON COLEMAN. Mr. Chairman, I have an amendment at the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 5, line 8, strike ''and''.

Page 5, after line 8, insert the following:

(10) an expert in the field of minority health; and

Page 5, line 9, strike ''(10)'' and insert ''(11)''.

The CHAIR. Pursuant to House Resolution 720, the gentlewoman from New Jersey (Mrs. WATSON COLEMAN) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from New Jersey.

Mrs. WATSON COLEMAN. Mr. Chairman, this amendment would simply ensure that, as we address what has rightly been called an epidemic, we consider the unique impacts and issues of drug addiction for minority communities by adding an expert on minority health to the task force that is created by this bill.

The dangers of opiate addiction are apparent across the board. Abuse of prescription opioids has contributed to a flood of cheap heroin to all communities.

Over the past 4 years, we have seen a 269 percent increase in heroin overdose deaths in White communities, but also a 213 percent increase in Black communities, 137 percent increase in Latino communities, and 236 percent in Native American communities.

With that in mind, it is important to remember that the opiate epidemic—both heroin and its prescription painkiller counterparts—looks very different from the perspective of communities of color. The compassion and clemency that we are showing now and the evidence-based solutions we are embracing were needed long ago, way before abuse by predominantly White and suburban communities.

As we craft the tools to solve this crisis, we must ensure the policies we create will help everyone affected. Adding an expert in minority health to this task force helps to make sure that the diverse needs of all Americans are represented at the table. We still live in a world of significant biases.

Just last month, the University of Virginia released a study that found that White medical students and residents genuinely believed that Black patients were less sensitive to pain and had less sensitive nerve endings than White patients, bearing out at least one reason for the consistently documented lack of pain management provided to Black patients.

As we give this task force the vital task of improving how we prescribe some of the most powerful and still-critical medication for pain management, let's do our part to eliminate as much bias as possible. This amendment takes an important step toward reaching that goal. I hope my colleagues will support it.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support the amendment.

The CHAIR. Without objection, the gentlewoman from Indiana is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I thank the gentlewoman from New Jersey for this important addition to the task force. I think that she has brought forth some interesting points and some statistics with respect to the opioid abuse and addiction problems facing the minority community. A minority health expert that is very focused on this would add tremendous expertise to the depth of this task force. I support the amendment.

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

Mrs. WATSON COLEMAN. Mr. Chairman, I thank the gentlewoman from Indiana for her leadership and for her support of this initiative.

Let me close by adding this. We are considering a number of bills this week aimed at curing the opioid and heroin epidemics ravaging so many American families. As we do so, we need to consider two things:

First is that communities of color have unique needs that deserve just as much consideration. That is why I have offered this amendment, and it is a theme I hope to see continued in other legislation we will debate.

The second is that, when we head back to our districts on Friday after completing consideration of these bills, we should not wash our hands and walk away from this issue. We need to fund the programs we have authorized. We need to look back with a critical eye at the ways we criminalized addictions in the past and offer those whom we failed solutions that will allow them to reenter society. Our work cannot stop there. I urge my colleagues to support this amendment.

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

The CHAIR. The question is on the amendment offered by the gentlewoman from New Jersey (Mrs. WATSON COLEMAN).

The amendment was agreed to.

AMENDMENT NO. 8 OFFERED BY MS. KUSTER

The CHAIR. It is now in order to consider amendment No. 8 printed in part A of House Report 114–551.

Ms. KUSTER. Mr. Chairman, I have an amendment at the desk.

The CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 5, after line 18, insert the following:

(B) research on trends in areas and communities in which the prescription opioid abuse rate and fatality rate exceed the national average prescription opioid abuse rate and fatality rate;

Page 5, line 19, strike ''(B)'' and insert ''(C)''.

Page 5, line 22, strike ''(C)'' and insert ''(D)''.

Page 6, line 6, strike ''(D)'' and insert ''(E)''.

Page 6, line 14, strike ''(E)'' and insert ''(F)''.

The CHAIR. Pursuant to House Resolution 720, the gentlewoman from New Hampshire (Ms. KUSTER) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from New Hampshire.

Ms. KUSTER. Mr. Chairman, the underlying bill before us authorizes the creation of an interagency task force to combat the opiate epidemic. I want to commend the gentlewoman from Indiana (Mrs. BROOKS) and the gentleman from Massachusetts (Mr. KENNEDY) for their hard work on this issue.

This important legislation will make it easier to tackle this crisis in a holistic way that addresses all angles of the crisis, including law enforcement, education and prevention, and, most importantly, treatment and lifelong recovery.

I thank Congresswoman BROOKS and Congressman KENNEDY for their great work on this bill, as well as the leadership of the chair and the ranking member.

□ 1445

In fact, a similar provision to this legislation was included in the STOP ABUSE Act that I introduced with my colleague, Mr. GUINTA, last year. Today he has joined me in introducing this important bipartisan amendment that will further improve the scope of the task force's effort.

In New Hampshire and across the country, four out of every five heroin users started out misusing prescription opioid medication. Last year more than 25,000 people died across this country from overdoses on prescription drugs.

There are complex reasons for why we have seen such a dramatic rise in prescription drug misuse, but one of the causes that we must examine more closely is prescribing practices and overprescribing.

I recently joined my colleague, Congressman MOONEY of West Virginia, in introducing legislation that would address this problem. This amendment with Mr. GUINTA would help to shine more light on prescription drug misuse by requiring the task force to research addiction trends in communities with high rates of prescription drug misuse and overdoses.

This research will be invaluable in the effort to identify why this crisis is hitting certain regions of our country particularly hard and in identifying further potential corrections to prescribing practices that can be made.

I thank my colleagues for taking up such important legislation this week, and I urge support for this amendment.

I yield 2 minutes to the gentleman from New Hampshire (Mr. GUINTA).

Mr. GUINTA. Mr. Chairman, I rise today in support of the amendment offered by my colleague, Congresswoman KUSTER, and myself, originally part of the STOP ABUSE Act that we authored earlier this year, as previously mentioned.

This amendment would simply require the task force to research addiction trends in communities with high rates of prescription drug abuse.

In our home State of New Hampshire, much of the heroin abuse we have seen today can be traced back to the overprescribing of narcotic drugs. This trend, which began in the 1990s, paved the way for the rampant heroin abuse that we are seeing today.

Last year, as you know, 430 people in our State died of an opioid overdose. This year that number is expected to be exceeded. So this amendment would research these trends so we can work to resolve the problem before the epidemic continues and expands. I would urge my colleagues to support this important amendment.

Again, I want to thank the gentlewoman from New Hampshire for her tireless work not just here, but on the Bipartisan Task Force to Combat Heroin Epidemic. We are clearly providing options and solutions to help those families in need.

Ms. KUSTER. Mr. Chairman, I will just close by thanking Mrs. BROOKS of Indiana for her leadership, Mr. KENNEDY for his leadership in offering this legislation, and thank Mr. GUINTA for this amendment.

I urge our colleagues to support this bipartisan amendment that will allow us to understand the underlying increase in the use of opioid medication and prescription drugs that are leading people into substance use disorder and, ultimately, sadly, into the use of heroin and fentanyl that is killing so many people in our homes and communities.

I yield back the balance of my time.

The Acting CHAIR (Mr. BYRNE). The question is on the amendment offered by the gentlewoman from New Hampshire (Ms. KUSTER).

The amendment was agreed to.

AMENDMENT NO. 9 OFFERED BY MR. SCHIFF

The Acting CHAIR. It is now in order to consider amendment No. 9 printed in part A of House Report 114–551.

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

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 3, strike ''and''.

Page 6, line 5, before the semicolon insert ''and the coordination of information collected from State prescription drug monitoring programs for the purpose of preventing the diversion of pain medication''.

The Acting CHAIR. Pursuant to House Resolution 720, the gentleman from California (Mr. SCHIFF) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from California.

Mr. SCHIFF. Mr. Chairman, I rise today to offer an amendment to H.R. 4641 that will require the interagency task force created by this legislation to study and report on the coordination of information collected from state prescription drug monitoring programs, or PDMPs, as part of its effort to update best practices for pain management strategies.

State PDMPs play a critical role in preventing the diversion of pain medication as well as other controlled substances. Chief among their benefits, access to a State PDMP provides an invaluable resource to prescribing physicians by allowing them to review a patient's history of prescription drugs and to spot signs of opioid abuse so that they may proactively refer a patient to substance abuse treatment, if appropriate. They allow medical professionals to intervene before an addiction spirals out of control.

Now active in 49 States, PDMPs can also inform prescribing physicians if a patient has recently accessed pain medication elsewhere and help to detect potential doctor-shopping activities by individuals with no legitimate medical need. Further, PDMPs also play an important role in identifying forged or stolen prescriptions.

While information sharing between some adjacent State PDMPs currently exists to prevent illicit doctor-shopping activities from occurring across State lines, I believe it is time that we boost efforts to strengthen the sharing of information across all State PDMPs.

I recently met with physicians from my district who described from their experience how prevalent the issue of doctor shopping is, particularly in the State of California, and how it is becoming more and more common for individuals with histories of opioid abuse to attempt to receive illicit prescriptions in nearby States.

With passage of this amendment, I urge the task force to explore the benefits of potentially establishing a national PDMP that will vastly approve our ability to prevent and disincentivize doctor shopping in all regions of the country, and I look forward to working with other concerned Members on this important topic.

By requiring that the interagency task force include State PDMP information as it formulates its expert input and improves prescribing guidelines, we will be able to better understand what is and isn't working and how we may be able to harness the power of State PDMPs to develop an effective national response to the opioid crisis that has devastated communities across the country.

It is beyond doubt that prescription drug monitoring programs serve an invaluable purpose, and any effort to address overprescription must include consideration of important data that is gleaned across State PDMPs.

While I hope that this Congress will ultimately provide the necessary resources to assure we are able to develop and implement a comprehensive plan to prevent opioid addiction and increase access to treatment, the recommendations developed by the task force created under this bill are an important initial step that must come to pass before achieving that goal.

I urge support for this amendment and for the bill.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I am in support of the amendment.

The Acting CHAIR. Without objection, the gentlewoman is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I would like to thank the gentleman from California for offering this amendment.

We know from talking to a lot of physicians and medical educators as well that the use of these PDMPs is a critically important tool in their tool chest to combat against those patients who might be doctor shopping.

We know, though, that not all States use it. Not all prescribers actually check that PDMP system like they should. So I appreciate the Congressman's concept of a feasibility study as to whether or not there should be a national PDMP system, and I urge its passage.

I yield back the balance of my time.

Mr. SCHIFF. Mr. Chairman, I thank the gentlewoman for her support as well as all of her good work in trying to address the opioid crisis in the United States.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from California (Mr. SCHIFF).

The amendment was agreed to.

AMENDMENT NO. 10 OFFERED BY MS. CLARK OF MASSACHUSETTS

The Acting CHAIR. It is now in order to consider amendment No. 10 printed in part A of House Report 114–551.

Ms. CLARK of Massachusetts. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, after line 5, insert the following:

(D) ongoing efforts at the Federal, State, and local levels to examine the potential benefits of electronic prescribing of opioids, including any public comments collected in the course of those efforts;

Page 6, line 6, strike ''(D)'' and insert ''(E)''.

Page 6, line 14, strike ''(E)'' and insert ''(F)''.

The Acting CHAIR. Pursuant to House Resolution 720, the gentlewoman from Massachusetts (Ms. CLARK) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Massachusetts.

Ms. CLARK of Massachusetts. Mr. Chairman, my amendment is simple. It directs the task force to consider any potential benefits from increasing the electronic prescribing of opioids.

We know that, with the increasing sophistication of health information technology, we have an opportunity to use that information for the benefit of our public health. We also know that paper prescriptions are subject to being stolen, copied, and misused.

While that is a fact, 67 percent of prescriptions nationally are ordered electronically, but the rate for controlled substances is less than 1 percent.

Electronic prescribing of opioids has the potential to provide data to help us identify problems, whether from a user or a prescriber, and focus our interventions on saving lives and preventing addiction.

Back home in my district, Cambridge Health Alliance has adopted electronic prescriptions for controlled substances and have found it reduces fraud and allows administrators to track prescription patterns and detect overprescribing. Electronic prescriptions can be a key tool in fighting this epidemic. I urge my colleagues to support this commonsense amendment.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentlewoman from Massachusetts (Ms. CLARK).

The amendment was agreed to.

AMENDMENT NO. 11 OFFERED BY MR. ROTHFUS

The Acting CHAIR. It is now in order to consider amendment No. 11 printed in part A of House Report 114–551.

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

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 13, strike ''and''.

Page 6, after line 16, insert ''and'' after the semicolon.

Page 6, after line 16, insert the following:

(F) the practice of co-prescribing naloxone for both pain patients receiving chronic opioid therapy and patients being treated for opioid use disorders;

The Acting CHAIR. Pursuant to House Resolution 720, the gentleman from Pennsylvania (Mr. ROTHFUS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Pennsylvania.

Mr. ROTHFUS. Mr. Chairman, I want to thank my good friend from Indiana for her leadership on this very important piece of legislation as well as the chairman and ranking member of the committee for working together to bring it to the floor today.

The United States is being ravaged by skyrocketing levels of prescription opioid and heroin abuse. This brutal epidemic has accounted for more than 28,000 American deaths in 2014, destroying families and devastating local communities alike.

My constituents in western Pennsylvania have been particularly hard hit. In the past two decades, there has been a 470 percent increase in drug overdose deaths. The vast majority of these have been heroin and opioid related.

Two weeks ago, at a local hospital in my district, five overdoses were treated in 1 day alone. In February, the same facility treated 20 overdoses in just 2 days.

We need meaningful and evidence-based solutions to combat this scourge. I have worked to help develop those solutions as part of the Bipartisan Task

Force to Combat the Heroin Epidemic and by holding roundtables with stakeholders in my district.

I strongly believe that the legislation we are considering today is another step forward in that process by creating an interagency task force to review and update best practices for pain management and prescribing pain medication.

As part of its work, the task force will consider various types of data and practices. For example, it must consider the existence and availability of different classes of opioids, including those with safety measures such as abuse deterrent technology. It must also consider how high-risk populations are managed by medical professionals.

The legislation has been entirely silent on the issue of naloxone, however. Thus, the amendment that I offered with my friend from Massachusetts (Mr. KEATING) simply seeks to have the task force take into consideration the practice of coprescribing this lifesaving drug as part of its work.

Naloxone has the ability to revive a victim who has suffered an overdoes within minutes. It is both safe and effective and has been used successfully to counteract more than 26,000 overdoses between 1996 and 2014. First responders who have seen what naloxone can do have referred to it as the miracle drug.

The American Medical Association and many community, State, and national groups have supported coprescribing naloxone to patients who are taking opioids as a critical part of the solution to the rising epidemic of opioid overdose-related deaths.

Considering the practice of coprescribing naloxone, particularly for high-risk populations or when other avenues of treatment have been tried and failed, it is an essential part of addressing the opioid and heroin epidemic.

By reviewing and updating best practices with respect to coprescribing naloxone, the interagency task force can ensure that health professionals at all levels, both inside and outside of government, are fully informed when prescribing and treating patients.

Simply put, Americans who are struggling with opioid and heroin addiction cannot be treated if they lose their lives to drug overdose. It is essential that we get naloxone into the hands that need it the most in a safe and effective manner. My amendment would ensure that the task force takes a close look at this.

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

□ 1500

Mr. KEATING. Mr. Chairman, I rise in support of Mr. ROTHFUS' amendment to H.R. 4641.

The Acting CHAIR. Without objection, the gentleman from Massachusetts is recognized for 5 minutes.

There was no objection.

Mr. KEATING. Mr. Chairman, I would like to thank my colleague from Pennsylvania (Mr. ROTHFUS).

I rise today in support of this amendment, our amendment. It is an amendment that I believe will move the task force to consider the practice of coprescribing of overdose reversal drugs such as naloxone as part of the review of its best practices for pain management and for prescribing pain medication.

Importantly, the medical community now realizes the need for having these important guidelines in place and having them being addressed, as over 80 percent of the AMA members have indicated they see the need for these guidelines now and the importance in terms of saving lives.

As a former district attorney, I took a public health approach a decade and a half ago, starting an Anti-Heroin Task Force. At the time, in our State, two people, on average, were dying every day from these overdoses. In just the last 6 years, that number has increased to almost four people a day.

As a Congressman, this hits really close to home to me because our latest stats in 2014 indicate that a quarter of the overdose deaths in Massachusetts occurred in counties in my district. Over 60 percent occurred in the cities of Fall River and New Bedford alone.

In fact, nearly twice the statewide average in Cape Cod, where the highest percentage of per capita rate of opioid-related overdoses occurs, represents a significant part of the epidemic in our Commonwealth.

Going forward, Mr. ROTHFUS and I introduced Co-Prescribing Saves Lives Act legislation to require Federal health agencies, including HHS, the Department of Defense, and the VA, to create guidelines for coprescribing naloxone alongside opioid prescriptions and making naloxone more widely available.

Our legislation creates a grant program as well, so the States will have the resources to do the same.

As our partnership shows, in an often divided Congress, we are coming together. We are coming together to confront a uniquely American epidemic.

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

Mr. ROTHFUS. Mr. Chairman, to close, increased access to naloxone, particularly for patients who are at high risk, has been identified as one of the most powerful tools for reducing the number of opioid and heroin-related overdose deaths.

Let's ensure that our health professionals are fully informed of this option when prescribing and treating patients.

I urge my colleagues to support this commonsense, bipartisan amendment.

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

The Acting CHAIR. The question is on the amendment offered by the gentleman from Pennsylvania (Mr. ROTHFUS).

The amendment was agreed to.

AMENDMENT NO. 12 OFFERED BY MS. CLARK OF MASSACHUSETTS

The Acting CHAIR. It is now in order to consider amendment No. 12 printed in part A of House Report 114–551.

Ms. CLARK of Massachusetts. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 13, strike ''and''.

Page 6, after line 16, insert the following:

(F) research that has been, or is being, conducted or supported by the Federal Government on prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults relative to any unique circumstances (including social and biological circumstances) of adolescents and young adults that may make adolescent-specific and young adult-specific treatment protocols necessary, including any effects that substance use and substance use disorders may have on brain development and the implications for treatment and recovery;

(G) Federal non-research programs and activities that address prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of the effectiveness of such programs and activities in—

(i) preventing substance use by and substance use disorders among adolescents and young adults;

(ii) treating such adolescents and young adults in a way that accounts for any unique circumstances faced by adolescents and young adults; and

(iii) supporting long-term recovery among adolescents and young adults; and

(H) gaps that have been identified by Federal officials and experts in Federal efforts relating to prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including gaps in research, data collection, and measures to evaluate the effectiveness of Federal efforts, and the reasons for such gaps;

The Acting CHAIR. Pursuant to House Resolution 720, the gentlewoman from Massachusetts (Ms. CLARK) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Massachusetts.

Ms. CLARK of Massachusetts. Mr. Chairman, my amendment would direct the task force to consider the programs and research relative to adolescents and young adults.

We know that addiction and recovery often start early, and we need to focus research on how to address the unique needs of our adolescents and young adults.

We need to understand how years of opioid abuse can affect the development of the brain, how it affects the development of coping skills, and how we can best support our kids in long-term recovery.

Most importantly, there are many gaps in research on this subject, and we need to know the status of the current research and where we need to focus our resources.

Recently, I met a constituent named Ryan. In seventh grade, he started taking drugs. When he did, he told me he felt like he finally fit in, like he had found the answers to the problems he felt and the pain he felt.

By the time he was 13, he started drinking, taking pills, and stealing money from his family. His mother was panicked. The minute he walked out of the house he had to get high. He also felt powerless.

At 15, he became convinced he was a bad person. He felt ashamed that he couldn't change, not even for his mother.

The last time he relapsed, his mom told him he couldn't see friends anymore, and he threw a piece of glass at her.

She looked him in the eyes and said: I don't know who you are anymore.

He went into treatment for three additional months, and that treatment is what changed his life. He said that it saved him. One day at the sober house he remembers sincerely laughing for the first time, and he thought: There's hope for me.

All these little things he forgot about himself, like humor, kindness and empathy. He said: I no longer felt like the shell of a person.

He asked for our leadership for two things: the people in recovery need not to be ashamed. It is not what defines them, even when their addiction starts very young; and that we need to come up with funding for treatment.

Ryan is an inspiration to me, and we owe it to the young victims of this epidemic to focus on the unique impact of this public health crisis on adolescents and young adults.

I urge my colleagues to support this commonsense amendment.

I reserve the balance of my time.

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support the amendment.

The Acting CHAIR. Without objection, the gentlewoman is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I would like to, once again, thank the gentlewoman from Massachusetts for this important amendment. As she spoke, she reminded me of a visit that I made to a recovery high school; and there are more recovery high schools being created across the country.

But I think when I visited the recovery high school in Indianapolis, called Hope Academy, it reminded me, as I listened to these young people, of the very different needs, but the very, very serious desire that they have to find themselves again, as the gentlewoman just stated.

A young woman who was turning 17 the next day shared that it was going to be her first birthday in 3 years where she would be sober, and she thanked her classmates and her colleagues there as they sat in that circle, and asked that they help her make sure that she didn't go home that night and relapse because she couldn't remember a birthday, really, where she had been sober.

So I do believe that having more studies specifically with respect to the programs and the research about adolescents and young adults is critically important because that is where it all starts.

I support this amendment.

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

Ms. CLARK of Massachusetts. Mr. Chairman, again, I just want to thank the gentlewoman from Indiana for all her leadership and advocacy, and my good friend and colleague from the Commonwealth of Massachusetts (Mr. KENNEDY) for his as well. This bill and their work will make an incredible difference to families across the country.

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

The Acting CHAIR. The question is on the amendment offered by the gentlewoman from Massachusetts (Ms. CLARK).

The amendment was agreed to.

AMENDMENT NO. 13 OFFERED BY MS. ESTY

The Acting CHAIR. It is now in order to consider amendment No. 13 printed in part A of House Report 114–551.

Ms. ESTY. Mr. Chairman, I have an amendment at the desk.

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 19, strike ''and''.

Page 6, line 25, strike the period and insert ''; and''.

Page 6, after line 25, insert the following:

(4) review, modify, and update best practices for pain management and prescribing pain medication, specifically as it pertains to physician education and consumer education.

Page 7, line 15, strike ''and''.

Page 7, line 20, strike the period and insert ''; and''.

Page 7, after line 20, insert the following:

(4) the modified and updated best practices described in subsection (d)(4).

The Acting CHAIR. Pursuant to House Resolution 720, the gentlewoman from Connecticut (Ms. ESTY) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentlewoman from Connecticut.

Ms. ESTY. Mr. Chairman, I rise today in support of my amendment, which would empower the interagency task force to help communities spread awareness about the dangers of drug addiction through consumer education, and help medical providers more effectively and safely address patient pain management.

Along with my colleague, Representative KNIGHT, I proudly introduced this amendment that was inspired by bipartisan legislation that I introduced earlier this year, with Representatives KNIGHT and COSTELLO, and that was identified as a legislative priority by the Bipartisan Task Force to Combat the Heroin Epidemic that I proudly serve on with so many of my colleagues here in this House.

Mr. Chairman, there is not a community in this great country that hasn't been touched by drug addiction, not one. Addiction knows no bounds. It knows no race, no gender, no economic status, no party affiliation.

In January, I was honored to have James Wardwell, the Chief of Police in New Britain, Connecticut, join me for the President's State of the Union Address, and he came to join me because of his leadership and his concern about the need to address this growing public health crisis.

Chief Wardwell, and many other first responders, medical professionals, substance abuse counselors, family members, and recovering addicts, have worked with me to help craft legislation to address our growing epidemic of prescription drug and heroin addiction.

I am glad that today, this House is taking action. Today's legislation is an example of what we, in Congress, are supposed to be doing. Our job is to work together, Democrats and Republicans, to address the needs of the American people.

Whenever I go home to central and northwest Connecticut, at community forums in Torrington, at Congress on Your Corner events in Waterbury and the Farmington Valley, constituents come up to me and ask: What are you in Congress doing to help our families with the heroin epidemic?

The families in Connecticut and across this country who are losing loved ones to drug addiction cannot afford for us to wait. We need to act now.

Recovering from addiction is possible, but it is hard. So much of our effort to combat drug addiction is focused on helping folks get the treatment they need, and that is important, but it is not enough to treat the crisis. We must help prevent people from getting addicted in the first place.

Our bipartisan amendment does just that by directing the interagency task force to establish guidelines that help prescribers more effectively and safely manage their patients' pain, and that strengthens consumer education about opioid addiction.

Our amendment takes an important step toward preventing drug addiction. Those who prescribe narcotics would benefit from an increased education about the dangers of addiction and ways in which they can help minimize the risks associated with prescribing narcotics.

Those hardest hit by this epidemic would benefit from having access to educational materials in our schools, community centers, and from local law enforcement, that help warn people about the dangers of opioid use and possible addiction.

I am very encouraged that the House and Senate are taking action to address this public health crisis, and I will continue doing everything within my power to make addiction prevention a priority.

Opioid and heroin addiction have already taken so many young lives and

needlessly torn apart so many families. We can't wait for more lives to be destroyed before we take action.

So let's work together today to prevent our children, our students, our patients, our neighbors, our families, and our friends, from becoming victims of this terrible public health crisis. Let's work together today to stop drug addiction before it begins.

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

Mrs. BROOKS of Indiana. Mr. Chairman, I claim the time in opposition, but I support the amendment.

The Acting CHAIR. Without objection, the gentlewoman is recognized for 5 minutes.

There was no objection.

Mrs. BROOKS of Indiana. Mr. Chairman, I would like to thank the gentlewoman from Connecticut for this important amendment.

Certainly, the job of the interagency task force, besides producing best practices and reviewing and modifying and talking about them, is not just to generate a report that Congress will have, as I have said, sitting on a shelf someplace, and that our staff or the Congressional Research Service can look at and study; it is really meant to educate the public, to educate the public, whether or not they are people in schools, whether or not they are in our hospitals.

But I think, most importantly, we need to make sure that our prescribers are being educated. We have had roundtable discussions with our medical educators, and there is a push around the country, and I applaud that push around the country of our medical educators, whether it is in our med schools for physicians or for nursing programs, dental programs, but to try to start at a much earlier level in their medical education about the research and the studies and the best practices around opioids.

Certainly, as being a lawyer, we are required to do continuing medical or continuing legal education, and it is something that I know that physicians and prescribers are certainly required to get continuing medical education. I just want to continue to encourage and applaud them for seeking out that medical education around opioids. I think it is critically important.

With this amendment, I think it will strengthen and educate our prescribers about the need to continue to educate themselves on pain management practices and the use of opioids.

I urge the amendment's passage.

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

□ 1515

Ms. ESTY. Mr. Chairman, again, I would like to thank my colleague, Representative KNIGHT, for cosponsoring this amendment. I would like to thank the bipartisan leadership for taking up this issue, and my good friend, the gentlewoman from Indiana, Representative BROOKS, for her leadership. I would like to thank the advocates in Connecticut who have worked so tirelessly with me, Chief Wardwell and Shawn Lang, among others. Shawn Lang recently was recognized by the White House for her advocacy and leadership on this issue for many, many years.

Mr. Chairman, I urge my colleagues to support this amendment.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentlewoman from Connecticut (Ms. ESTY).

The amendment was agreed to.

AMENDMENT NO. 14 OFFERED BY MR. WELCH

The Acting CHAIR. It is now in order to consider amendment No. 14 printed in part A of House Report 114–551.

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

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, line 19, strike ''and''.

Page 6, line 25, strike the period and insert ''; and''.

Page 6, after line 25, insert the following:

(4) examine and identify—

(A) the extent of the need for the development of new pharmacological, nonpharmacological, and medical device alternatives to opioids;

(B) the current status of research efforts to develop such alternatives; and

(C) the pharmacological, nonpharmacological, and medical device alternatives to opioids that are currently available that could be better utilized.

Page 7, line 15, strike ''and''.

Page 7, line 20, strike the period and insert ''; and''.

Page 7, after line 20, insert the following:

(4) the results of the examination and identification conducted pursuant to subsection (d)(4), and recommendations regarding—

(A) the development of new pharmacological, nonpharmacological, and medical device alternatives to opioids; and

(B) the improved utilization of pharmacological, nonpharmacological, and medical device alternatives to opioids that are currently available.

The Acting CHAIR. Pursuant to House Resolution 720, the gentleman from Vermont (Mr. WELCH) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Vermont.

Mr. WELCH. Mr. Chair, on January 8, 2014, an extraordinary thing happened in Vermont. Our Governor, Peter Shumlin, giving a State of the State Address, devoted its entirety to the opioid epidemic in Vermont. I remember how stunned people were that a Governor would take such a difficult topic and spend his entire address on it. I remember the reaction of many of my colleagues here, who said: Peter, isn't that dangerous? You are talking about something that is not great for the reputation of the State.

What, in fact, was great for the reputation of the State was that our Governor and our leaders acknowledged the existence of a problem that was creating heartbreak and heartache in all of our communities; and a problem acknowledged is the first step in dealing with a problem to be solved.

Since then, Vermont has been extraordinary in its efforts to attack this problem. Communities like Rutland, St. Albans, Barre, and Burlington have coordinated with the police force, with our medical providers and our hospitals to provide a treatment-based approach to helping folks who have an addiction to opioids—many of them coming by it as a result of prescriptions for legitimate medical needs.

We had, in Rutland, a community coming together to create Project VISION, which has faith-based groups, the police, and the medical community doing everything they can to basically give individual attention to folks who are trying to help themselves get off of opiates.

The problem continues to be severe, but what we have is a community that is fully engaged in it, including our State legislature, which provided funds for treatment—a treatment-based approach—to helping people with a hub-and-spoke system that is really working well. Folks who are getting prescriptions, folks who have a problem, an addiction, are getting access to methadone or other prescribed products, take that in a hub so it is supervised, and they are able then to go to work.

So this has been a situation in Vermont where, as a result of the Governor's focus on the problem, we have had community engagement to stem the tide of this issue.

It has been working, but challenges remain because we don't have enough treatment funds. This legislation is an important acknowledgment on the part of Congress that we are getting it, that across this country we are all being affected by the challenges that our communities face.

I thank the sponsors of this legislation, Mr. PALLONE, and Mr. UPTON, too, for their leadership.

My hope, by the way, is that we get the message, too, in Congress that we have got to send some funds back to our communities that are struggling with these programs. We can't micromanage the treatment here. It is up to the courageous people in our communities to do it, and some of the tax dollars that they send to us we have got to send back to them. That is why I, among others, am supporting an emergency appropriation of $600 million. That would help quite a bit.

The amendment that I have on this bill, which establishes an interagency task force to review, modify, and update the best practices for pain management, would ask that we also review developing nonopioid forms of pain relief. If opioids diminish pain but they create misery, let's find another way to do it and help our folks who need pain relief to get it.

The second thing, it would examine existing nonopioid alternatives that could be better utilized.

So this is tremendous that there has been such a bipartisan coming together

to sponsor practical steps that we can take. I see us in Congress as essentially acknowledging what Governor Shumlin identified as a real problem for us and we are hearing about in our communities. But I hope we are ready to take some next steps and actually focus on getting resources back to our communities that are doing the very, very challenging work at the local level where it needs to be done to help folks relieve themselves from the addiction of opioids.

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

The Acting CHAIR. The question is on the amendment offered by the gentleman from Vermont (Mr. WELCH).

The amendment was agreed to.

AMENDMENT NO. 15 OFFERED BY MR. SESSIONS

The Acting CHAIR. It is now in order to consider amendment No. 15 printed in part A of House Report 114–551.

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

The Acting CHAIR. The Clerk will designate the amendment.

The text of the amendment is as follows:

Page 6, after line 25, insert the following (and redesignate the subsequent subsections accordingly):

(e) CONSIDERATION OF STUDY RESULTS.—In reviewing, modifying, and updating, best practices for pain management and prescribing pain medication, the task force shall take into consideration existing private sector, State, and local government efforts related to pain management and prescribing pain medication.

The Acting CHAIR. Pursuant to House Resolution 720, the gentleman from Texas (Mr. SESSIONS) and a Member opposed each will control 5 minutes.

The Chair recognizes the gentleman from Texas.

Mr. SESSIONS. Mr. Chairman, I want to take time to recognize the gentleman from New Jersey, representing the Energy and Commerce Committee, and the gentlewoman from Indiana (Mrs. BROOKS) for their service not only to this conference, but also to the issues and the ideas that are being brought forth.

The gentlewoman from Indiana has served our Nation as a United States attorney in Indiana. She has been on the front line of battles, albeit a few years ago, but the front line of battles that the American people face, how we protect the American public from all sorts of things that get in our way as families and communities. But in this case today, she is serving as a Member of Congress firsthand to fight a problem with opioids. Opioids are a synthetic heroin, Mr. Chairman, and synthetic heroin is a national problem. It is a national problem and one which this Congress is undertaking.

We are following up today on the United States Senate bill and this bill that came through regular order in the House of Representatives under two primary committees. The Judiciary Committee and the Energy and Commerce Committee have addressed bills that are being debated today that will be passed, will be done in a bipartisan way, and will bring the best ideas of the House of Representatives to the plate. With that in mind, that is what I stand for today, sir, to do.

I join in, as my colleague from Vermont has done, in adding to this interagency task force with an amendment that I brought forth that I would ask us to consider. I will offer this amendment to ensure that the existing best practices of State and local governments, as well as the private sector, are specifically considered as the task force which was established by H.R. 4641 conducts their business.

Mr. Chairman, the opportunity for us to understand the amendment process means that not only I, but also other Members of this body, bring forth ideas that we think are the best ways to combat this problem. I believe in State and local governments. I believe in the private sector. I think they are the essence of, really, where the rubber meets the road on the solution of problems, not to kick around ideas and to find something that doesn't work, but to kick around ideas that do work.

Local communities, local governments, and the private sector collaborate back home daily. They do this in Dallas, Texas, which is my home, which I represent, and we have something that is called the Dallas Area Drug Prevention Partnership. It was established in 2007, and it represents what I believe is the best collaborative effort between local communities focusing on preventing drug abuse.

A few years ago, Dallas, Texas, the epicenter of something that was a heroin epidemic, was looking at a marketing effort by Mexican drug dealers with something that was called cheese. Cheese was a marketing effort, but it was heroin, and it was being packaged and sold as cheese. In fact, it caused the death of some 25 people in Dallas, Texas, very quickly before law enforcement recognized what the problem was.

Law enforcement worked with community leaders, church leaders, religious leaders, Boy Scout troops, Girl Scout troops, youth groups, YMCAs, and we got a handle on what the problem was. But it was not solved by the Federal Government. It was not done just by an interagency departmental group of people in Washington, D.C. It was solved with Washington, D.C., and with people back home who saw the problem firsthand, who took responsibility for the problem firsthand.

In this case, what we are trying to say is we are dealing with a nationwide epidemic, a nationwide epidemic which we have spoken very plainly about today that is one that is caused through opioid use and then the transition to heroin at some point in a person's life. It is creating thousands of deaths across our country. Something must be done. But the something to be done is a collaborative effort between the Federal Government, interagency responsibility up in Washington and other places back home, but with State and local organizations and with private sector organizations that really will be not just the boots on the ground, but many times with the best expertise about the best way to do it in the best place.

Mr. Chairman, I bring forth this amendment. I urge my colleagues to support this amendment and the underlying bill.

I yield back the balance of my time.

The Acting CHAIR. The question is on the amendment offered by the gentleman from Texas (Mr. SESSIONS).

The amendment was agreed to.

The Acting CHAIR. The question is on the committee amendment in the nature of a substitute, as amended.

The amendment was agreed to.

The Acting CHAIR. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. SESSIONS) having assumed the chair, Mr. BYRNE, Acting Chair of the Committee of the Whole House on the state of the Union, reported that that Committee, having had under consideration the bill (H.R. 4641) to provide for the establishment of an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes, and, pursuant to House Resolution 720, he reported the bill back to the House with an amendment adopted in the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the amendment reported from the Committee of the Whole?

If not, the question is on the committee amendment in the nature of a substitute, as amended.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore (Mr. BYRNE). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mrs. BROOKS of Indiana. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

□ 1530

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules

on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

INFANT PLAN OF SAFE CARE IMPROVEMENT ACT

Mr. BARLETTA. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4843) to amend the Child Abuse Prevention and Treatment Act to require certain monitoring and oversight, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4843

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 ''Infant Plan of Safe Care Improvement Act''.

SEC. 2. BEST PRACTICES FOR DEVELOPMENT OF PLANS OF SAFE CARE.

Section 103(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5104(b)) is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively; and

(2) by inserting after paragraph (4), the following:

''(5) maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;''.

SEC. 3. STATE PLANS.

Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)(iii)) is amended by inserting before the semicolon at the end the following: ''to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through—''

''(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

''(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver''.

SEC. 4. DATA REPORTS.

(a) IN GENERAL.—Section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by adding at the end of the following:

''(17)(A) The number of infants identified under subsection (b)(2)(B)(ii).

''(B) The number of infants for whom a plan of safe care was developed under subsection (b)(2)(B)(iii).

''(C) The number of infants for whom a referral was made for appropriate services, including services for the affected family or caregiver, under subsection (b)(2)(B)(iii).''.

(b) REDESIGNATION.—Effective on May 29, 2017, section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by redesignating paragraph (17) (as added by subsection (a)) as paragraph (18).

SEC. 5. MONITORING AND OVERSIGHT.

(a) AMENDMENT.—Title I of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq.) is further amended by adding at the end the following:

''SEC. 114. MONITORING AND OVERSIGHT.

''The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which—

''(1) shall—

''(A) be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and

''(B) include monitoring of State policies and procedures required under clauses (ii) and (iii) of section 106(b)(2)(B); and

''(2) may include—

''(A) a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;

''(B) a review of information available on the Website of the State relating to its compliance with the requirements of section 106(b);

''(C) site visits, as may be necessary to carry out such monitoring; and

''(D) a review of information available in the State's Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).''.

(b) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 note) is amended by inserting after the item relating to section 113, the following:

''Sec. 114. Monitoring and oversight.''.

SEC. 6. RULE OF CONSTRUCTION.

Nothing in this Act, or the amendments made by this Act, shall be construed to authorize the Secretary of Health and Human Services or any other officer of the Federal Government to add new requirements to section 106(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)), as amended by this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania (Mr. BARLETTA) and the gentlewoman from Massachusetts (Ms. CLARK) each will control 20 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. BARLETTA. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous materials on H.R. 4843.

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

There was no objection.

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

I rise today in strong support of H.R. 4843, the Infant Plan of Safe Care Improvement Act.

Every 25 minutes in America, a baby is born suffering from opiate withdrawal. It is an eye-opening statistic. The more you consider what it really means, the more tragic it becomes.

Every 25 minutes a child enters the world having already been exposed to drugs. Every 25 minutes a newborn has to pay the price for something that he or she was defenseless against. Every 25 minutes another infant becomes a victim of the national opiate crisis.

These are the victims this bill will help protect. Federal policies, including the Child Abuse Prevention and Treatment Act, or CAPTA, have long supported State efforts to identify, assess, and treat children who are victims of abuse and neglect.

The law provides States with resources to improve their child protective services systems if they assure the Department of Health and Human Services that they have put in place certain child welfare policies, for example, requiring healthcare providers to notify child protective service agencies when a child is born with prenatal illegal substance exposure and requiring the development of something known as a safe care plan to keep these newborns and their caregivers healthy and safe.

Last year a Reuters investigation examined the care that infants receive when they are born to parents struggling with opiate addiction. The investigation detailed the heartbreaking consequences those infants had to endure, consequences like suffering through the physical pain of withdrawal and, in the most shocking cases, terrible deaths.

It is hard to imagine that stories like these could be any more tragic. Unfortunately, they are because they should have and, in many cases, could have been prevented. As Reuters revealed, HHS is providing Federal funds to States that do not have the necessary child welfare policies in place.

In short, the law is not being properly followed and enforced and some of our most vulnerable children and families are slipping through the cracks.

That is why Representative CLARK and I worked with a number of our colleagues on both sides of the aisle and introduced the legislation before us today. The bill requires HHS to better ensure States are meeting their legal responsibilities when it comes to preventing and responding to child abuse and neglect.

Through a number of commonsense measures, it strengthens protections for infants born with illegal substance exposure, improves accountability related to the care of infants and their families, and ensures States will have the best practices for developing plans to keep infants and their caregivers healthy and safe.

As the House works this week to fight the opiate epidemic that is destroying communities and lives across the country, these are commonsense reforms that we all should embrace. By working together and advancing this legislation, we can help ensure these children, their mothers, and their families have the help they need and the care that they deserve.

I urge my colleagues to support this bipartisan legislation.

I reserve the balance of my time.

Ms. CLARK of Massachusetts. Mr. Speaker, I yield myself such time as I may consume.

I am pleased to join with Representative BARLETTA to introduce this important bill to help the most vulnerable victims of the opioid epidemic.

In every corner of our country, the opioid crisis is having a devastating effect. In Massachusetts, last year 1,379 people succumbed to fatal overdoses. Nationwide, drug overdoses are the leading cause of accidental death and we lose 129 people a day to fatal drug overdoses. This epidemic doesn't see race, gender, income, or political ideology and does not spare newborns and infants.

We know that every 25 minutes a baby is born suffering from opioid withdrawal symptoms. This is a condition known as neonatal abstinence syndrome. While there is no silver bullet to address this crisis in our country, this bill takes important steps to help.

This bill, the Infant Plan of Safe Care Improvement Act, strengthens and updates the care plans required by the Child Abuse Prevention and Treatment Act of 1974, also known as CAPTA.

CAPTA itself is up for reauthorization. This is just one portion of that important legislation where timely reauthorization will protect children in many different and difficult situations.

This legislation will help infants by ensuring that States have access to the best practices for establishing safe care plans for newborns with prenatal substance exposure.

It will also improve accountability by collecting data on the incidence of babies born exposed to drugs and the care that is provided to them and their families.

Perhaps most importantly, it will prevent tragedies by ensuring that babies and their moms and their families have the supports they need to be healthy and to build a future. We know that children have the best opportunity to thrive when their parents and caregivers are at the center of care.

I am grateful to the partnership with Representative BARLETTA and glad that we are taking this important step with this bill to ensure that the whole family is healthy and successful and supported.

I urge my colleagues to support this bill.

I reserve the balance of my time.

Mr. BARLETTA. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. KLINE), the chairman of the Education and the Workforce Committee.

Mr. KLINE. Mr. Speaker, I thank Mr. BARLETTA for yielding the time and for his leadership on this issue.

Mr. Speaker, I rise today in strong support of the Infant Plan of Safe Care Improvement Act. Like many of the bills the House has slated to consider this week, this legislation will help address the growing opioid epidemic that has swept across America, focusing specifically on the most vulnerable among us.

This crisis has led to a number of painful consequences for individuals and families across the country. But few are as tragic as those suffered by infants born to parents struggling with an opioid addiction.

As is often the case with addiction, the parents' struggle affects those around them, including their newborns. In fact, according to a recent Reuters investigation mentioned earlier by Mr. BARLETTA, more than 130,000 babies born in the United States in the last decade entered the world addicted to drugs.

This report described the pain suffered by newborns going through withdrawal and told the stories of infants who actually lost their lives because of a terrible addiction. Many of the stories are too disturbing to even mention. But perhaps even more disturbing than the details is the fact that these deaths should have been prevented.

Current policies, including the Child Abuse Prevention and Treatment Act, are meant to prevent these tragedies from ever happening. The law is simple. If a State wants to receive Federal funding, then the State has to provide some basic assurances about their child welfare policies. The Department of Health and Human Services has a responsibility to ensure those policies are actually in place.

As we now know all too well, this important Federal law is not being properly followed and enforced. Earlier this year I sent a letter to the Department of Health and Human Services to better understand how it works with States to ensure they are meeting current child welfare requirements.

Not surprisingly, the Department passed the buck and suggested recent changes to the law somehow absolved them from their enforcement responsibilities, a disappointing response, to say the least.

Fortunately, thanks to the work of Mr. BARLETTA and Ms. CLARK, we are here today to consider our response to this preventable problem: the bill before us today. I appreciate their leadership in developing a bipartisan bill that will require the Department to do its job and assist States in their efforts to prevent and respond to child abuse and neglect.

I urge my colleagues to support this important legislation and to help ensure the most vulnerable victims of the opioid epidemic receive the help and care they desperately need.

Ms. CLARK of Massachusetts. Mr. Speaker, I yield 3 minutes to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT of Virginia. Mr. Speaker, I rise in support of H.R. 4843, the Infant Plan of Safe Care Improvement Act.

Mr. Speaker, one of our highest national priorities should be to ensure that children have early quality opportunities to remove barriers to success in future life. But children born dependent on addictive substances face severe obstacles to overcome, and we know that many of these obstacles can be removed.

The Child Abuse Prevention and Treatment Act, CAPTA, is meant to support infants born addicted to these illegal substances. Unfortunately, nearly every State fails to follow the CAPTA requirements, which work to ensure that children born of these circumstances have a plan of safe care that will help them grow up healthy.

H.R. 4843 is a strong positive first step to safeguard the well-being of our Nation's most vulnerable children. It will strengthen an infant's plan of safe care. It will help families and caregivers give the guidance and support they need in order to provide a nurturing environment for these children.

I welcome this bipartisan agreement to amend CAPTA as part of the comprehensive efforts to intervene and treat those affected by substance abuse. I therefore urge my colleagues to support H.R. 4843.

Ms. CLARK of Massachusetts. Mr. Speaker, I want to thank the gentleman from Virginia (Mr. SCOTT) for his leadership on this issue and so many involving the welfare and health of our children.

I reserve the balance of my time.

Mr. BARLETTA. Mr. Speaker, in response to an inquiry from the Education and the Workforce Committee Chairman KLINE and Chairman ROKITA of the Subcommittee on Early Childhood, Elementary, and Secondary Education, HHS indicated that it would request additional information from States regarding their child protective services notification processes and plans of safe care policies. HHS has started this process.

I include in the RECORD the HHS Children's Bureau Program Instruction requesting this additional information.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES

1. Log No: ACYF–CB–PI–16–03
2. Issuance Date: April 13, 2016
3. Originating Office: Children's Bureau
4. Key Words: Title IV–B Child and Family Services Plan; Annual Progress and Services Report; Child Abuse Prevention and Treatment Act State Plan; Chafee Foster Care Independence Program; Education and Training Vouchers Program

PROGRAM INSTRUCTION

To: State Agencies, Territories, and Insular Areas Administering or Supervising the Administration of Title IV–B, subparts 1 and 2, and Title IV–E of the Social Security Act (the Act); Organization Designated by the Governor to Apply for Child Abuse and Neglect Prevention and Treatment Programs State Grant Funds; State Independent Living and Education and Training Voucher Coordinators.

Subject: June 30, 2016, submission of: (1) the second Annual Progress and Services Report (APSR) to the 2015–2019 Child and Family Services Plan (CFSP) for the Stephanie Tubbs Jones Child Welfare Services (CWS), the Promoting Safe and Stable Families (PSSF) and Monthly Caseworker Visit Grant programs; and the Chafee Foster Care Independence Program (CFCIP) and the Education and Training Vouchers (ETV) Program; (2) the Child Abuse Prevention and Treatment Act (CAPTA) State Plan update; and (3) the CFS–101, Part I, Annual Budget Request, Part II, Annual Summary of Child and Family Services, and Part III, Annual Expenditure Report–Title IV–B, subparts 1 and 2, CFCIP, and ETV.

Legal and Related References: Title IV–B, subparts 1 and 2, sections 421–425, 428, 430–438, and title IV–E, section 477 of the Act; sections 106 and 108 of CAPTA (42 U.S.C. 5106a. and 5106d.), as amended by Public Law (P.L.) 111–320, the CAPTA Reauthorization Act of 2010; the Indian Child Welfare Act. (ICWA) of 1978 (P.L. 95–608); the Indian Self-Determination and Education Assistance Act (P.L. 93–638); 45 CFR Parts 1355 and 1357; The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110–351); the Patient Protection and Affordable Care Act (P.L. 111–148); the Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112–34); the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113–183); and the Justice for Victims of Trafficking Act of 2015 (P.L. 114–22).

Purpose: This Program Instruction (PI) provides guidance to states, territories, and insular areas (hereafter ''states,'' unless otherwise noted) on actions they are required to take to receive their allotments for federal fiscal year (FY) 2017 (subject to the availability of appropriations) authorized under title IV–B, subparts 1 and 2, section 106 of CAPTA, CFCIP and ETV programs.

This PI summarizes the actions required in completion and submission of (1) the second APSR to the 2015–2019 CFSP, (2) the CAPTA Update, and (3) the CFS–101, Parts I, II, and III.

A separate PI addresses requirements for tribes, tribal consortia, and tribal organizations applying for funding under these programs.

We note that the title IV–B programs (subparts 1 and 2) are required to be reauthorized periodically by the Congress. The Child and Family Services Improvement and Innovation Act, signed into law on September 30, 2011, last reauthorized funding for these programs for five years through FY 2016. The guidance provided in this PI assumes that the programs will be extended without significant changes. Should new legislation be enacted that would affect the steps that states must take to receive funding for FY 2017, additional guidance will be provided.

INFORMATION: ORGANIZATION OF THE PROGRAM INSTRUCTION

Section A. Background

Section B. Continued Integration of the Child and Family Services Review Process with the CFSP/APSR

Section C. Requirements for 2017 APSR (Due June 30, 2016)

Section D. CAPTA State Plan Requirements and Update

Section E. Chafee Foster Care Independence Program

Section F. Updates to Targeted Plans within the 2015–2019 CFSP

Section G. Statistical and Supporting Information

Section H. Financial Information

Section I. Instructions for the Submission of the 2017 APSR for States, Puerto Rico, and the District of Columbia

Section J. Submittal Rule for Insular Areas

Attachments

SECTION D. CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA) STATE PLAN REQUIREMENTS AND UPDATE

States submitted a plan for the CAPTA State Grant on June 30, 2011. Once approved by CB, the CAPTA State Plan remains in effect for the duration of the state's participation in the CAPTA State Grant program. However, section 108(e) of CAPTA requires states receiving a CAPTA State Grant to submit an annual report describing its use of the grant. To facilitate coordination between the CAPTA State Plan and the title IV–B plan, as required by section 106(b)(2)(A) of CAPTA, CB requires that the annual report describing use of CAPTA funds be submitted with the APSR. In addition, CB encourages states to use CAPTA State Grant funds in a manner that aligns with and supports their overall goals for the delivery and improvement of child welfare services, as they continue to implement their 2015–2019 CFSP and APSR goals.

IN THE STATE'S 2017 ANNUAL CAPTA REPORT

Describe substantive changes, if any, to state law or regulations, including laws and regulations relating to the prevention of child abuse and neglect, that could affect the state's eligibility for the CAPTA State Grant (section 106(b)(1)(C)(i) of CAPTA). The state must also include an explanation from the State Attorney General as to why the change would, or would not, affect eligibility. (Note: States do not have to notify ACF of statutory changes or submit them for review if they are not substantive and would not affect eligibility.)

Describe any significant changes from the state's previously approved CAPTA plan in how the state proposes to use funds to support the 14 program areas enumerated in section 106(a) of CAPTA. (See section 106(b)(1)(C)(ii) of CAPTA).

Describe how CAPTA State Grant funds were used, alone or in combination with other federal funds, in support of the state's approved CAPTA plan to meet the purposes of the program since the state submitted its last update on June 30, 2015 (section 108(e) of CAPTA).

Submit a copy of the annual report(s) from the citizen review panels and a copy of the state agency's most recent response(s) to the panels and state and local child protective services agencies, as required by section 106(c)(6) of CAPTA.

Update on Services to Substance-Exposed Newborns

In addition to the information outlined above, CB requests an update from states on implementation of CAPTA provisions relating to substance-exposed newborns. Sections 106(b)(2)(B)(ii) and (iii) of CAPTA require states to have a statewide program relating to child abuse and neglect that includes:

—policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to—

I. establish a definition under Federal law of what constitutes child abuse or neglect; or

II. require prosecution for any illegal action.

—the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder.

The most recent national data on child abuse and neglect from the National Child Abuse and Neglect Data System (NCANDS) showed increases in FY 2014 compared to FY 2013 in the number of children referred to CPS, the number of children who received a CPS investigation or alternative response and the number of children who were determined to be victims of child abuse and neglect. While increases nationally were relatively small, some states saw increases of 15 percent or more in the number of children determined to be victims. Nationally, states reported to NCANDS that more than one-quarter (27.4%) of victims were younger than 3 years and that the victimization rate was highest for children younger than 1 year (24.4 per 1,000 children in the population of the same age).

State commentary and data on risk factors associated with reports of abuse and neglect indicate that caretaker alcohol and drug abuse are significant factors associated with reports of child abuse and neglect. For states reporting to NCANDS, 9.2 percent of victims and 3.8 percent of nonvictims were reported with the alcohol abuse caregiver risk factor and 26.0 percent of victims and 8.2 percent of nonvictims were reported with the drug abuse caregiver risk factor. Beyond reports to NCANDS, increasing public attention is being paid to the significant effect of opioid addiction on individuals, families and communities.

In light of these trends, states are requested to provide an update on their implementation of these provisions of CAPTA.

IN THE 2017 CAPTA ANNUAL REPORT

Describe the policies and procedures the state has in place to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants (section 106(b)(2)(B)(ii) of CAPTA). We note that such notification should occur in any instance in which an infant is demonstrating withdrawal symptoms due to prenatal drug exposure, whether the drugs were obtained legally or illegally.

Describe the state's policies and procedures for developing a plan of safe care for infants born and identified as being affected by illegal substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder (section 106(b)(2)(B)(iii)). Describe which agency or entity is responsible for developing a plan of safe care, how it is monitored and how follow-up is conducted to ensure the safety of these infants.

Describe any technical assistance the state needs to improve practice and implementation in these areas, including how to support mothers and families, as well as infants, through a plan of safe care.

Amendments to CAPTA made by P.L. 114–22, the Justice for Victims of Trafficking Act of 2015:

As noted in Section A of this PI, the Justice for Victims of Trafficking Act of 2015 included amendments to CAPTA that become effective on May 29, 2017.

The law amended CAPTA's definition of ''child abuse and neglect'' and ''sexual abuse'' by adding a special rule that a child shall be considered a victim of 'child abuse and neglect' and of 'sexual abuse' if the child is identified, by a state or local agency employee of the state or locality involved, as being a victim of sex trafficking or severe forms of trafficking (as defined in sections 103(9)(A) and (10) of the Trafficking Victims Protection Act (TVPA)).

—As defined in section 103(10) of TVPA, ''sex trafficking'' means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act.

—As defined in section 103(9)(A) of TVPA, ''severe forms of trafficking in persons'' means sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

The amendments also specify that, notwithstanding the general definition of a ''child'' in CAPTA, a state may opt to apply the sex trafficking portion of the definition of ''child abuse and neglect'' and ''sexual abuse'' to a person who has not attained age 24.

In addition to expanding the definitions of child abuse and neglect and sexual abuse applicable to the CAPTA State Grant, the law added new requirements to the list of assurances a state must provide to receive a CAPTA State Grant. Each state will now need to provide an assurance that the state has in effect and is operating a statewide program, relating to child abuse and neglect that includes:

—provisions and procedures regarding identifying and assessing all reports involving known or suspected child sex trafficking victims (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (TVPA) (22 U.S.C. 7102)); and

—provisions and procedures for training CPS workers about identifying, assessing and providing comprehensive services to children who are sex trafficking victims, including efforts to coordinate with state law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters.

Finally, the amendments add to the list of data elements a state must annually report, to the maximum extent practicable, as a condition of receiving their CAPTA State Grant. Beginning with submission of FY 2018 data, the CB expects to ask states to report the number of children who are victims of sex trafficking. The CB anticipates collecting this information through NCANDS. Additional information on NCANDS data reporting will be provided separately from this PI.

IN THE 2017 CAPTA ANNUAL REPORT

Describe the steps that the state is taking or will need to take to address the amendments to CAPTA relating to sex trafficking in order to implement those provisions by May 29, 2017.

Provide an assessment of the changes the state will need to make to its laws, policies or procedures to ensure that victims of sex trafficking, as defined in sections 103(9)(A) and (10) of the TVPA, are considered victims of child abuse and neglect and sexual abuse. We note that it is likely that some states will need to make changes to state laws to come into compliance. Indicate whether the state is electing to apply the sex trafficking portion of the definition of ''child abuse and neglect'' and ''sexual abuse'' to persons who are over age 18 but have not yet attained age 24.

Provide an update on the state's progress and planned activities in the coming year to develop provisions and procedures regarding identifying and assessing all reports involving known or suspected child sex trafficking victims.

Provide an update on the state's progress and planned activities in the coming year to develop provisions and procedures for training CPS workers about identifying, assessing and providing comprehensive services to children who are sex trafficking victims, including efforts to coordinate with state law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters.

In addition, no later than May 29, 2017, states must submit the new CAPTA assurances relating to sex trafficking. These assurances are to be provided in the form of a certification signed by the State's Governor (see Attachment F). The signed assurance may be returned with the 2017 CAPTA Annual Report submitted with the APSR due June 30, 2016, if the state is ready to submit them by that time. If not, the state may submit the certification at a later date, but no later than May 29, 2017.

If the state anticipates it will be unable to submit these assurances by May 29, 2017, provide an explanation as to why that is the case.

Identify any technical assistance needs the state has identified relating to implementation of the amendments to CAPTA made by the Justice for Victims of Trafficking Act of 2015.

States must include all required information indicated above in their 2017 CAPTA Annual Report to be submitted as part of the 2017 APSR. Missing or incomplete information will result in the withholding of CAPTA funds until such time as approval can be granted by CB. Please note that compliance with the eligibility requirements for a CAPTA State Grant program is a prerequisite for eligibility to receive finding under the Children's Justice Act State Grant Program, authorized by section 107(a) of CAPTA.

Finally, to facilitate ongoing communication between CB and states on issues relating to CAPTA and child abuse and neglect, please submit the name, address, and email for the state CAPTA coordinator (also known as the State Liaison Officer) or where this information can be found on the state's website.

Mr. BARLETTA. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. THOMPSON).

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I rise in support of H.R. 4843, the Infant Plan of Safe Care Improvement Act. Introduced by my colleague and friend, Mr. BARLETTA, this bill takes steps to strengthen protections for our Nation's most precious and vulnerable population: infants and children.

In Pennsylvania alone, nearly 8,000 infants were diagnosed with neonatal abstinence syndrome between 2010 and 2014, and that number is increasing every day.

□ 1545

Neonatal abstinence syndrome, or NAS, is defined by the National Institutes of Health as a set of problems that occurs in a newborn who was exposed to addictive opiate drugs while in the mother's womb. Infants experiencing NAS can endure fevers, rapid breathing, seizures, and even death.

While States are currently required to certify to the Department of Health and Human Services that they have developed a safe care plan for infants born under these conditions, it has come to light that HHS does not independently verify State plans unless there is a specific reason to do so.

My cosponsorship of this bill is a direct assertion of my belief that our Nation's infants deserve more from legislators, Federal agencies, and the administration. This valuable legislation will help clarify the intent of safe care plans, provide States with best practices for keeping infants safe, and improve accountability across the board.

Mr. Speaker, every district in every State in the United States has been affected by what has been referred to as a substance abuse epidemic. While there is hope in the fact that the House is taking up more than a dozen opioid bills this week, we must not lose sight of the long road ahead of us.

I urge my colleagues to support H.R. 4843 and join the fight to defend our Nation's children.

Ms. CLARK of Massachusetts. Mr. Speaker, I reserve the balance of my time.

Mr. BARLETTA. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. I thank the gentleman for yielding.

Mr. Speaker, I rise in support of H.R. 4843, the Infant Plan of Safe Care Improvement Act, because when newborn infants are tragically affected by illegal substance abuse, they deserve the best possible care and treatment.

The Child Abuse Prevention and Treatment Act, which was enacted in 1974, set the groundwork for Federal coordination in addressing the issues of neglect and child abuse that is present in our country. H.R. 4843 builds on that by updating and improving existing laws to ensure that States are utilizing Federal dollars in a safe and effective way in providing care for children who suffer from illegal substance abuse, withdrawal symptoms, or fetal alcohol spectrum disorders.

Under this bill, infants who are born with having had exposure to illegal substances will have strengthened protections through improved safe care plans and best practices. As a lifelong pharmacist and healthcare professional, I have seen firsthand families as they struggle to provide the care that is needed by infants who suffer from these conditions.

I commend Congressman BARLETTA and the Committee on Education and the Workforce for their leadership on this important legislation, and I encourage my colleagues to support this bill so we can care for precious newborn infants across the country.

Ms. CLARK of Massachusetts. Mr. Speaker, I reserve the balance of my time.

Mr. BARLETTA. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. WALBERG).

Mr. WALBERG. I thank Mr. BARLETTA for what he is doing here today.

Mr. Speaker, I rise as a proud original cosponsor of H.R. 4843, the Infant Plan of Safe Care Improvement Act, which takes important steps in protecting our most vulnerable citizens from the damaging effects of addiction.

As communities in Michigan and around the country fight against the growing opioid epidemic, it is important for stakeholders at all levels to work together to reverse the trends of addiction and find solutions for the families who are swept up by this public health crisis. Tragically, we know that, every 25 minutes, a baby is born in our country having been exposed to drugs and suffering from opioid withdrawal.

A Federal law is already in place to help ensure these newborns have the necessary protections and care once they are born, but the system is still failing some of our most defenseless children and their families. Recent investigations have uncovered the failure of the Department of Health and Human Services to effectively monitor the implementation of State-level plans to prevent child abuse and neglect, and some States are still receiving taxpayer dollars despite their not following the laws that are in place to ensure the safe care of newborns.

The bill we are considering today would require HHS to review and confirm that States are properly following and enforcing the policies that are outlined in Federal law to protect infants who are affected by drug dependency. It also strengthens protections for infants who have been exposed to illegal substances, and it ensures best practices are disseminated to States for developing plans to keep infants and their caregivers safe.

Mr. Speaker, we must do better to provide these babies and their mothers with the help they need.

I thank my colleagues, Representatives BARLETTA and CLARK, for their leadership in crafting this bipartisan bill, and I encourage all of my colleagues to vote in support.

Ms. CLARK of Massachusetts. Mr. Speaker, I yield myself the balance of my time.

Again, many thanks to the gentleman from Pennsylvania for his partnership and his leadership on this issue.

Mr. Speaker, I am particularly proud that this legislation takes a comprehensive look at not only protecting our newborns and infants but at putting the supports in place to ensure that their mothers and fathers and grandparents and families have the services they need and deserve to have the best outcomes for these babies and children and their family units. I am very pleased that this bill is before us today, and I urge my colleagues to support this bill.

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

Mr. BARLETTA. Mr. Speaker, I yield myself the remainder of my time.

In closing, I reiterate the purpose and the importance of this legislation. No government, Federal or State, should be allowed to skirt its responsibilities on the taxpayers' dime, especially when those responsibilities involve the health and safety of children. We have seen what can happen when they do, and none of us should be okay with allowing those kinds of consequences to continue. Making sure they don't is a responsibility that we all share.

In the end, this bill is not about pointing fingers or about placing blame. It is about the kids who need help, not only the infants who are affected by the opioid crisis, but all of the victims of child abuse and neglect. This bill is about ensuring that we work together to strengthen the protections for our country's most vulnerable children and their families.

I urge my colleagues to support this legislation.

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

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4843, the ''Improving Safe Care for the Prevention of Infant Abuse and Neglect Act,'' approved by the Education and the Workforce Committee.

In the past decade and a half, the growth in the number of physicians prescribing opioids to help patients deal with pain from surgeries, dental work and chronic conditions has resulted in an increasing number of patients becoming dependent on the powerful and highly addictive painkillers—with patients not only abusing the use of those painkillers but often turning to heroin once their opioid prescription ended.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States, and it is estimated that in 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

The Health and Human Services Department estimates that the number of unintentional overdose deaths from prescription painkillers almost quadrupled between 1999 and 2013 and that abuse of prescription opioids now kills nearly 30,000 Americans each year.

The ''Child Abuse Prevention and Treatment Act'' (CAPTA; PL 93–247) was enacted in 1974 to coordinate federal and state efforts to prevent and respond to child abuse and neglect.

The law provides states with federal funds to improve their child protective services systems; however, to receive the funds, states are supposed to implement certain child welfare policies.

CAPTA was amended in 2003 by the ''Keeping Children and Families Safe Act,'' (PL 108–36) that requires health care providers to notify child protective services agencies when a child is born with prenatal substance exposure or addiction.

The protective services agencies are supposed to develop a ''safe care plan'' to protect the babies.

The law explicitly states that it is meant to protect drug-dependent newborns and not to punish mothers who are dealing with addiction.

In December 2015, Reuters published the first in a series of articles documenting the failure of health care providers and state child protective services to help these infants.

Based on information from 2013, the latest year for which data are available, there were 27,000 cases of drug-dependent babies born that year, up from 5,000 in 2003 when CAPTA's notification requirements were enacted.

However, more than 30 states do not require doctors to report cases of infants born with addictions.

Some states have interpreted the law to mean that only addiction to illegal substances need be reported.

This means that if the mother is taking prescribed drugs, even if the infant is born with an addiction, they do not require that the addiction be reported.

In addition, even in states where infants born with drug dependencies must be reported to child protective services agencies, these agencies often take no steps toward developing a safe care plan for these infants.

As a result, infants die because of neglect or abuse in their homes.

Reuters identified 110 fatalities since 2010 of babies and toddlers whose mother used opioids during pregnancy and who later died from causes that could have been prevented.

I recognize that infant mortality is at unprecedentedly high rates in our nation.

Seeking to right the same wrongs as H.R. 4843, the ''Improving Safe Care for the Prevention of Infant Abuse and Neglect Act,'' I introduced the ''Stop Infant Mortality and Recidivism Reduction Act of 2016,'' or the ''SIMARRA Act,'' which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders, by establishing a pilot program of critical-stage, developmental nurseries in Federal prisons for children born to inmates.

It is time that our nation recognizes a long-persistent need to break the cycle of generational, institutional incarceration amongst mothers serving time for non-violent crimes and the children they birth behind prison bars.

H.R. 5130, the ''SIMARRA Act of 2016,'' gives those infants born to incarcerated mothers a chance to succeed in life.

''SIMARRA'' is not merely yet another second chance program, demanding leniency from the criminal justice system.

Instead, H.R. 5130 asks our national criminal justice system what it can do for those young Americans born and relegated to a life of nearly impossible odds of survival.

''SIMARRA'' provides that first chance—a first chance for American infants—that many of their mothers, born themselves to mothers behind bars, never received.

H.R. 4843 requires the Health and Human Services Department (HHS) to review and confirm that states have enacted and implemented the child protection policies required by the Child Abuse and Treatment Act, including the requirement that addicted newborns are cared for.

Specifically, in order to receive a grant for its child protective services system, a state must certify that it has a law or statewide program for child abuse and neglect that includes a safe care plan for an infant born with substance addiction after the infant is released from the care of health care providers.

HHS must monitor the compliance of each state that receives a grant.

Under the measure, states must also develop and implement monitoring systems to follow the safe care plans and determine whether local entities are providing referrals to, and delivery of, appropriate services for the infant and the affected family or caregiver.

States must include in their annual data reports the total number of affected infants for whom a safe care plan was developed and for whom there were referrals to appropriate services, including services for the affected family or caregiver.

The bill requires HHS to maintain and disseminate information regarding the requirements and best practices relating to the development of safe care plans for infants born with substance addiction.

H.R. 4843, the "Improving Safe Care for the Prevention of Infant Abuse and Neglect Act," is a valuable piece of legislation that I encourage my colleagues to support.

Additionally, I urge my colleagues to join me in sponsoring and supporting all legislation targeting the improvement of care for the prevention of infant abuse and neglect, such as H.R. 5130, the "Stop Infant Mortality and Recidivism Reduction Act of 2016" or the "SIMARRA Act."

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. BARLETTA) that the House suspend the rules and pass the bill, H.R. 4843, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BARLETTA. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on questions previously postponed.

Votes will be taken in the following order:

Passage of H.R. 4641, and suspending the rules and passing H.R. 4843.

The first electronic vote will be conducted as a 15-minute vote. The second electronic vote will be conducted as a 5-minute vote.

ESTABLISHING PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE

The SPEAKER pro tempore. The unfinished business is the vote on passage of the bill (H.R. 4641) to provide for the establishment of an inter-agency task force to review, modify, and update best practices for pain management and prescribing pain medication, and for other purposes, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the passage of the bill.

The vote was taken by electronic device, and there were—yeas 412, nays 4, not voting 17, as follows:

[Roll No. 184]

YEAS—412

Abraham
Adams
Aderholt
Aguilar
Allen
Amodei
Ashford
Babin
Barletta
Barr
Barton
Bass
Beatty
Becerra
Benishek
Bera
Beyer
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Blumenauer
Bonamici
Bost
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brat
Bridenstine
Brooks (IN)
Brown (FL)
Brownley (CA)
Buchanan
Buck
Bucshon
Burgess
Bustos
Butterfield
Byrne
Calvert
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Carter (GA)
Carter (TX)
Castro (TX)
Chabot
Chaffetz
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clawson (FL)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (NY)
Comstock
Conaway
Connolly
Conyers
Cook
Cooper
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Curbelo (FL)
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
Delaney
DeLauro
DelBene
Denham
Dent
DeSantis
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Dold
Donovan
Doyle, Michael F.
Duckworth
Duffy
Duncan (SC)
Duncan (TN)
Edwards
Ellison
Ellmers (NC)
Emmer (MN)
Engel
Eshoo
Esty
Farenthold
Farr
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foster
Foxx
Frankel (FL)
Frelinghuysen
Fudge
Gabbard
Gallego
Garamendi
Garrett
Gibbs
Gibson
Gohmert
Gosar
Gowdy
Graham
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Grothman
Guinta
Guthrie
Gutiérrez
Hahn
Hanna
Hardy
Harper
Harris
Hartzler
Heck (NV)
Heck (WA)
Hensarling
Hice, Jody B.
Higgins
Hill
Himes
Hinojosa
Holding
Honda
Hoyer
Hudson
Huelskamp
Huffman
Huizenga (MI)
Hultgren
Hunter
Hurd (TX)
Hurt (VA)
Israel
Issa
Jackson Lee
Jeffries
Jenkins (KS)
Jenkins (WV)
Johnson (GA)
Johnson (OH)
Johnson, E. B.
Johnson, Sam
Jolly
Jones
Jordan
Joyce
Kaptur
Katko
Keating
Kelly (IL)
Kelly (MS)
Kelly (PA)
Kennedy
Kildee
Kilmer
Kind
King (IA)
King (NY)
Kinzinger (IL)
Kirkpatrick
Kline
Knight
Kuster
LaHood
LaMalfa
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Loudermilk
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lummis
Lynch
MacArthur
Maloney, Sean
Marchant
Marino
Matsui
McCarthy
McCaul
McClintock
McCollum
McDermott
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meadows
Meehan
Meeks
Meng
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Moore
Moulton
Mullin
Mulvaney
Murphy (FL)
Murphy (PA)
Nadler
Napolitano
Neal
Neugebauer
Newhouse
Noem
Nolan
Norcross
Nugent
Nunes
O'Rourke
Olson
Palazzo
Pallone
Palmer
Pascrell
Paulsen
Payne
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pocan
Poe (TX)
Poliquin
Polis
Pompeo
Posey
Price (NC)
Price, Tom
Quigley
Rangel
Ratcliffe
Reed
Reichert
Renacci
Ribble
Rice (NY)
Rice (SC)
Richmond
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney (FL)
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce
Ruiz
Ruppersberger
Rush
Russell
Ryan (OH)
Salmon
Sánchez, Linda T.
Sanchez, Loretta
Sanford
Sarbanes
Scalise
Schakowsky
Schiff
Schrader
Schweikert
Scott (VA)
Scott, Austin
Scott, David
Sensenbrenner
Serrano
Sessions
Sherman
Shimkus
Shuster
Simpson
Sinema
Sires
Slaughter
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Speier
Stefanik
Stewart
Stivers
Stutzman
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiberi
Tipton
Titus
Tonko
Torres
Trott
Tsongas
Turner
Upton
Valadao
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Weber (TX)
Webster (FL)
Welch
Wenstrup
Westerman
Westmoreland
Williams
Wilson (FL)
Wilson (SC)
Wittman
Womack
Woodall
Yarmuth
Yoder
Yoho
Young (AK)
Young (IA)
Young (IN)
Zeldin
Zinke

NAYS—4

Amash
Brooks (AL)
Labrador
Massie

NOT VOTING—17

Boustany
Cartwright
Castor (FL)
Collins (GA)
Fattah
Fincher
Franks (AZ)
Goodlatte
Hastings
Herrera Beutler
Latta
Maloney, Carolyn
Mooney (WV)
Pitts
Sewell (AL)
Takai
Whitfield

□ 1615

Mr. ELLISON, Ms. WASSERMAN SCHULTZ, and Mr. ENGEL changed their vote from "nay" to "yea."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. BOUSTANY. Mr. Speaker, on rollcall No. 184, I was unavoidably detained. Had I been present, I would have voted "yes."

Mr. GOODLATTE. Mr. Speaker, on rollcall No. 184, I was unavoidably detained. Had I been present, I would have voted "yea."

INFANT PLAN OF SAFE CARE IMPROVEMENT ACT

The SPEAKER pro tempore (Mr. VALADAO). The unfinished business is the vote on the motion to suspend the rules and pass the bill (H.R. 4843) to amend the Child Abuse Prevention and Treatment Act to require certain monitoring and oversight, and for other purposes, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. BARLETTA) that the House suspend the rules and pass the bill, as amended.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 421, nays 0, not voting 12, as follows:

[Roll No. 185]

YEAS—421

Abraham
Adams
Aderholt
Aguilar
Allen
Amash
Amodei
Ashford
Babin

Barletta
Barr
Barton
Bass
Beatty
Becerra
Benishek
Bera
Beyer
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Blumenauer
Bonamici
Bost
Boustany
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Brown (FL)
Brownley (CA)
Buchanan
Buck
Bucshon
Burgess
Bustos
Butterfield
Byrne
Calvert
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Carter (GA)
Carter (TX)
Castro (TX)
Chabot
Chaffetz
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clawson (FL)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (GA)
Collins (NY)
Comstock
Conaway
Connolly
Conyers
Cook
Cooper
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Curbelo (FL)
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
Delaney
DeLauro
DelBene
Denham
Dent
DeSantis
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Dold
Donovan
Doyle, Michael F.
Duckworth
Duffy
Duncan (SC)
Duncan (TN)
Edwards
Ellison
Ellmers (NC)
Emmer (MN)
Engel
Eshoo
Esty
Farenthold
Farr
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foster
Foxx
Frankel (FL)
Frelinghuysen
Fudge
Gabbard
Gallego
Garamendi
Garrett
Gibbs
Gibson
Gohmert
Goodlatte
Gosar
Gowdy
Graham
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Grothman
Guinta
Guthrie
Gutiérrez
Hahn
Hanna
Hardy
Harper
Harris
Hartzler
Heck (NV)
Heck (WA)
Hensarling
Hice, Jody B.
Higgins
Hill
Himes
Hinojosa
Holding
Honda
Hoyer
Hudson
Huelskamp
Huffman
Huizenga (MI)
Hultgren
Hunter
Hurd (TX)
Hurt (VA)
Israel
Issa
Jackson Lee
Jeffries
Jenkins (KS)
Jenkins (WV)
Johnson (GA)
Johnson (OH)
Johnson, E. B.
Johnson, Sam
Jolly
Jones
Jordan
Joyce
Kaptur
Katko
Keating
Kelly (IL)
Kelly (MS)
Kelly (PA)
Kennedy
Kildee
Kilmer
Kind
King (IA)
King (NY)
Kinzinger (IL)
Kirkpatrick
Kline
Knight
Kuster
Labrador
LaHood
LaMalfa
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lee
Levin
Lewis
Lieu, Ted
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Loudermilk
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lummis
Lynch
MacArthur
Maloney, Carolyn
Maloney, Sean
Marchant
Marino
Massie
Matsui
McCarthy
McCaul
McClintock
McCollum
McDermott
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meadows
Meehan
Meeks
Meng
Messer
Mica
Miller (FL)
Miller (MI)
Moolenaar
Moore
Moulton
Mullin
Mulvaney
Murphy (FL)
Murphy (PA)
Nadler
Napolitano
Neal
Neugebauer
Newhouse
Noem
Nolan
Norcross
Nugent
Nunes
O'Rourke
Olson
Palazzo
Pallone
Palmer
Pascrell
Paulsen
Payne
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pocan
Poe (TX)
Poliquin
Polis
Pompeo
Posey
Price (NC)
Price, Tom
Quigley
Rangel
Ratcliffe
Reed
Reichert
Renacci
Ribble
Rice (NY)
Rice (SC)
Richmond
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney (FL)
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce
Ruiz
Ruppersberger
Rush
Russell
Ryan (OH)
Salmon
Sánchez, Linda T.
Sanchez, Loretta
Sanford
Sarbanes
Scalise
Schakowsky
Schiff
Schrader
Schweikert
Scott (VA)
Scott, Austin
Scott, David
Sensenbrenner
Serrano
Sessions
Sewell (AL)
Sherman
Shimkus
Shuster
Simpson
Sinema
Sires
Slaughter
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Speier
Stefanik
Stewart
Stivers
Stutzman
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiberi
Tipton
Titus
Tonko
Torres
Trott
Tsongas
Turner
Upton
Valadao
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Weber (TX)
Webster (FL)
Welch
Wenstrup
Westerman
Westmoreland
Williams
Wilson (FL)
Wilson (SC)
Wittman
Womack
Woodall
Yarmuth
Yoder
Yoho
Young (AK)
Young (IA)
Young (IN)
Zeldin
Zinke

NOT VOTING—12

Cartwright
Castor (FL)
Fattah
Fincher
Franks (AZ)
Hastings
Herrera Beutler
Latta
Mooney (WV)
Pitts
Takai
Whitfield

□ 1622

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

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

WOMEN AIRFORCE SERVICE PILOT ARLINGTON INURNMENT RESTORATION ACT

Mr. ABRAHAM. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (H.R. 4336) to amend title 38, United States Code, to provide for the burial in Arlington National Cemetery of the cremated remains of certain persons whose service has been determined to be active service, with the Senate amendments thereto, and concur in the Senate amendments.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will report the Senate amendments.

The Clerk read as follows:

Senate amendments:

(1) On page 2, line 1, strike ''**BURIAL**'' and insert ''**INURNMENT**''.
(2) On page 2, line 8, strike ''that'' and insert ''that,''.
(3) On page 2, line 11, insert ''above ground'' before ''inurnment''.

Amend the title so as to read: ''An Act to amend title 38, United States Code, to provide for the inurnment in Arlington National Cemetery of the cremated remains of certain persons whose service has been determined to be active service.''.

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

There was no objection.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on additional motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Any record votes on postponed questions will be taken later.

OPIOID REVIEW MODERNIZATION ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4976) to require the Commissioner of Food and Drugs to seek recommendations from an advisory committee of the Food and Drug Administration before approval of certain new drugs that are opioids without abuse-deterrent properties, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4976

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 ''Opioid Review Modernization Act of 2016''.

SEC. 2. FDA OPIOID ACTION PLAN.

Chapter V of the Federal Food, Drug, and Cosmetic Act is amended by inserting after section 569 of such Act (21 U.S.C. 350bbb–8) the following:

''SEC. 569–1. OPIOID ACTION PLAN.

''(a) NEW DRUG APPLICATION.—

''(1) IN GENERAL.—Subject to paragraph (2), prior to the approval pursuant to an application under section 505(b) of a new drug that is an opioid and does not have abuse-deterrent properties, the Secretary shall refer the application to an advisory committee of the Food and Drug Administration to seek recommendations from such advisory committee.

''(2) PUBLIC HEALTH EXEMPTION.—A referral to an advisory committee under paragraph (1) is not required with respect to a new drug if the Secretary—

''(A) finds that such a referral is not in the interest of protecting and promoting public health;

''(B) finds that such a referral is not necessary based on a review of the relevant scientific information; and

''(C) submits a notice containing the rationale for such findings to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

''(b) PEDIATRIC OPIOID LABELING.—The Secretary shall convene the Pediatric Advisory Committee of the Food and Drug Administration to seek recommendations from such Committee regarding a framework for the inclusion of information in the labeling of

drugs that are opioids relating to the use of such drugs in pediatric populations before the Secretary approves any labeling or change to labeling for any drug that is an opioid intended for use in a pediatric population.

''(c) SUNSET.—The requirements of subsections (a) and (b) shall cease to be effective on October 1, 2022.''.

SEC. 3. PRESCRIBER EDUCATION.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, as part of the Food and Drug Administration's evaluation of the Extended-Release/Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, and in consultation with relevant stakeholders, shall develop recommendations regarding education programs for prescribers of opioids pursuant to section 505–1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355–1), including recommendations on—

(1) which prescribers should participate in such programs; and

(2) how often participation in such programs is necessary.

SEC. 4. GUIDANCE ON EVALUATING THE ABUSE DETERRENCE OF GENERIC SOLID ORAL OPIOID DRUG PRODUCTS.

Not later than 2 years after the end of the period for public comment on the draft guidance entitled ''General Principals for Evaluating the Abuse Deterrence of Generic Solid Oral Opioid Drug Products'' issued by the Center for Drug Evaluation and Research of the Food and Drug Administration in March 2016, the Commissioner of Food and Drugs shall publish in the Federal Register a final version of such guidance.

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.

Mr. Speaker, I rise in support of H.R. 4976, the Opioid Review Modernization Act of 2016, introduced by the gentleman from New York (Mr. SEAN PATRICK MALONEY) and the gentleman from New Jersey (Mr. LANCE).

□ 1630

Opioid use disorder and overdose deaths have reached epidemic levels. A comprehensive approach is needed to reverse these trends and the tragic toll they have taken on families and communities across our country.

The Food and Drug Administration does have a critical role to play in such an approach. Patients living with serious pain must have access to safe and effective therapies to help them function and lead productive lives. FDA reviews prescription pain relievers, like all new drug products, to determine whether their benefits outweigh their risks.

It is important that the FDA hear recommendations from expert advisory committees prior to making key product and labeling decisions, particularly to ensure that any such risks are effectively communicated, understood, and mitigated.

Specifically, H.R. 4976 requires that FDA receives input from an advisory committee regarding approval of new opioids that do not utilize abuse-deterrent properties, in addition to developing a framework for labeling any opioid intended for pediatric use.

The bill also requires the agency to finalize guidance on evaluating abuse deterrence in generic opioid medications and issue recommendations regarding prescriber education tied to the risk evaluation mitigation strategy programs.

This bill would strengthen FDA's Opioid Action Plan, defining outcomes with meaningful timeframes. I urge my colleagues to support H.R. 4976.

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

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

Mr. Speaker, I rise in support of H.R. 4976, the Opioid Review Modernization Act.

We know that there is not one solution addressing the opioid crisis that is striking communities across the country. A comprehensive approach that balances the appropriate use of opioids, while deterring misuse and diversion, requires the involvement of many government agencies, including the Food and Drug Administration.

As the agency tasked with reviewing pain medications for safety and effectiveness, we know that the FDA can play a critical role in addressing the safe use of these products for patients with chronic or acute pain.

I was pleased when the FDA announced earlier this year that the agency developed a comprehensive action plan to help reduce the burden of opioid abuse on American families and communities. In this plan, the FDA outlined concrete steps it intended to take, including:

Expanding its use of advisory committees before approving any new opioid drug that does not have abuse-deterrent properties;

Updating the risk evaluation and mitigation strategy program to incorporate advisory committee recommendations regarding medical training on pain management and safe prescribing of opioids; and

Taking actions to expand patient access to abuse-deterrent formulations for opioids to help discourage their abuse.

The Opioid Review Modernization Act builds on these efforts and would require the FDA to work closely with expert advisory committees before making critical opioid approach and labeling decisions, develop recommendations regarding prescriber education programs that address extended-release and long-acting opioids, including those who should participate and how often, and encouraging development and approval of generic opioids with abuse-deterrent properties.

H.R. 4976 will engage a key public agency, the FDA, to help address our current opioid crisis by improving regulatory oversight of opioids early in the process while also assisting prescribers in the safe dispensing of these products.

I would like to thank Representative SEAN PATRICK MALONEY and Congressman LEONARD LANCE for their leadership in introducing this bill. I encourage my colleagues to support H.R. 4976.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. LANCE), my good friend and a fellow member of the Energy and Commerce Committee.

Mr. LANCE. Mr. Speaker, I certainly thank Mr. GUTHRIE of Kentucky and Mr. GENE GREEN of Texas for their leadership on this overall issue. We on the Energy and Commerce Committee have worked in a completely bipartisan fashion on this terrible crisis that affects the American people.

Mr. Speaker, I rise in strong support of H.R. 4976, the Opioid Review Modernization Act. I thank Congressman SEAN PATRICK MALONEY from the State of New York for his partnership on this legislation, and I certainly thank Chairman UPTON and Ranking Member PALLONE of the Energy and Commerce Committee for leading this and many other bipartisan bills to passage today that address this pressing national issue.

This bill and the larger package together are a great step forward in the fight against the scourge of drug addiction. In my home State of New Jersey, we face a drug epidemic that is hitting many communities hard, and that is true across the entire Nation. This crisis strains law enforcement and taxpayer resources, and, of course, tragically, it cuts too many lives short.

H.R. 4976 targets opioid addiction's strong ties to prescription drug abuse and the issue of overprescription. Studies have shown healthcare providers write nearly 300 million opioid prescriptions a year in this country. That number is truly staggering.

Our legislation will make sure that the Food and Drug Administration rigorously reviews the benefits and risks of opioid pain medications and how they are communicated to prescribers and patients. The bill reforms critical product approval and labeling decisions and encourages the development and approval of opioids with abuse-deterrent properties.

Our Federal health agencies must be working in concert with the medical and pharmaceutical communities to combat drug abuse, and this legislation helps make that happen.

Just last week I met with Hunterdon County, New Jersey, Prosecutor Anthony Kearns on what law enforcement is doing on the ground level to fight this epidemic. In New Jersey, Mr. Speaker, the county prosecutor is the equivalent of the county district attorney in most States across the Nation.

Public servants like Prosecutor Kearns and others are doing all they can to protect our children and keep our local communities drug free, but this legislative package will help in their efforts and give them and other governmental entities more critical tools.

Those in Washington and local leaders need to be working together for the benefit of the American people. H.R. 4976 and the larger package will work toward that goal and ultimately help combat this drug abuse crisis.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. SEAN PATRICK MALONEY), a cosponsor of this bill.

Mr. SEAN PATRICK MALONEY of New York. Mr. Speaker, I thank my good friend from Texas for yielding. I want to echo my thanks as well to Chairman UPTON and Ranking Member PALLONE and my good friend, Mr. LANCE of New Jersey.

I rise in support of my legislation, H.R. 4976, the Opioid Review Modernization Act.

Heroin and opioid addiction is a serious and growing epidemic, especially in the communities I represent in the lower Hudson Valley of New York. After more than 55 townhalls with my neighbors across the Hudson Valley in the last 3½ years, I can say there is no subject I have heard about more in visits to communities throughout my district. Really, everywhere I go, I hear heartbreaking stories of addiction and of loss, and we have had far too many funerals.

I spoke to a woman named Cynthia in Newburgh who told me her son struggles every day with addiction. He is trying to stay clean, but he can't find a meeting locally to visit.

A woman named Samantha from Brewster said she is worried about the basic lack of options for treating addicts like her son.

Patricia in Warwick has said the facilities there lack the basic necessities for treating addicts like her son.

We have a shortage of beds for patients who are seeking treatment. In Dutchess County, New York, alone, we have seen a 160 percent increase in the number of drug overdoses since 2009. This epidemic is being felt nationwide. It doesn't care about the color of your skin or the size of your paycheck.

Deaths from heroin overdoses have more than tripled since 2010 in our country, and it is often driven by an addiction first to prescription pain medicine. We now have more than 47,000 people dying a year, the equivalent of 125 Americans every day. It is a staggering figure, Mr. Speaker, and we in Congress can and must do more to fight this growing epidemic.

So my bill takes an important, but simple, step to avoid opioid addiction and to avoid further loss by using both new technologies and a little common sense.

Specifically, it would require the Food and Drug Administration to consult with expert advisory committees for the approval of new opioids that do not use deterrent properties, such as extended-release capsules. We know this can thwart the misuse of these products by people who are struggling with addiction.

Additionally, the legislation will encourage the development of generic opioids that utilize these abuse-deterrent properties. And, of course, the FDA can do more.

We can require them to evaluate and make recommendations on better programs to prevent prescribers of opioids from overprescribing, since we often hear that it is that overprescription that leads people into trouble with opioids and, later, with heroin.

As part of a comprehensive package of legislation to combat the opioid epidemic, my bill is just one more tool in our toolkit, providing incentives for pharmaceutical companies to use antiabuse technologies and create a plan to educate our well-meaning doctors about the potential dangers of prescription opioids.

I urge my colleagues to vote ''yes'' on this important measure.

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

Mr. GUTHRIE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this bill, the FDA's Opioid Action Plan, is important in our larger package of bills. I urge my colleagues to support this measure, H.R. 4976.

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

Mr. PALLONE. Mr. Speaker, I wish to voice my support for H.R. 4976, which would complement the efforts taken by the Food and Drug Administration to combat the opioid abuse crisis.

The opioid epidemic has hit nearly all communities across the country—young and old, rich and poor, urban and rural. The Energy and Commerce Committee has held a number of hearings on this issue, inviting a wide range of stakeholders to come and share with us their suggestions on how Congress can help to address this crisis. What has been made clear is that there is not one solution. It will take the collaboration and expertise of a variety of agencies, and it must not only appropriately account for the need for access to opioids for those with acute and chronic pain, but it must also discourage misuse and diversion.

As the public health agency responsible for reviewing pain medications for safety and efficacy, the Food and Drug Administration should play a critical role in making clear how prescription opioids can be safely used, in encouraging the development of technologies to prevent abuse, and identifying what education would assist prescribers who treat patients with opioids.

In February, FDA outlined an action plan that included a number of steps focused on the agency's regulatory approach to opioids.

These actions included: reassessing the risk-benefit approval framework for opioid use; convening an expert advisory committee before approving any new drug application for an opioid that does not have abuse-deterrent properties; consulting with the Pediatric Advisory Committee regarding recommendations for pediatric opioid labeling before any new labeling is approved; updating the Risk Evaluation and Mitigation Strategy or REMS program for extended-release and long-acting opioids regarding prescriber training; developing changes to immediate-release opioid labeling to include additional warnings and safety information; reviewing options to make naloxone more accessible, such as availability over-the-counter; and strengthening post-market requirements, among other steps.

I was pleased by the agency's announcement as I believe it was an important step forward in improving regulatory oversight of opioids, and would help to take another step towards addressing the opioid crisis holistically.

H.R. 4976, the Opioid Review Modernization Act, was introduced by Representatives SEAN PATRICK MALONEY and LEONARD LANCE to build on the actions announced by the FDA. The legislation would require the agency to work closely with expert advisory committees before making critical product approval and labeling decisions, make recommendations regarding education programs for prescribers of extended-release and long-acting opioids, and would encourage the development and approval of generic opioids with abuse-deterrent properties.

These actions will be critical to improving the way we regulate opioids to ensure that these products are used safely and appropriately and I urge my colleagues to support this legislation.

The SPEAKER pro tempore (Mr. STEWART). 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. 4976.

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.

CO-PRESCRIBING TO REDUCE OVERDOSES ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3680) to provide for the Secretary of Health and Human Services to carry out a grant program for co-prescribing opioid overdose reversal drugs, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3680

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 ''Co-Prescribing to Reduce Overdoses Act of 2016''.

SEC. 2. OPIOID OVERDOSE REVERSAL DRUGS PRESCRIBING GRANT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than six months after the date of the enactment of this Act, the Secretary of Health and Human Services may establish, in accordance with this section, a five-year opioid overdose reversal drugs prescribing grant program (in this Act referred to as the ''grant program'').

(2) MAXIMUM GRANT AMOUNT.—A grant made under this section may not be for more than $200,000 per grant year.

(3) ELIGIBLE ENTITY.—For purposes of this section, the term ''eligible entity'' means a federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), an opioid treatment program under part 8 of title 42, Code of Federal Regulations, any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)), or any other entity that the Secretary deems appropriate.

(4) PRESCRIBING.—For purposes of this section and section 3, the term ''prescribing'' means, with respect to an opioid overdose reversal drug, such as naloxone, the practice of prescribing such drug—

(A) in conjunction with an opioid prescription for patients at an elevated risk of overdose;

(B) in conjunction with an opioid agonist approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for the treatment of opioid abuse disorder;

(C) to the caregiver or a close relative of patients at an elevated risk of overdose from opioids; or

(D) in other circumstances, as identified by the Secretary, in which a provider identifies a patient is at an elevated risk for an intentional or unintentional drug overdose from heroin or prescription opioid therapies.

(b) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary of Health and Human Services, in such form and manner as specified by the Secretary, an application that describes—

(1) the extent to which the area to which the entity will furnish services through use of the grant is experiencing significant morbidity and mortality caused by opioid abuse;

(2) the criteria that will be used to identify eligible patients to participate in such program; and

(3) how such program will work to try to identify State, local, or private funding to continue the program after expiration of the grant.

(c) USE OF FUNDS.—An eligible entity receiving a grant under this section may use the grant for any of the following activities, but may use not more than 20 percent of the grant funds for activities described in paragraphs (4) and (5):

(1) To establish a program for prescribing opioid overdose reversal drugs, such as naloxone.

(2) To train and provide resources for health care providers and pharmacists on the prescribing of opioid overdose reversal drugs, such as naloxone.

(3) To establish mechanisms and processes for tracking patients participating in the program described in paragraph (1) and the health outcomes of such patients.

(4) To purchase opioid overdose reversal drugs, such as naloxone, for distribution under the program described in paragraph (1).

(5) To offset the co-pays and other cost sharing associated with opioid overdose reversal drugs, such as naloxone, to ensure that cost is not a limiting factor for eligible patients.

(6) To conduct community outreach, in conjunction with community-based organizations, designed to raise awareness of prescribing practices, and the availability of opioid overdose reversal drugs, such as naloxone.

(7) To establish protocols to connect patients who have experienced a drug overdose with appropriate treatment, including medication assisted treatment and appropriate counseling and behavioral therapies.

(d) EVALUATIONS BY RECIPIENTS.—As a condition of receipt of a grant under this section, an eligible entity shall, for each year for which the grant is received, submit to the Secretary of Health and Human Services information on appropriate outcome measures specified by the Secretary to assess the outcomes of the program funded by the grant, including—

(1) the number of prescribers trained;

(2) the number of prescribers who have coprescribed an opioid overdose reversal drug, such as naloxone, to at least one patient;

(3) the total number of prescriptions written for opioid overdose reversal drugs, such as naloxone;

(4) the percentage of patients at elevated risk who received a prescription for an opioid overdose reversal drug, such as naloxone;

(5) the number of patients reporting use of an opioid overdose reversal drug, such as naloxone; and

(6) any other outcome measures that the Secretary deems appropriate.

(e) REPORTS BY SECRETARY.—For each year of the grant program under this section, the Secretary of Health and Human Services shall submit to the appropriate committees of the House of Representatives and of the Senate a report aggregating the information received from the grant recipients for such year under subsection (d) and evaluating the outcomes achieved by the programs funded by grants made under this section.

SEC. 3. PROVIDING INFORMATION TO PRESCRIBERS IN CERTAIN FEDERAL HEALTH CARE AND MEDICAL FACILITIES ON BEST PRACTICES FOR PRESCRIBING OPIOID OVERDOSE REVERSAL DRUGS.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may, as appropriate, provide information to prescribers within Federally qualified health centers (as defined in paragraph (4) of section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), and the health care facilities of the Indian Health Service, on best practices for prescribing opioid overdose reversal drugs, such as naloxone, for patients receiving chronic opioid therapy, patients being treated for opioid use disorders, and other patients that a provider identifies as having an elevated risk of overdose from heroin or prescription opioid therapies.

(b) NOT ESTABLISHING A MEDICAL STANDARD OF CARE.—The information on best practices provided under this section shall not be construed as constituting or establishing a medical standard of care for prescribing opioid overdose reversal drugs, such as naloxone, for patients described in subsection (a).

(c) ELEVATED RISK OF OVERDOSE DEFINED.—In this section, the term ''elevated risk of overdose'' has the meaning given such term by the Secretary, which—

(1) may be based on the criteria provided in the Opioid Overdose Toolkit published by the Substance Abuse and Mental Health Services Administration (SAMHSA); and

(2) may include patients on a first course opioid treatment, patients using extended-release and long-acting opioid analgesics, and patients with a respiratory disease or other co-morbidities.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out this Act $5,000,000 for the period of fiscal years 2017 through 2021.

SEC. 5. CUT-GO COMPLIANCE.

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by inserting before the period at the end the following: ''(except such dollar amount shall be reduced by $5,000,000 for fiscal year 2018)''.

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 may 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.

Mr. Speaker, I rise today in support of H.R. 3680, the Co-Prescribing to Reduce Overdoses Act of 2016, introduced by my colleague on the Energy and Commerce Committee, Mr. SARBANES of Maryland.

In 1999, there were 6.1 overdose deaths per 100,000 Americans involving opioid analgesics and heroin. By 2014, that number doubled to 14.7 overdose deaths. The rate of overdose for individuals aged 24 to 34 nearly tripled, going from 8.1 overdose deaths per 100,000 to 23.1 overdose deaths.

Naloxone is an opioid antagonist that can prevent opioid overdose deaths by binding to the opioid receptors in the body and preventing the overdose. The World Health Organization estimated that, if naloxone was more widely available in the United States, more than 20,000 overdose deaths could be prevented annually.

H.R. 3680 is a step in promoting wider access of naloxone or other opioid-overdose reversal drugs that may come to market. It directs the Secretary of Health and Human Services to carry out a grant program for coprescribing opioid reversal drugs and helps develop best practices for doing so.

Mr. Speaker, I urge my colleagues to support this legislation.

I reserve the balance of my time.

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

Mr. Speaker, I rise to voice my support for H.R. 3680, the Co-Prescribing to Reduce Overdoses Act. We must do more to prevent opioid addiction and ensure those currently suffering have access to potentially lifesaving treatments.

Naloxone has been proven effective in reversing opioid overdoses, and it is a cost-effective public health intervention. Naloxone blocks and reverses the effects of opioid medication and is used to treat narcotic overdose in emergency situations.

In addition to recent efforts to improve access to naloxone through first responders and community-based health organizations, providing naloxone to at-risk patients in a healthcare setting may reduce overdoses and encourage patients to use prescription drugs more safely.

□ 1645

The Co-Prescribing to Reduce Overdoses Act would create a demonstration grant program to facilitate coprescribing of naloxone when appropriate.

Coprescribing refers to the practice of prescribing that naloxone alongside an opioid prescription to patients with heightened risk of overdose. This could include patients who take significant doses of opioids for long-term chronic pain management, patients with a history of substance abuse, or patients who have been discharged from emergency care following poisoning or intoxication from an opiate.

The bill would further authorize funding to train healthcare providers and pharmacists on coprescribing, establish mechanisms for tracking patients and their health outcomes, and other efforts to expand access to naloxone.

We must act swiftly in order to save lives and stem the growing prescription drug epidemic in our country. The Co-Prescribing to Reduce Overdoses Act is an important step toward preventing overdose deaths, which is a critical part of the fight against our devastating drug crisis.

I want to thank the bill's sponsor, the gentleman from Maryland, Representative JOHN SARBANES, who is a member of our Subcommittee on Health, for his leadership in introducing this bill.

I urge my colleagues to support the Co-Prescribing to Reduce Overdoses Act.

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

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. SHUSTER), the distinguished chairman of the Committee on Transportation and Infrastructure.

Mr. SHUSTER. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 3680, which is one of several initiatives being taken up by the House this week to combat the devastating opioid epidemic our Nation is facing.

Every person in my district knows someone who has been impacted by this crisis, and each day that we wait is another day we go without taking action to save the lives of the people feeling the terrible effects of this addiction.

Each day without action is another day that our communities are ravaged by these drugs.

We can combat this crisis and repair our communities. This is a needed step that both Republicans and Democrats are working together to achieve.

I strongly support this legislation because it will provide funding to our health centers to coprescribe naloxone, a lifesaving drug.

My entire district has been plagued by the scourge of this crisis. The alarming rise in overdose deaths show the urgent need for naloxone to be readily available to both healthcare professionals and those with increased risk of overdose.

These efforts are one part of a broader solution that will undoubtedly save lives. I applaud my colleagues on both sides of the aisle for taking these steps, and I look forward to continuing to work to make our communities a safer place by ridding them of this epidemic.

I urge all my colleagues to support H.R. 3680.

Mr. GENE GREEN of Texas. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Maryland (Mr. SARBANES), my colleague on the committee.

Mr. SARBANES. I thank the gentleman for yielding.

Mr. Speaker, I first want to thank Ranking Members PALLONE and GREEN, as well as Chairmen UPTON and PITTS, for working diligently with me to bring this bill to the floor today.

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

Why is this bill needed, Mr. Speaker?

More than 100 Americans are dying every single day of preventable drug overdose, and overdose fatality is now the leading cause of accidental death in the Nation.

In 2014, in my home State of Maryland, there were 887 opioid-related deaths. In Baltimore, 192 people died from heroin overdoses. In Anne Arundel County in 2014, there were 360 opioid overdoses, fatal and nonfatal; 49 of those were fatal.

The problem is getting worse. From 2001 to 2013, there was a fivefold increase in the total number of deaths from heroin. This is an epidemic, but it is an epidemic that we can begin to stem if we take action.

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

More people need access to this lifesaving medication. One part of that proactive approach is the idea of coprescribing naloxone to patients, or their caregivers, who are taking opioids and are at high risk of overdose.

The Co-Prescribing to Reduce Overdoses Act would create a demonstration project for federally qualified health centers, opioid treatment centers, and other providers, to encourage coprescribing of naloxone and other opioid reversal drugs.

This bill has been endorsed by the AMA, the American Society of Addiction Medicine; the American Academy of Family Physicians; and the Harm Reduction Coalition.

There are five Republican cosponsors, I am pleased to say, proving that this is a bipartisan issue affecting virtually every part of the country.

I am pleased as well to note that the bill received unanimous support in the Committee on Energy and Commerce.

I urge support of this bill today because I know that it will save lives and help begin to stem the tide of this terrible epidemic.

I also support the other bills being debated this evening, and believe that these are all important initiatives to address the opioid crisis.

However, it is just as critical that we provide adequate resources for all aspects of this epidemic to prevent addiction, to provide effective treatment, and to increase access to lifesaving opioid reversal drugs in order to truly bring an end to this epidemic.

Mr. Speaker, I urge support of this important legislation.

Mr. GUTHRIE. Mr. Speaker, one of the great privileges of the people's House, people come here from all walks of life with all different expertise.

I yield such time as he may consume to the gentleman from Georgia (Mr. CARTER), the only registered pharmacist that serves in the House of Representatives, who is here to speak on this and several of the bills today.

Mr. CARTER of Georgia. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 3680, the Co-Prescribing to Reduce Overdoses Act, which gives patients the tools they need to protect themselves from opioid overdoses.

H.R. 3680 calls for the Department of Health and Human Services to create a grant program that will increase the ability for healthcare providers to coprescribe opioid reversal medication like naloxone when those providers prescribe opioid-based medications for patients.

This new direction by HHS will work to decrease the risk of fatally overdosing on opioids while also allowing healthcare providers to learn more about the opioid reversal medication benefits.

In addition, with the grant money, providers will be able to track patient outcomes to make sure that the reversal medication has the desired effect.

As a lifelong pharmacist, I consider it my duty to always care for my patients and give them every tool I can to protect and serve them the best way I can, and I have carried this duty to the United States House of Representatives.

The Co-Prescribing to Reduce Overdoses Act does just this and is a major step in the right direction to ending the opioid addiction deaths in America.

I encourage all of my colleagues to support this bill.

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

Mr. GUTHRIE. Mr. Speaker, I appreciate the gentleman from Maryland (Mr. SARBANES) bringing this forward and all the bipartisan work that was put into it. 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 H.R. 3680 the "Co-Prescribing To Reduce Overdoses Act of 2015."

This bill requires the Department of Health and Human Services (HHS) to establish a grant program to support prescribing opioid overdose reversal drugs, such as naloxone, for patients at an elevated risk of overdose, including patients prescribed an opioid.

Opioids are drugs with effects similar to opium, such as heroin and certain pain medications.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States.

In 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

Both states and the federal government have begun responding to this growing public health crisis.

The Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services.

H.R. 3680 would encourage and train health care providers to prescribe lifesaving overdose reversal drugs.

Enacting this legislation will help reduce drug overdoses across the country by giving at-risk patients better access to lifesaving overdose reversal drugs.

The plague of opioid overdose deaths across the nation is disturbing, but there are ways to combat this trend.

H.R. 3680 is supported by the American Medical Association, the American Society of Addiction Medicine and the Harm Reduction Coalition.

A party, or organization receiving a grant under this legislation will use the grant for the following reasons:

1. To establish a program for co-prescribing opioid overdose reversal drugs.

2. To train and provide resources for health care providers and pharmacists on the co-prescribing of opioid reversal drugs.

3. To establish mechanisms and processes for tracking patients participating in the program.

4. To purchase opioid overdose reversal drugs for distribution.

5. To offset the copays and other cost sharing associated with opioid overdose reversal drugs to ensure that cost is not a limiting factor for eligible patients.

6. To conduct community outreach, in conduction with community based organizations, designed to raise awareness of co-prescribing practices and the availability of opioid overdose reversal drugs.

7. To establish protocols to connect patients who have experienced a drug overdose with appropriate treatment, including medications assisted treatment and appropriate counseling and behavioral therapies.

Mr. Speaker, the mounting number of people adversely affected and the over 25,000 lives lost expressly demonstrates the need for this type of legislation.

H.R. 3680 is a positive step in the right direction and I urge all members to support this important legislation.

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. 3680, 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.

NURTURING AND SUPPORTING HEALTHY BABIES ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4978) to require the Government Accountability Office to submit to Congress a report on neonatal abstinence syndrome (NAS) in the United States and its treatment under Medicaid, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4978

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 ''Nurturing And Supporting Healthy Babies Act'' or as the ''NAS Healthy Babies Act''.

SEC. 2. GAO REPORT ON NEONATAL ABSTINENCE SYNDROME (NAS).

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate a report on neonatal abstinence syndrome (in this section referred to as ''NAS'') in the United States.

(b) INFORMATION TO BE INCLUDED IN REPORT.—Such report shall include information on the following:

(1) The prevalence of NAS in the United States, including the proportion of children born in the United States with NAS who are eligible for medical assistance under State Medicaid programs under title XIX of the Social Security Act at birth and the costs associated with NAS through such programs.

(2) The services for which coverage is available under State Medicaid programs for treatment of infants with NAS.

(3) The settings (including inpatient, outpatient, hospital-based, and other settings) for the treatment of infants with NAS and the reimbursement methodologies and costs associated with such treatment in such settings.

(4) The prevalence of utilization of various care settings under State Medicaid programs for treatment of infants with NAS and any Federal barriers to treating such infants under such programs, particularly in non-hospital-based settings.

(5) What is known about best practices for treating infants with NAS.

(c) RECOMMENDATIONS.—Such report also shall include such recommendations as the Comptroller General determines appropriate for improvements that will ensure access to treatment for infants with NAS under State Medicaid programs.

SEC. 3. EXCLUDING ABUSE-DETERRENT FORMULATIONS OF PRESCRIPTION DRUGS FROM THE MEDICAID ADDITIONAL REBATE REQUIREMENT FOR NEW FORMULATIONS OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—The last sentence of section 1927(c)(2)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)(C)) is amended by inserting before the period at the end the following: '', but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act.

SEC. 4. LIMITING DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1128J (42 U.S.C. 1320a–7k) the following new section:

''SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

''(a) REFERENCE TO PREDICTIVE MODELING TECHNOLOGIES REQUIREMENTS.—For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI, see section 4241 of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m).

''(b) LIMITING DISCLOSURE OF PREDICTIVE MODELING TECHNOLOGIES.—In implementing such provisions under such section 4241 with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

''(1) NONAPPLICATION OF FOIA.—The covered algorithms used or developed for purposes of such section (including by the Secretary or a State (or an entity operating under a contract with a State)) shall be exempt from disclosure under section 552(b)(3) of title 5, United States Code.

''(2) LIMITATION WITH RESPECT TO USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.—

''(A) IN GENERAL.—A State agency may not use or disclose covered algorithms used or developed for purposes of such section except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under title XIX or the State child health plan (or a waiver of the plan) under the Children's Health Insurance Program under title XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud, and abuse with respect to such programs.

''(B) INFORMATION SECURITY.—A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered algorithms used or developed for purposes of such section 4241 and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

''(C) PROCEDURAL REQUIREMENTS.—State agencies to which information is disclosed pursuant to such section 4241 shall adhere to

uniform procedures established by the Secretary.

''(c) COVERED ALGORITHM DEFINED.—In this section, the term 'covered algorithm'—

''(1) means a predictive modeling or other analytics technology, as used for purposes of section 4241(a) of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a–7m(a)) to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children's Health Insurance Program under title XXI; and

''(2) includes the mathematical expressions utilized in the application of such technology and the means by which such technology is developed.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (80), by striking ''and'' at the end;

(B) in paragraph (81), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (81) the following new paragraph:

''(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

(2) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7) of the Social Security Act (42 U.S.C. 1397bb(a)(7)) is amended—

(A) in subparagraph (A), by striking '', and'' at the end and inserting a semicolon;

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

(C) by adding at the end the following new subparagraph:

''(C) to ensure that the State agency involved is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).''.

SEC. 5. MEDICAID IMPROVEMENT FUND.

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended to read as follows:

''(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for fiscal year 2021 and thereafter, $5,000,000.''.

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.

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

Mr. Speaker, I rise in support of H.R. 4978, the Nurturing and Supporting Healthy Babies Act, sponsored by Representative EVAN JENKINS. This commonsense, bipartisan piece of legislation contains two important policies which will help strengthen our efforts to curb opioid abuse.

First, the bill requires the Government Accountability Office to carefully study ways to improve care for babies born with neonatal abstinence syndrome, NAS. NAS is a drug-withdrawal syndrome that most commonly occurs after an in-utero exposure to opioids that has, sadly, grown into prevalence in recent years.

As the New England Journal of Medicine noted last year, from 2000 through 2009, the incidence of neonatal abstinence syndrome in the United States nearly tripled, with several States reporting even larger recent increases.

That same study noted that, in 2013, the number of NICU hospital days nationwide attributed to the care of infants with NAS was six to seven times greater than it was in 2004.

So this bill will expand our knowledge of care of NAS babies by requiring GAO to study what is known about the prevalence of NAS in the United States, the number of NAS babies covered by Medicaid, the settings for care of NAS babies, and access to care for NAS babies under State Medicaid programs.

Based on the recommendation of Representative ANDY BARR, the bill also directs GAO to identify what is known about best practices providing care for infants with NAS.

This comprehensive study, including the research focusing on best practices, can help us improve our efforts to provide care for some of the most vulnerable among us.

This bill takes a second important step to help combat opioid abuse by fixing an unintended consequence with the Medicaid drug rebate program that effectively discourages drug manufacturers from producing opioids that are harder to abuse.

Specifically, this second policy would exempt abuse-deterrent formulations of drugs from the definition of ''line extension'' for the purpose of calculating Medicaid rebates.

Abuse-deterrent formulations of drugs represent a critically important tool in the Federal policy toolbox. In its Opioids Action Plan, FDA said its goal is to ''expand access to abuse-deterrent formulations to discourage abuse.'' And in its ADF guidance to manufacturers, the agency said it ''considers the development of these products a high public health priority.''

This policy enjoys bipartisan support, and was introduced by Representative BILIRAKIS previously. This policy was also included in the President's FY 2017 budget, which noted that correcting the law would ''incentivize continued development of abuse-deterrent formulations.''

This policy can help save lives. Currently, more than 4 million Americans misuse or abuse prescription painkillers and more than 16,000 individuals die from prescription painkiller overdoses each year. This change will help ensure there is continued investment in important abuse-deterrent drug technologies to help reduce the number of patients who abuse opioid drugs.

Finally, to help offset the cost of the Medicaid drug rebate change, this bill includes a third policy that was introduced by Representative BILIRAKIS in the past, and recently was included in the President's 2017 budget.

It would protect from public disclosure the program integrity algorithms CMS uses to identify and predict waste, fraud, and abuse in Medicare, Medicaid, and CHIP.

Today the mathematical algorithms and predictive technologies that CMS uses in Medicare, Medicaid, and CHIP are vital to uncovering fraud, waste, and abuse.

However, if various aspects of these algorithms were to become publicly known, fraudsters could utilize the information to redirect their schemes to avoid detection.

This policy would simply prevent the disclosure of these anti-fraud tools from freedom of information-related laws while still allowing CMS and State Medicaid and CHIP programs to freely share algorithms and other predictive analytic tools. Doing so saves taxpayers money and offsets the cost of the rebate policy.

Mr. Speaker, this bill would enhance our knowledge about how to care for infants with NAS, encourage more abuse-deterrent formulations of drugs, and prevent powerful, anti-fraud tools from falling into the wrong hands.

I urge support for this commonsense, bipartisan piece of legislation.

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

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

Mr. Speaker and Members, I rise to voice my support for H.R. 4978, the Nurturing and Supporting Healthy Babies Act.

Nearly every community in every State has been impacted by heroin and opioid addiction. Tragically, newborns are the most vulnerable victims of this epidemic. It is estimated that every 25 minutes, a baby is born suffering from neonatal abstinence syndrome, or opioid withdrawal. According to a study by the New England Journal of Medicine, from 2004 to 2013, the incidence of NAS has quadrupled.

Neonatal abstinence syndrome, or NAS, arises from the exposure to opioids during pregnancy and impacts far too many of our Nation's newborns. Maternal exposure to opioids can be caused by both nonprescription and prescription medication, and the subsequent neonatal withdrawal can result in extended hospital stays and severe, heartbreaking symptoms.

□ 1700

NAS is associated with preterm births and low birth weight complications such as respiratory distress and seizures.

H.R. 4978, the Nurturing and Supporting Healthy Babies Act, is an important part of our efforts to combat drug abuse. The legislation will expand our knowledge of care and treatment for babies with NAS. It will direct the GAO to identify the prevalence of NAS and the number of cases covered by Medicaid, the setting of care for these infants, and identify access barriers to treatment. H.R. 4978 will further our ability to meet this crisis head-on and provide America's children the healthy start they deserve.

I want to thank the bill's sponsor, Representative CHERI BUSTOS, for her

leadership in introducing this bill and urge my colleagues to support the Nurturing and Supporting Healthy Babies Act.

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

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from West Virginia (Mr. JENKINS), my friend and the sponsor of this legislation.

Mr. JENKINS of West Virginia. Mr. Speaker, as you have just heard, every 25 minutes in this Nation a baby is born who was exposed to drugs during pregnancy. This is called neonatal abstinence syndrome, or NAS, and it is a devastating way to begin one's life.

Today before the House is the Nurturing and Supporting Healthy Babies Act. I am proud to sponsor this bipartisan legislation that will expand our knowledge of care for babies born with NAS.

Hearing the sounds of babies crying as they experience drug withdrawal is heartbreaking. We can only truly address this crisis by working together. For the past 5 years, I have worked tirelessly in my hometown of Huntington, West Virginia, to help those treating newborns with NAS and to help find new and innovative treatment methods.

This firsthand experience highlighted the many challenges facing hospitals, doctors, nurses, and others seeking to treat these babies, and it has shown me the suffering these babies experience and just how much we need to help them. This bill will bring much-needed information on best practice models of care to our healthcare providers for the most vulnerable impacted by this drug crisis.

Through this bill, we will also learn more about just how many newborns are suffering from withdrawal and more about the Federal obstacles to treating them. This bill will bring us closer to guaranteeing a healthy and happy start to life for every newborn.

I thank the Energy and Commerce Committee's chairmen, Chairman UPTON and Chairman PITTS, for their tireless work to find solutions to the drug crisis and to help NAS babies start their lives healthy and happy. I thank Congresswoman CHERI BUSTOS for joining me in cosponsoring this legislation.

We are making progress. We must continue to strive for solutions to this tragic epidemic.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentlewoman from Illinois (Mrs. BUSTOS).

Mrs. BUSTOS. Mr. Speaker, I thank Congressman GENE GREEN for yielding me time and for working with me to find better treatment for babies born with neonatal abstinence syndrome, also known as NAS.

Mr. Speaker, every 25 minutes, as we have heard, every 25 minutes in America, another baby is born addicted to heroin or other deadly opioids. It results from their mother's struggle with addiction.

As the heroin epidemic sweeps our towns and our cities throughout the United States and impacts far too many families, many of the most overlooked victims have been the most vulnerable among us. It is heart-wrenching and it is terrible that an innocent newborn, trembling, crying uncontrollably, clenching her small fists, and gasping for air, again, is born every 25 minutes.

These are just a few of the symptoms babies face when they are born addicted to opioids, and nothing from my perspective as a mother and as a grandmother could be more demanding of our immediate attention. That is why I joined Congressman EVAN JENKINS from West Virginia to introduce the Nurturing and Supporting Healthy Babies Act.

This bipartisan legislation will improve care for babies born with neonatal abstinence syndrome. It will expand our knowledge of care for NAS babies, including its prevalence in the United States. It will also examine access to care for NAS babies under the State Medicaid programs and direct the Government Accountability Office to identify any Federal obstacles to care for NAS babies.

In short, this legislation will do a top-to-bottom review to make sure we are doing everything we can to help babies born with addiction and withdrawal.

Mr. Speaker, we must do our part to help all children reach their full potential.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), my friend and colleague from the Committee on Energy and Commerce.

Mr. BILIRAKIS. Mr. Speaker, I rise in support of H.R. 4978, the Nurturing and Supporting Healthy Babies Act. This bill will help our most vulnerable Americans.

H.R. 4978 will require the GAO to study and report on the prevalence of neonatal abstinence syndrome to help determine the size and scope of this prescription drug problem and its impact on newborns.

Neonatal abstinence syndrome refers to a group of conditions that occur when a child is born addicted to narcotics and is going through withdrawal. This, unfortunately, affects my district in Florida and all over the country.

I visited babies in the hospital. In 2013, during a drug summit in Pasco County, health officials discussed the growing problem of babies born addicted to prescription drugs. Pinellas County, my home county, at that time ranked first in the State for babies born addicted. We must do all we can to help those struggling infants and their families.

This bill also includes two provisions I have worked on to reform Medicaid payments for abuse deterrent formulations and fight fraud in Medicare and Medicaid. Currently, Medicaid does not sufficiently cover abuse deterrent formulations for generic drugs. During a hearing, I spoke to Secretary Burwell about this problem, and she expressed to me the need for a legislative fix to this payment issue. This bill provides a solution and helps prevent drug abuse within Medicaid.

This bill also includes a provision to protect the predictive analytic algorithm which identifies and prevents the payment of improper claims in Medicare. These tools, designed to prevent fraud, need to be protected from being disclosed to bad actors.

Back in 2013, I introduced legislation to protect these predictive analytic algorithms from the Freedom of Information Act disclosure, and H.R. 4978 includes this important legislation.

This legislation will help protect our newborns and all those facing prescription drug abuse and addiction.

Mr. Speaker, again, I thank Representative JENKINS and the Energy and Commerce Committee, and I urge my colleagues to support H.R. 4978.

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 Kentucky (Mr. BARR), my good friend and fellow Kentuckian.

Mr. BARR. Mr. Speaker, I thank my colleague from Kentucky (Mr. GUTHRIE) for his leadership on this issue, and I want to thank my colleague from West Virginia (Mr. JENKINS) for his leadership on this important legislation.

Mr. Speaker, I rise today to encourage my colleagues to support his bill, H.R. 4978, the NAS Healthy Babies Act, which seeks to increase our understanding of neonatal abstinence syndrome and would help further strengthen best practices for treating this dangerous but preventable condition.

According to the National Institute on Drug Abuse, there has been a dramatic increase in maternal opioid use; and as a tragic result, a baby is born suffering from neonatal abstinence syndrome, or NAS, every 25 minutes in the United States.

To help address this public health challenge, this legislation contains language drafted in coordination with my constituent, University of Kentucky pediatrician, Dr. Henrietta Bada-Ellzey, and members of the Sixth Congressional District Drug Abuse Task Force. Specifically, this provision would mandate a study which would gain critical data about the specific treatment options given to newborns with NAS during and after their hospital stay and identify treatment outcomes. This vital information would help lead pediatricians to provide improved care for the most vulnerable in our society.

I would like to thank the leader's office and the Energy and Commerce Committee staff for giving me an opportunity to include this important recommendation from the Sixth Congressional District Drug Abuse Task

Force in this legislation. The opioid heroin crisis in America impacts every congressional district, and my district is not immune. So I am proud that the people's House is taking up a series of important measures to combat this scourge in our society, and I can't think of any more important measure than dealing with these innocent victims of NAS.

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 2 minutes to the gentlewoman from Missouri (Mrs. WAGNER), my good friend.

Mrs. WAGNER. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of the Nurturing and Supporting Healthy Babies Act, which will improve care for babies who are so sadly suffering from exposure to opioids while in their mother's womb.

Hospital usage for opioid overuse in Missouri increased 137 percent between 2005 and 2014, with the highest rates being in the St. Louis region. We must do everything we can to combat this epidemic from all angles.

Mr. Speaker, it is absolutely heartbreaking to stand in front of you knowing that in the United States an opioid-dependent baby is born every 20 minutes, immediately suffering from withdrawal: trembling, crying inconsolably, and clenching their tiny muscles as they gasp for breath.

My principal mission as a Member of this Chamber is to provide a voice to the voiceless, and it is our duty to defend the most vulnerable. Ensuring babies have access to care and allowing them to recover from these horrible physical and emotional circumstances is not only common sense, but, Mr. Speaker, it is simply the right thing to do.

Mr. Speaker, I urge the passage of H.R. 4978, and I thank Representative EVAN JENKINS for introducing this legislation.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER), my good friend.

Mr. CARTER of Georgia. I thank the gentleman from Kentucky for yielding and for his work on this most important subject, as well as the gentleman from West Virginia.

Mr. Speaker, I rise today in support of H.R. 4978, the NAS Healthy Babies Act because newborn infants deserve every opportunity to live a happy and healthy life.

H.R. 4978 requires the Government Accountability Office to compile a report on the amount of babies born each year with NAS, Medicaid insurance coverage for families that have an NAS baby, and Federal obstacles for children who seek treatments for NAS. With this new information, we can increase our understanding of NAS and our ability to provide care for babies born with NAS. This new understanding is vital, considering the number of newborns with NAS has increased with the rise in the number of Americans addicted to opioids.

As a lifelong pharmacist, I believe we should take every step possible to fight the addiction crisis in America, and the protection of our children should be our top priority. I encourage all of my colleagues to support this measure.

Mr. GUTHRIE. Mr. Speaker, I yield such time as he may consume to the gentleman from Maine (Mr. POLIQUIN).

Mr. POLIQUIN. Mr. Speaker, it cannot be said enough that every 25 minutes in this great country, there is a baby born addicted to drugs. Last year alone, 1,000 of those babies were born in the great State of Maine.

Now, 80 percent of these addicted infants are covered by Medicaid and treated at local hospitals, but our hospitals are overwhelmed. They are not equipped to provide the specialized care that these babies desperately need to recover from the drugs in their tiny bodies. I am very proud to serve as an original cosponsor of the Nurturing and Supporting Healthy Babies Act.

□ 1715

I am thrilled that this bill, Mr. Speaker, is being considered today on the floor. I want to congratulate Congressman EVAN JENKINS from West Virginia, a Republican, and I want to congratulate Congresswoman BUSTOS from Illinois, a Democrat, for their leadership on this issue. This is not a political issue, Mr. Speaker. This is about our kids. This is about our babies. This is about that generation.

H.R. 4978 made sure that we get the information we need as to how hospitals and other medical facilities are currently treating these addicted babies, such that we can fill in the gap with Medicaid coverage.

Mr. Speaker, every baby born into this world deserves our compassion and our care. This bill offers real hope for a healthy and a safe and a loving start for thousands of American babies born addicted to drugs.

Let's all get together and get this done, Mr. Speaker. This is not a political issue. This is about our kids.

Mr. GENE GREEN from Texas. Mr. Speaker, I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I appreciate my friend from West Virginia and our colleague from Illinois for moving this forward.

I urge the passage of H.R. 4978, and I would like for my colleagues to vote for this.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4978, the "Nurturing & Supporting Healthy Babies Act," approved by the Energy and Commerce Committee.

In the past decade and a half, the growth in the number of physicians prescribing opioids to help patients deal with pain from surgeries, dental work and chronic conditions has resulted in an increasing number of patients becoming dependent on the powerful and highly addictive painkillers—with patients not only abusing the use of those painkillers but often turning to heroin once their opioid prescription ended.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States.

It is estimated that in 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

The Health and Human Services Department estimates that the number of unintentional overdose deaths from prescription painkillers almost quadrupled between 1999 and 2013 and that abuse of prescription opioids now kills nearly 30,000 Americans each year.

Both states and the federal government have begun responding to this growing public health crisis, with many states moving to make anti-overdose drugs more available and shield first-responders from liability in administering those drugs.

President Obama, meanwhile, has updated prescribing guidelines to encourage doctors to be more cautious when prescribing opioid painkillers and to emphasize non-opioid therapies for certain conditions.

Additionally, the Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services.

In the president's FY 2017 budget the administration proposed $1.1 billion to combat drug addiction and is also considering modifying certain rules to improve treatment.

Our counterparts in the Senate, on March 10, 2016, passed S. 524, an antiopioid abuse bill that would authorize grants for opioid treatment services and first-responder training in using anti-overdose drug by a 94–1 vote, as well as create a task force to review and update best practices for prescribing pain medication.

S. 524 also mandates investigations into heroin distribution and unlawful distribution of prescription opioids, and requires the creation of a national drug awareness campaign that takes into account the association between prescription opioid abuse and heroin use.

The science indicates that opioids can have particularly harrowing effects on infants whose mothers took the drugs during pregnancy, including medical issues stemming from drug withdrawal known as neonatal abstinence syndrome.

Advocacy groups note that the incidence of neonatal abstinence syndrome almost tripled from 1.20 per 1,000 hospital births in 2000 to 3.39 per 1,000 hospital births in 2009.

In conjunction with H.R. 4978, the "Nurturing & Supporting Healthy Babies Act," the Congressional Budget Office (CBO) has estimated that 45 percent of births in the United States are now covered by the joint federal-state Medicaid program.

This bill directs the Government Accountability Office (GAO) to report to Congress on neonatal abstinence syndrome among children covered by Medicaid, including any federal barriers to treating such infants.

The GAO must also provide recommendations for improvements that will ensure access to treatment for infants with neonatal abstinence syndrome under state Medicaid programs.

Additionally, the measure modifies Medicaid to provide incentives for the development of abuse-deterrent formulations of prescription drugs and to prevent disclosure of Medicaid anti-fraud algorithms.

The bill requires that GAO's report identify the prevalence of neonatal abstinence syndrome in the United States, including the proportion of affected children who are eligible for Medicaid at birth and the costs associated with neonatal abstinence syndrome.

GAO will also be required to examine Medicaid-eligible services that are available for treatment of infants with neonatal abstinence syndrome, settings for such treatment, related reimbursement methodologies and costs, and the utilization of various care settings under state Medicaid programs for such treatment.

This GAO's report must be submitted to Congress within one year of the bill's enactment.

Seeking to right the same wrongs as H.R. 4978, the ''Nurturing And Supporting Healthy Babies Act,'' I introduced the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016,'' or the ''SIMARRA Act,'' which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders, by establishing a pilot program of critical-stage, developmental nurseries in Federal prisons for children born to inmates.

It is time that our nation recognizes a long-persistent need to break the cycle of generational, institutional incarceration amongst mothers serving time for non-violent crimes and the children they birth behind prison bars.

H.R. 5130, the, ''SIMARRA Act of 2016,'' gives those infants born to incarcerated mothers a chance to succeed in life.

''SIMARRA'' is not merely yet another second chance program, demanding leniency from the criminal justice system.

Instead, H.R. 5130 asks our national criminal justice system what it can do for those young Americans born and relegated to a life of nearly impossible odds of survival.

''SIMARRA'' provides that first chance—a first chance for American infants—that many of their mothers, born themselves to mothers behind bars, never received.

The bill excludes abuse-deterrent formulations of prescription drugs from Medicaid's additional rebate requirement for new prescription drug formulations, which is intended to encourage the development of these drugs by allowing drug companies to reduce the rebates they otherwise must pay to Medicaid.

The measure also limits disclosure of predictive modeling and other analytics technologies that are used to identify and prevent waste, fraud and abuse in Medicaid, including by exempting covered program integrity algorithms from the Freedom of Information Act (FOIA) and requiring state Medicaid and Children's Health Insurance Program (CHIP) agencies to have adequate data security policies to ensure the security of covered algorithms.

Finally, the measure makes $5 million available to the Medicaid Improvement Fund for expenditures for FY 2021 and beyond.

CBO estimates that enacting H.R. 4978 would not, on net, change direct spending over the 2017–2026 period.

While opponents argue that some provisions of the bill will increase direct spending by $80 million over that period, I point out that other provisions would decrease direct spending by the same amount balancing the total cost.

Enacting the legislation would affect direct spending, rather than revenues.

Under current law, pharmaceutical manufacturers are required to pay rebates to states for prescription drugs provided through Medicaid.

The formula which determines rebate amounts in the Medicaid program has several components, with some components generating rebates that are paid to states and shared with the federal government, and others generating rebates that are paid to states and subsequently transferred in their entirety to the federal government.

Abuse deterrent formulation, or ADF, is a new technology that is being implemented by the pharmaceutical industry to prevent the abuse of prescription pain medications.

For example, some ADFs make it more difficult for an individual to crush, break, or dissolve a drug to inappropriately extract and use its active ingredient.

Under the bill, the component of the rebate formula that would no longer apply to ADFs of brand-name drugs is one that is paid to states and transferred in full to the federal government.

Therefore, states would not be directly affected by this section of the bill.

CBO estimates that this section would increase federal Medicaid costs by about $75 million over the 2017–2026 period by reducing rebates.

CBO anticipates that an increasing number of ADFs of brand name drugs will launch over time; therefore, the component of the rebate affected by H.R. 4978 would also grow over time.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 10-year periods beginning in 2026.

H.R. 4978 contains no intergovernmental or private-sector mandate as defined in UMRA and would impose no costs on state, local, or tribal governments.

In sum, H.R. 4978, the ''Nurturing & Supporting Healthy Babies Act,'' is a valuable piece of legislation that I encourage my colleagues to support.

Additionally, I urge my colleagues to join me in sponsoring and supporting all legislation targeting the improvement of care for the prevention of infant abuse and neglect, such as H.R. 5130, the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016'' or the ''SIMARRA Act.''

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. 4978, 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 require the Government Accountability Office to submit to Congress a report on neonatal abstinence syndrome (NAS) in the United States and its treatment under Medicaid, and for other purposes.''.

A motion to reconsider was laid on the table.

IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3691) to amend the Public Health Service Act to reauthorize the residential treatment programs for pregnant and postpartum women and to establish a pilot program to provide grants to State substance abuse agencies to promote innovative service delivery models for such women, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3691

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 ''Improving Treatment for Pregnant and Postpartum Women Act of 2016''.

SEC. 2. REAUTHORIZATION OF RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.

Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended—

(1) in subsection (p), in the first sentence, by inserting ''(other than subsection (r))'' after ''section''; and

(2) in subsection (r), by striking ''such sums'' and all that follows through ''2003'' and inserting ''$16,900,000 for each of fiscal years 2017 through 2021''.

SEC. 3. PILOT PROGRAM GRANTS FOR STATE SUBSTANCE ABUSE AGENCIES.

(a) IN GENERAL.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended—

(1) by redesignating subsection (r), as amended by section 2, as subsection (s); and

(2) by inserting after subsection (q) the following new subsection:

''(r) PILOT PROGRAM FOR STATE SUBSTANCE ABUSE AGENCIES.—

''(1) IN GENERAL.—From amounts made available under subsection (s), the Director of the Center for Substance Abuse Treatment shall carry out a pilot program under which competitive grants are made by the Director to State substance abuse agencies to—

''(A) enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

''(B) help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential based settings; and

''(C) promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery.

''(2) REQUIREMENTS.—In carrying out the pilot program under this subsection, the Director shall—

''(A) require State substance abuse agencies to submit to the Director applications, in such form and manner and containing such information as specified by the Director, to be eligible to receive a grant under the program;

''(B) identify, based on such submitted applications, State substance abuse agencies that are eligible for such grants;

''(C) require services proposed to be furnished through such a grant to support family-based treatment and other services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

''(D) not require that services furnished through such a grant be provided solely to women that reside in facilities;

''(E) not require that grant recipients under the program make available through use of the grant all services described in subsection (d); and

''(F) consider not applying requirements described in paragraphs (1) and (2) of subsection (f) to applicants, depending on the circumstances of the applicant.

''(3) REQUIRED SERVICES.—

''(A) IN GENERAL.—The Director shall specify a minimum set of services required to be made available to eligible women through a grant awarded under the pilot program under this subsection. Such minimum set—

''(i) shall include requirements described in subsection (c) and be based on the recommendations submitted under subparagraph (B); and

''(ii) may be selected from among the services described in subsection (d) and include other services as appropriate.

''(B) STAKEHOLDER INPUT.—The Director shall convene and solicit recommendations from stakeholders, including State substance abuse agencies, health care providers, persons in recovery from substance abuse, and other appropriate individuals, for the minimum set of services described in subparagraph (A).

''(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

''(5) EVALUATION AND REPORT TO CONGRESS.—The Director of the Center for Behavioral Health Statistics and Quality shall fund an evaluation of the pilot program at the conclusion of the first grant cycle funded by the pilot program. The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on such evaluation. The report shall include at a minimum outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs; engagement in treatment services; retention in the appropriate level and duration of services; increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and other appropriate measures.

''(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term 'State substance abuse agency' means, with respect to a State, the agency in such State that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.''.

(b) FUNDING.—Subsection (s) of section 508 of the Public Health Service Act (42 U.S.C. 290bb–1), as amended by section 2 and redesignated by subsection (a), is further amended by adding at the end the following new sentence: ''Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.''.

SEC. 4. CUT-GO COMPLIANCE.

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by striking ''through 2018'' and inserting ''through 2016, $133,300,000 for fiscal year 2017, and $138,300,000 for fiscal year 2018''.

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 may 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.

Mr. Speaker, I rise in support of H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act of 2015, introduced by my colleagues on the Energy and Commerce Committee, Mr. BEN RAY LUJÁN of New Mexico, Mr. TONKO of New York, Ms. CLARKE of New York, Ms. MATSUI of California, and Mr. CÁRDENAS of California.

In most instances, withdrawal or detoxification is not clinically appropriate for pregnant women with opioid use disorders. The withdrawal symptoms associated with discontinuing opioid use in pregnant women can lead to miscarriage or other negative birth outcomes. Buprenorphine and methadone can be used to treat a woman's opioid use disorder while pregnant. Such treatment can result in improved outcomes for both mothers and babies.

Unfortunately, babies exposed to opioids in utero may be born with neonatal abstinence syndrome, NAS, which refers to medical issues associated with opioid withdrawal in newborns. Mothers suffering from opioid use disorder may be sent home with babies who have NAS with very little guidance or support, which can have negative consequences for their babies.

NAS can result from the use of prescription opioids as prescribed for medical reasons, abuse of prescription opioid medication, or the use of illegal opioids like heroin.

The grant program reauthorized in H.R. 3691 helps support residential treatment facilities where women and their children receive support, education, treatment, and counseling that they need to address opioid addiction and NAS. The newly created pilot program will allow States more flexibility in providing these services for women and children in need.

Mr. Speaker, I urge my colleagues to support this legislation.

I reserve the balance of my time.

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

Mr. Speaker, I rise and voice my support for H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act. The Pregnant and Postpartum Women—PPW—program is administered by the Substance Abuse and Mental Health Services Administration—SAMHSA—Center for Substance Abuse Treatment.

The program was designed to expand the availability of comprehensive residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women and their children. The program provides grants to public and nonprofit private entities to provide substance use disorder treatment to women in residential facilities.

For too long our laws have taken a punitive approach with pregnant women and new mothers suffering from addiction. Criminal approaches have failed to work. Solutions should emphasize a nonpunitive, public health approach like the PPW program.

Substance abuse treatment that supports the family as a unit has proven effective for maintaining sobriety and enhancing child well-being. Given the magnitude of this epidemic, there is a need for increased availability of treatment options that are responsive to women's complex responsibilities.

H.R. 3691 reauthorizes residential treatment programs for pregnant and postpartum women. This vital program provides for substance use treatment for women in need as well as their minor children. Family-based treatment services include individual and family counseling, prenatal and postpartum care, and training on parenting.

The bill will also create a pilot program to allow up to 25 percent of the grants to be made for outpatient treatment services. This will give State substance abuse agencies greater flexibility to provide access to treatment and address gaps in delivery of care for pregnant and postpartum women, including services in nonresidential settings, and encourage new approaches of services available to pregnant women along the continuum of care.

I want to thank the bill's sponsor, Representative BEN RAY LUJÁN, who is a member of the Energy and Commerce Committee and the Health Subcommittee, for his leadership in introducing this bill.

I urge my colleagues to support the Improving Treatment for Pregnant and Postpartum Women Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 3691 so that pregnant and postpartum women can receive comprehensive, residential substance abuse treatment when fighting opioid drug addiction.

According to the National Perinatal Association, 4 percent of all live births in the U.S. occur in women who abuse illicit or prescription drugs, such as

opioid pain relievers. This would equate to 159,436 births in 2014 from women who abuse illicit or prescription drugs.

This is simply unacceptable. We must take action to ensure that pregnant and postpartum women receive the care they need to protect American families.

H.R. 3691 simply states that support should be extended for residential substance abuse treatment programs for pregnant and postpartum women through 2020 and the Center for Substance Abuse Treatment should carry out a pilot program to make grants to State substance abuse agencies to support services for pregnant and postpartum women who have a substance abuse disorder.

By extending these services and working through this pilot program, we can ensure that pregnant and postpartum women can receive the care that they need so that they can care for their families. That is why I am supporting H.R. 3691.

I encourage my colleagues to support this bill so we can extend care to all mothers and soon-to-be mothers who fight drug addiction.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentleman from New Mexico (Mr. BEN RAY LUJÁN), the cosponsor of the bill.

Mr. BEN RAY LUJÁN of New Mexico. Mr. Speaker, I would like to start by thanking the chairman and ranking member of the Energy and Commerce Committee and the Subcommittee on Health for their bipartisan efforts to address the Nation's drug crisis and for advancing my legislation, the Improving Treatment for Pregnant and Postpartum Women Act.

Our Nation continues to face a substance abuse crisis that is tearing apart communities and families. In New Mexico, we have seen a crisis that is multi-generational, with people growing up in communities where abuse is commonplace.

The grant program for residential treatment that my bill enhances is an important part of our effort to break the cycle of drug abuse that grips our communities. My bill would also increase funding for the Pregnant and Postpartum Women grant.

As originally written, my bill contained an authorization of $40 million, significantly above the current level, to avoid any cuts to existing residential programs. Through bipartisan cooperation, we arrived at a small increase over the next 5 years.

By focusing on women with young children and soon-to-be mothers, we help ensure that these families get on the right path from the very beginning. People want to be better. But, unfortunately, too often there are too few resources and avenues for help.

Certainly this is true in New Mexico, which is among the States most impacted by the epidemic plaguing our country. Too many people are suffering, and too many people are being shut out from access to help.

This bill helps address this by creating a demonstration project in the existing Pregnant and Postpartum Women grant program to allow grants to be used for nonresidential care.

Residential programs are critically important where they are available. In my home State of New Mexico, there are far too few residential programs to serve the needs of my constituents. In addition, many of the existing facilities have wait lists. With New Mexico's vastness, residential facilities are out of reach for too many.

That is why this demonstration project is critical. It will allow us, while continuing to support residential treatment programs, to explore how to ensure the services and care we are providing work for those in need.

While I am pleased that we have been able to work together across the aisle in an effort to authorize increased funding and ensure the inclusion of the demonstration project, I think it is important to say more must be done.

Supporting residential facilities and innovation to make treatment more available is essential, and both will require significant investments.

Mr. Speaker, in 2014, 47,055 people died from drug overdoses. That is 129 people per day. We must do more.

I hope that, as we continue this conversation beyond today, we can all come to recognize the need for funding above and beyond what we are doing today.

I respectfully ask for support of this bill.

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

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentlewoman from Texas (Ms. JACKSON LEE), my colleague and neighbor from Houston.

Ms. JACKSON LEE. Mr. Speaker, let me congratulate the gentleman from Texas for his leadership and the gentleman from New Mexico for his outstanding leadership on this important legislation and his concern and passion.

Let me thank my friends who are managing the legislation and let the American people know and our colleagues know that we are continuing our commitment on dealing with the issues of addiction, in this instance, opioid. And, of course, we know that there are other forms of addiction, from alcohol, to crack, to cocaine, but we are moving forward.

I rise to support H.R. 3691, the Improving Treatment for Pregnant and Postpartum Women Act of 2015. It is clear that this is an issue that has plagued both the woman and as well the newborn baby.

Let me offer to say that President Obama has updated that guideline to encourage doctors to be more cautious when prescribing opioid painkillers and to emphasize nonopioid therapies for certain conditions. Many times women who are pregnant are under treatment.

Additionally, the Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services. In the President's FY 2017 budget, the administration proposed $1.1 billion to combat drug addition considering modifying certain rules to improve treatment.

As misuse of opioids have increased over the past decade, so has the incidence of neonatal abstinence syndrome, referring to the medical effects on newborn infants suffering from drug withdrawal because their mothers were drug addicts.

The GAO report found that a lack of available treatment programs for pregnant women and newborns with neonatal abstinence syndrome, including the availability of comprehensive care and enabling services, such as transportation and child care, has hampered Federal efforts to address the issue.

□ 1730

I am glad that this bill, which is why I rise to support it, reauthorizes residential treatment grant programs for pregnant and postpartum women who have substance abuse problems—programs that are administered by the Health and Human Service Department's Center for Substance Abuse Treatment, increasing the authorized funding level by 6 percent. This gives me an opportunity to say that, with regard to all of these bills, I know that we will all join together to make sure the right funding is available for these bills to really work.

I join in support of this legislation and add to it legislation that I have introduced, Improving Safe Care for the Prevention of Infant Abuse and Neglect Act, and, which I introduced recently, the Stop Infant Mortality and Recidivism Reduction Act of 2016, which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders by establishing a pilot program of critical stage development nurseries in Federal prisons for children born to inmates. Likewise, at that time, one may discover the concerns that are being expressed here today.

However, the Improving Treatment for Pregnant and Postpartum Women Act of 2016, also establishes a pilot program to provide grants to State substance abuse agencies to promote innovative service delivery models for pregnant women who have a substance use disorder, such as opioid addiction, including for family-based services in nonresidential settings.

This is a good bill because it is more than the adult who is being treated here. It is a good bill because we are concerned about the newborn, the innocent baby who needs to have a start in life. In this instance, this legislation will both treat the mother and provide assistance—residential and nonresidential care—so that these individuals can have the starts in life that they need.

Let us be reminded of the fact that this addiction of these drugs becomes

an illness. We have seen overdoses that cause the loss of life. Let us be part of stemming the tide, but, more importantly, let us help those who are trying to hang onto life and to start a new life. This legislation does that, and I ask my colleagues to support it.

Again, I thank the gentleman from Texas for his leadership, and I thank him for yielding to me.

Mr. Speaker, I rise in support of H.R. 3691, the ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' that was approved by the Energy and Commerce Committee.

In the past decade and a half, the growth in the number of physicians prescribing opioids to help patients deal with pain from surgeries, dental work and chronic conditions has resulted in an increasing number of patients becoming dependent on the powerful and highly addictive painkillers—with patients not only abusing the use of those painkillers but often turning to heroin once their opioid prescription ended.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States.

It is estimated that in 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

The Health and Human Services Department estimates that the number of unintentional overdose deaths from prescription painkillers almost quadrupled between 1999 and 2013.

Abuse of prescription opioids now kills nearly 30,000 Americans each year.

Both states and the federal government have begun responding to this growing public health crisis, with many states moving to make anti-overdose drugs more available and shield first-responders from liability in administering those drugs.

President Obama, meanwhile, has updated prescribing guidelines to encourage doctors to be more cautious when prescribing opioid painkillers and to emphasize non-opioid therapies for certain conditions.

Additionally, the Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services.

In the president's FY 2017 budget the administration proposed $1.1 billion to combat drug addiction, considering modifying certain rules to improve treatment.

As misuse of opioids has increased over the past decade, so has the incidence of neonatal abstinence syndrome, referring to the medical effects on newborn infants suffering from drug withdrawal because their mothers were drug addicts.

A 2015 Government Accountability Office (GAO) report found that a lack of available treatment programs for pregnant women and newborns with neonatal abstinence syndrome, including the availability of comprehensive care and enabling services such as transportation and child care, has hampered federal efforts to address the issue.

This bill reauthorizes residential treatment grant programs for pregnant and postpartum women who have substance abuse problems that are administered by the Health and Human Services (HHS) Department's Center for Substance Abuse Treatment, increasing the authorized funding level by 6%.

Seeking to right the same wrongs as H.R. 4843, the ''Improving Safe Care for the Prevention of Infant Abuse and Neglect Act,'' I introduced the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016,'' or the ''SIMARRA Act,'' which will help the Federal Bureau of Prisons to improve the effectiveness and efficiency of the Federal prison system for pregnant offenders, by establishing a pilot program of critical-stage, developmental nurseries in Federal prisons for children born to inmates.

It is time that our nation recognizes a long-persistent need to break the cycle of generational, institutional incarceration amongst mothers serving time for non-violent crimes and the children they birth behind prison bars.

H.R. 5130, the, ''SIMARRA Act of 2016,'' gives those infants born to incarcerated mothers a chance to succeed in life.

''SIMARRA'' is not merely yet another second chance program, demanding leniency from the criminal justice system.

Instead, H.R. 5130 asks our national criminal justice system what it can do for those young Americans born and relegated to a life of nearly impossible odds of survival.

''SIMARRA'' provides that first chance—a first chance for American infants—that many of their mothers, born themselves to mothers behind bars, never received.

The ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' also establishes a pilot program to provide grants to state substance abuse agencies to promote innovative service delivery models for pregnant women who have a substance use disorder, such as opioid addiction, including for family-based services in nonresidential settings.

Of the amounts appropriated for the HHS residential treatment program, up to 25% would be available to carry out the pilot program.

No funds would be made available to carry out the pilot program for a fiscal year, however, unless the amount made available to carry out the residential treatment program for the fiscal year is more than the comparable amount made available for FY 2016.

The Senate on March 10, 2016, passed by a 94–1 vote, S 524, an antiopioid abuse bill that would authorize grants for opioid treatment services and first-responder training in using anti-overdose drugs, as well as create a task force to review and update best practices for prescribing pain medication.

The measure offsets the increased authorization through a $5 million reduction in the existing FY 2017 authorization for Centers for Disease Control (CDC) public health capability enhancement activities.

Under current law, $138.3 million is authorized for those activities each year through FY 2018.

The Congressional Budget Office (CBO) has not yet released a cost estimate for the bill.

H.R. 3691 would also mandate investigations into heroin distribution and unlawful distribution of prescription opioids, and require the creation of a national drug awareness campaign that takes into account the association between prescription opioid abuse and heroin use.

This week we are scheduled to consider a series of more than a dozen bills that address the opioid abuse problem facing America.

This measure reauthorizes grants from HHS's Center for Substance Abuse Treatment to public and nonprofit private entities that provide residential substance abuse treatment for pregnant and postpartum women, authorizing $16.9 million each year through FY 2021—$1 million (6%) more than the current $15.9 million authorization.

Under the pilot grant program, proposed services for eligible pregnant and postpartum women would not have to be provided solely to women who reside in facilities.

However, the center must specify a minimum set of services, including substance abuse counseling, and it must solicit stakeholder input.

The bill directs HHS's Center for Behavioral Health Statistics and Quality to fund an evaluation of the pilot program at the conclusion of the first grant cycle.

Under the program, grant recipients are required to provide an individualized plan of services for each participating woman that includes substance abuse counseling and certain supplemental services, such as pediatric health care for the woman's children.

The measure directs the Center for Substance Abuse Treatment to carry out a five-year pilot grant program to help state substance abuse agencies address identified gaps in the services that are furnished to pregnant and postpartum women with substance abuse issues, and encourage new approaches and models of service delivery.

H.R. 3691, the ''Improving Treatment for Pregnant & Postpartum Women Act of 2015,'' is a valuable piece of legislation that I encourage my colleagues to support.

Additionally, I urge my colleagues to join me in sponsoring and supporting all legislation targeting the improvement of care for the prevention of infant abuse and neglect, such as H.R. 5130, the, ''Stop Infant Mortality and Recidivism Reduction Act of 2016'' or the ''SIMARRA Act.''

Mr. GENE GREEN of Texas. Mr. Speaker, I have no further requests for time.

I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I encourage all of my colleagues to vote for H.R. 3691.

I yield back the balance of my time.

The SPEAKER pro tempore (Mr. JODY B. HICE of Georgia). 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. 3691, 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.

VETERAN EMERGENCY MEDICAL TECHNICIAN SUPPORT ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1818) to amend the Public Health Service Act to provide grants to States to streamline State requirements and procedures for veterans with military emergency medical training to become civilian emergency medical technicians, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1818

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 ''Veteran Emergency Medical Technician Support Act of 2016''.

SEC. 2. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN EMERGENCY MEDICAL TECHNICIANS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

''SEC. 315. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN EMERGENCY MEDICAL TECHNICIANS.

''(a) PROGRAM.—The Secretary shall establish a program consisting of awarding demonstration grants to States to streamline State requirements and procedures in order to assist veterans who completed military emergency medical technician training while serving in the Armed Forces of the United States to meet certification, licensure, and other requirements applicable to becoming an emergency medical technician in the State.

''(b) USE OF FUNDS.—Amounts received as a demonstration grant under this section shall be used to prepare and implement a plan to streamline State requirements and procedures as described in subsection (a), including by—

''(1) determining the extent to which the requirements for the education, training, and skill level of emergency medical technicians in the State are equivalent to requirements for the education, training, and skill level of military emergency medical technicians; and

''(2) identifying methods, such as waivers, for military emergency medical technicians to forgo or meet any such equivalent State requirements.

''(c) ELIGIBILITY.—To be eligible for a grant under this section, a State shall demonstrate that the State has a shortage of emergency medical technicians.

''(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

''(e) FUNDING.—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.''.

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 may have 5 legislative days in which to revise and extend their remarks and to insert extraneous materials into the RECORD.

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 in support of H.R. 1818, the Veteran Emergency Medical Technician Support Act of 2016, introduced by my colleagues on the Committee on Energy and Commerce—Mr. KINZINGER from Illinois and Mrs. CAPPS from California.

Members of the U.S. military who trained as combat medics face State licensing challenges when they try to find similar work after discharge. Many States do not recognize their qualifications as being applicable to the licensing requirements of the civilian healthcare system for emergency medical services, such as EMTs or paramedics. State licensing laws vary, and while some States make exceptions for former military medics to allow for reciprocity and a chance to sit for the licensing exam without repeating their training, many States do not.

This legislation would provide grants to States with emergency medical technician shortages so as to help streamline State requirements for veterans to enter the EMT workforce without there being an unnecessary duplication of their training. This will help them more easily transition to their becoming civilian EMTs.

I urge my colleagues to support this legislation.

Mr. Speaker, 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. 1818, the Veteran Emergency Medical Technician Support Act.

Our Nation's servicemen and -women receive some of the best medical training and experience in emergency medicine while serving our country. Their commitment to duty, training, real-world experience, and ability to work effectively in challenging environments make them exceptionally well suited for working as emergency medical technicians, EMTs, upon their return to civilian life.

However, experienced military medics who want to work in civilian EMT jobs are often required to repeat their medical training at the most basic level to receive certification in order to be hired. Depending on the State, a returning veteran may have to obtain or renew their EMS license. The requirements can vary significantly by State. This is an unnecessary impediment for both our service personnel and our communities that are in need of qualified emergency medical service personnel. We should not be keeping veterans out of the workforce and withholding valuable medical personnel from supporting our communities.

According to the Bureau of Labor Statistics' Occupational Outlook Handbook, approximately 55,000 new civilian EMT and paramedic jobs have already been or will be created between 2012 and 2022. Highly skilled and properly trained veterans are well positioned to fill these essential provisions.

H.R. 1818 will authorize a demonstration grant program for States to streamline certification and licensure requirements for returning veterans with military EMT training so they can work as civilian EMTs as quickly as possible. Streamlining the licensing process will make it easier for the civilian EMS community to hire experienced combat medics. This is not only beneficial to our veterans, but also to our communities, and it will enhance the level of care that is provided to our citizens.

I thank the bill's sponsors—Representative LOIS CAPPS, who is a member of the Committee on Energy and Commerce and of our Subcommittee on Health, and Congressman ADAM KINZINGER—for introducing and championing this legislation.

I urge my colleagues to support the Veteran Emergency Medical Technician Support Act.

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

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. KINZINGER), my colleague and good friend on the Committee on Energy and Commerce, who is a veteran Air Force pilot himself.

Mr. KINZINGER of Illinois. I appreciate the gentleman for yielding.

Mr. Speaker, the Veteran Emergency Medical Technician Support Act will help our veterans and our communities by assisting States in reducing burdens for military medics who want to become civilian EMTs.

Emergency medical technicians are an important part of the medical workforce and, as first responders, are critical to our goal of combating the thousands of opioid overdoses each year. EMTs respond to hundreds of thousands of overdoses. In 2014 alone, EMTs responded to 240,000 calls at which naloxone was administered.

According to the Department of Labor, the demand for EMTs and paramedics is expected to increase by 33 percent by the year 2020. This expected shortage is on top of some communities that are already reporting a shortage of EMTs.

My legislation, H.R. 1818, the Veteran EMT Support Act, works to address this by helping States to streamline requirements and procedures in order to assist veterans who completed military EMT training in the Armed Forces to meet the certification, the licensure, and other requirements to become civilian EMTs.

Although some service branches train military medics to EMT national certification standards, States generally have required additional training for State licensure. This creates a barrier for servicemembers who have received some of the best EMT training and have practiced their profession on the battlefield.

The Veteran EMT Support Act is a commonsense way to help veterans transition into the civilian workforce, improve public health, and ensure communities have highly qualified, professional men and women to answer challenging emergency calls like opioid overdoses.

I thank Congresswoman CAPPS for her strong support and advocacy of this

legislation, and I thank my colleagues on both sides of the aisle. I urge my colleagues on both sides of the aisle to vote in favor of this legislation.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. I thank my colleague for yielding.

Mr. Speaker, I rise in support of H.R. 1818, the Veteran Emergency Medical Technician Support Act.

As the ranking member of our committee just said, our military medics receive some of the best technical training in emergency medicine on the battlefield, and it is proven in extreme circumstances. However, when these medics return home and attempt to apply their skills to work in the civilian EMT sector, they are often forced to start back at square one. Repeating coursework isn't just a waste of time, it is also incredibly expensive. Similarly, civilian EMTs who are also in the military or in the reserves often must let their civilian certifications lapse when they are deployed.

In either circumstance, this is an unfair burden on our military men and women who have bravely defended our country. It is also so shortsighted for our communities, which could benefit from their expertise. We need these valuable medical personnel to be working in our communities, especially as we now deal with this opioid crisis.

That is why I am so pleased to have again joined with my Republican colleague, Representative KINZINGER, to introduce the Veteran EMT Support Act. The bill is a small but straightforward effort to help States streamline their EMT certification processes to take military medic training into account for civilian licensure. It is the least we can do to help ensure that our military medics' transition home is a little bit easier, and it is the least we can do to ensure that our communities have the best civilian first responder personnel working for them.

I thank Chairmen UPTON and PITTS and Ranking Members PALLONE and GREEN and their staffs for their support in getting this bill to the floor. I urge my colleagues to support it.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. COSTELLO).

Mr. COSTELLO of Pennsylvania. Mr. Speaker, I rise in support of H.R. 1818, the Veteran Emergency Medical Technician Support Act. I thank Congressman KINZINGER for his leadership on this bill. I also recognize the chief operations officer for the Western Berks EMS, in my district, Ed Moreland, who came to my office and shared with me what this bill was all about.

It is a very easy bill to support. Not only is it an easy bill to support, but it is a very important, valuable bill for me and other Members to support because in my State of Pennsylvania where I used to be a county commissioner and, before that, a township supervisor, we would see firsthand the very valuable role that EMTs and paramedics provide to local communities. We also know that there is a demand for more EMTs and paramedics. In fact, over the next 8 years, it is estimated that there will be another 40,000 EMTs and paramedics that we will need in this country.

I have the honor to serve on the House Committee on Veterans' Affairs. One of the things on which we focus on that committee is to work to find innovative solutions to help our veterans find successful careers when they return home and to utilize the skills that many servicemen and servicewomen obtain and possess during their service. Indeed, many of the best training and experience that military men and women get overseas is in the area of emergency medicine.

When one looks at what it takes to be an EMT—the education, training, skill level, and what is required in the Commonwealth of Pennsylvania and in many other States—you realize that there is an equivalency that many veterans already have, which they obtained while serving in the military.

This bill seeks to streamline the process so that if a veteran already has the training, the education, the skill level, the experience, we can basically not require that veteran to spend more time and more money going through the process of obtaining a certification. Instead, we can get him into the practice of actually serving his community and working in a professional environment. It gets qualified veterans to work quicker. It also fills the communities' safety needs quicker.

It is commonsense, bipartisan legislation to address the demand for qualified professionals in our communities, and it provides veterans with good job opportunities. It is why I encourage my colleagues to support it. It is why I commend Congressman KINZINGER and why I thank Ed Moreland of the Western Berks EMS for bringing this to my attention.

□ 1745

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 urge all my colleagues to vote for H.R. 1818.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 1818, the "Veteran Emergency Medical Technician Support Act of 2015," which emphasizes the necessity to add requirements and procedures that assist veterans with military EMT training to meet state EMT certification, licensure, and other requirements.

I support this legislation, because it benefits states with a shortage of emergency medical technicians.

H.R. 1818 allows veterans to reenter society and assist the helpless within the emergency medical community.

The bill enables the Public Health Service Act to direct the Department of Health and Human Services in an efficient approach for veteran assistance.

Specifically, H.R. 1818 requires the secretary to establish a program consisting of awarding demonstration grants to states to streamline state requirements and procedures.

H.R. 1818 determines the extent to which the requirements for education, training, and skill level of emergency medical technicians are equivalent to the requirements for military emergency medical technicians.

The bill identifies methods to facilitate the attainment of state requirements for military emergency medical technicians.

For proper usage of the grant provided by the bill, a state shall demonstrate its shortage of emergency medical technicians.

This bill introduces a feasible alternative for veterans within the community.

With consistent experience in high pressure situations and emergency environments, veterans are the appropriate choice for this profession.

This is a comprehensive bill that will simultaneously provide opportunity for veterans while alleviating the shortage of staff in a medical specialty involving care for undifferentiated and unscheduled patients with illnesses or injuries requiring immediate medical attention.

I urge all Members to join me in support of H.R. 1818.

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. 1818, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. GUTHRIE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

JOHN THOMAS DECKER ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4969) to amend the Public Health Service Act to direct the Centers for Disease Control and Prevention to provide for informational materials to educate and prevent addiction in teenagers and adolescents who are injured playing youth sports and subsequently prescribed an opioid, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4969

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 ''John Thomas Decker Act of 2016''.

SEC. 2. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

(a) TECHNICAL CLARIFICATION.—Effective as if included in the enactment of the Children's Health Act of 2000 (Public Law 106–310), section 3405(a) of such Act (114 Stat. 1221) is amended by striking ''Part E of title III'' and inserting ''Part E of title III of the Public Health Service Act''.

(b) AMENDMENT.—Title III of the Public Health Service Act is amended by inserting after part D of such title (42 U.S.C. 254b et seq.) the following new part E:

"PART E—OPIOID USE DISORDER

"SEC. 341. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

''(a) REPORT.—The Secretary shall—

''(1) not later than 24 months after the date of the enactment of this section, make publicly available a report determining the extent to which informational materials and resources described in subsection (b) are available to teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups; and

''(2) for purposes of educating and preventing addiction in teenagers and adolescents who are injured playing youth sports and are subsequently prescribed an opioid, not later than 12 months after such report is made publicly available and taking into consideration the findings of such report, develop and, in coordination with youth sports groups, disseminate informational materials and resources described in subsection (b) for teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups.

''(b) MATERIALS AND RESOURCES DESCRIBED.—For purposes of this section, the informational materials and resources described in this subsection are informational materials and resources with respect to youth sports injuries for which opioids are potentially prescribed and subsequently potentially lead to addiction, including materials and resources focused on the dangers of opioid use and misuse, treatment options for such injuries that do not involve the use of opioids, and how to seek treatment for addiction.

''(c) NO ADDITIONAL FUNDS.—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.''.

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 to revise and extend their remarks and to include any extraneous material 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 rise today in support of H.R. 4969, the John Thomas Decker Act of 2016, introduced by my colleagues, Mr. MEEHAN of Pennsylvania, Mr. KIND of Wisconsin, Mr. ROONEY of Florida, and Mr. VEASEY of Texas.

Young athletes have been disproportionately impacted by the opioid epidemic currently plaguing our country. One study found that adolescent males who played sports were twice as likely to be prescribed opioids than their peers and four times more likely to abuse them than nonathletes. Writing a prescription for opioids in a population that may not fully grasp the risk associated with the drugs can be dangerous and lead to unintended negative outcomes.

H.R. 4969 amends the Public Health Service Act to direct the Secretary of Health and Human Services to study what information and resources are available to youth athletes and their families regarding the dangers of opioid use and abuse, nonopioid treatment options, and how to seek additional addiction treatment.

The Secretary would then be required to report the findings and work with stakeholders to disseminate resources to students, parents, and those involved in treating a sports-related injury.

Mr. Speaker, I urge my colleagues to support this legislation.

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. 4969, the John Thomas Decker Act.

A crisis of this magnitude requires a multiprong, robust response across the full continuum of those exposed to and affected by addiction. People suffering from addiction are originally prescribed or exposed to opioids in a wide variety of circumstances, one of which is through youth sports injuries.

H.R. 4969, the John Thomas Decker Act, will bring needed education on the danger of opioids and the benefits of alternative approaches to pain treatment to youth sports.

The John Thomas Decker Act will direct the Centers for Disease Control and Prevention and the National Center for Injury Prevention to examine and report on what informational materials and resources are currently available to teenagers and adolescents participating in sports on the dangers of opioid use and misuse, alternative treatment options, and how to seek treatment for addiction.

Based on the findings of this report, the legislation directs the CDC and the National Center for Injury Prevention to develop and disseminate such informational materials as necessary.

Young people playing sports who incur an injury for which painkillers are frequently prescribed can be uniquely vulnerable to addiction if they or their parents, guardians, and coaches are not well informed of the potential for misuse, abuse, and addiction.

H.R. 4969 will play a role in helping curb the epidemic opioid abuse and heroin use by ensuring adequate and appropriately tailored resources for our Nation's youth.

I thank the bill sponsor, Representative MEEHAN, for introducing this legislation. I encourage my colleagues to support the John Thomas Decker Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 5 minutes to the gentleman from Pennsylvania (Mr. MEEHAN).

Mr. MEEHAN. Mr. Speaker, I thank my colleagues from both sides of the aisle for their strong support of this very, very important bill, which will use the resources of the Centers for Disease Control in very important outreach to young people, particularly student athletes.

Now, we have heard heart-wrenching stories all day long about the tremendous growth of the use of opioids. In fact, 207 million prescriptions were written in 2013 for opioids. Unfortunately, that has led to about 2.1 million Americans who are hooked on opioids.

And when the opioid is not available, we have begun to see them switch to a cheaper alternative, which is heroin. 450 million Americans are currently hooked on heroin.

I know in my own State of Pennsylvania we lose seven people a day to heroin addiction. We are seeing it in the important nature of the comprehensive bills that have been put forward today. We are seeing it in veterans. Many are coming back with traumatic injury and are finding release in the opioids. We are seeing it in pregnant mothers and the impact that it has in children. One of the single biggest increase is in women, mothers who are over 30.

One of the niches that is often underappreciated, but remarkably dangerous, is young student athletes. The reason being is that young student athletes are more inclined than just about anybody else to suffer sports-related injuries. Some of those injuries can be serious, and what we are seeing is a high rate of prescription of opioids for some of these athletes.

Now, in the NCAA, you have a little bit more oversight. Even there, we see abuse. Almost 26 percent of college-level athletes will use opioids at some point in time, many without prescriptions.

Where the real danger comes down is at the high school level. I have the good privilege of chairing one of the youth sports caucuses with my good friend, Mr. KIND of Wisconsin. We deal with a broad variety of issues promoting healthy activity and youth sports, but we are seeing a piece of this challenge right now in which we are watching the opioid addiction and problems with young athletes.

Eleven percent of high school athletes will use painkillers without a prescription. That is something that I talked to one of the trainers in my high school, a student trainer, about how kids who want to play in the game will hide their injuries and self-medicate. What a danger that is.

This brings me to the young man who inspired this bill, the John Thomas Decker Act. This is John Thomas Decker. I had the privilege of knowing John personally and knowing his wonderful family.

John was an incredible athlete. I watched him play football. He set a receiving record that was held for nearly a decade in our region of Pennsylvania.

He went on to play lacrosse at Cornell University in a program that won

a national championship. So John was the consummate blue-chip athlete and a wonderful kid to boot. He was a great student and a great leader.

But John, like so many other kids, fought through the pain because he wanted to play. So what he did was he self-medicated and began to deal with the issue of opioid addiction.

Now, John worked his way through it as an athlete, but later in life returned again to using opioids and, ultimately, heroin. Ultimately, it led to his death.

His story inspired me to say we have to do something about it because many high school kids just like John who are playing through the pain believe that, because they are using the opioids and because they are prescription medicines, somehow there is no danger of any kind of addiction or otherwise, that somehow it is nowhere near as dangerous as heroin. Yet, it is unfortunately too easy.

In fact, one of the other misconceptions is: I don't have to worry about a dependency. But the medical authorities have confirmed that daily use for even a short period of time, just a few weeks or even days, can create the kind of psychological dependency in which there is the beginning of the misuse of the opioids.

One of the things we begin to see as well is, as the opioid begins to lose its protective effect, they will take more and higher doses in order to have the same pain-killing capacity. So they start to move further on down the chain.

Oftentimes they are able to kick it for a period of time. But when they come back, they will go back to using the opioid at the higher level than they once did before. Imagine the implication of that.

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

Mr. GUTHRIE. Mr. Speaker, I yield an additional 2 minutes to the gentleman from Pennsylvania.

Mr. MEEHAN. Mr. Speaker, the CDC is in a position now to be able to utilize the resources it has to do a better study of making sure that we are aware of the information and resources that are being made available to those who are in the privity of relationship with these students—these can be coaches; these can be school nurses; these can be the students themselves—and then come up with a plan for us to be able to distribute this in an effective manner, all the way down through the network.

There can be appropriate use under medical care with the kind of attention to concerns about addiction so that, where there is legitimate pain—we don't want to suggest that there is never a use, but this will now create the kinds of guidelines in which there is genuine oversight if opioids are introduced.

This will also give the kinds of guidelines to local trainers and others, even local physicians, about taking more time to assess the backgrounds of individuals that they are giving the opioids to, not appreciating perhaps that a young man may be dealing with depression or other kinds of things, a binge drinker in association with that opioid that could lead to death.

All of these things are things that could be part of the CDC's approach to doing much better education so that we can prevent the next young star athlete like John from coming into opioid addiction and ultimately leading to his demise.

Let us let John's voice be heard. Let us use this as the opportunity to ensure that future student athletes are not addicted to opioids.

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 Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman from Kentucky for his work on this bill.

I rise today in support of H.R. 4969 because opioid addiction does not discriminate based on age.

H.R. 4969 requires the CDC to report on information regarding prescription opioid abuse after youth sports injuries. According to a study by the National Council on Alcoholism and Drug Dependence, 12 percent of male athletes and 8 percent of female athletes have used prescription opioids in the last 12 months.

According to the U.S. Substance Abuse and Mental Health Services Administration, 80 percent of these teenagers and adolescents made the switch to heroin after abusing opioid painkillers, according to the U.S. Substance Abuse and Mental Health Services Administration. This is completely unacceptable and 100 percent preventable.

Every effort should be made to ensure that our youth are protected from the trap of drug abuse. That is why I am supporting H.R. 4969. We need all the information available so we can take the right steps to ensure our youth are protected.

I encourage my colleagues to support this 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 urge my colleagues to vote for H.R. 4969.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in strong support of H.R. 4969, the "John Thomas Decker Act of 2016."

Our nation values the importance of transparency and availability of public information regarding prescription drugs.

This bill amends the Public Health Service Act to require the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention to report on the availability of information regarding prescription of opioids after youth sports injury.

This report includes the information on opioid use and misuse, injury treatments that do not involve opioids, and treatment for opioid addiction.

The report must determine the extent this information is available to teenagers and adolescents who play youth sports, their families, youth sports groups, and health care providers.

Opioids are drugs with effects similar to opium, such as heroin and certain pain medications.

In addition to stimulants and central nervous system (CNS) depressants, prescription opioids are one of the three main broad categories of medications that present abuse liability.

Due to prescription opioids' similarity to heroin and morphine, they present an intrinsic abuse and addiction liability for non-medical purposes.

Opioid, heroin, and morphine act on the same brain systems.

In an effort to increase their euphoric effects, the "high", people tend to take them in their most dangerous and addictive methods.

Understanding the dangers of these addictive drugs highlight the importance of John Thomas Decker Act, which increases awareness and educating the youth people of the adverse effects of opioids.

H.R. 4969 also allows for public transparency in making available public reports, informational materials, and resources are available to teenagers, their families, and health professionals.

Our country has acknowledged the importance of preventive healthcare and education within our nation.

Providing education to those directly or indirectly associated with opioid usage enables them to have control over their thoughts and actions, offsetting the potential for drug abuse.

I support this legislation because it will help protect the integrity of consumers through implementation of effective preventative strategies.

H.R. 4969 provides the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention with specific responsibilities for dissemination.

H.R. 4969 is a positive step in the right direction and I urge my colleagues to join me in supporting its passage.

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. 4969, 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.

□ 1800

LALI'S LAW

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4586) to amend the Public Health Service Act to authorize grants to States for developing standing orders and educating health care professionals regarding the dispensing of opioid overdose reversal medication without person-specific prescriptions, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4586

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 ''Lali's Law''.

SEC. 2. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

(a) TECHNICAL CLARIFICATION.—Effective as if included in the enactment of the Children's Health Act of 2000 (Public Law 106–310), section 3405(a) of such Act (114 Stat. 1221) is amended by striking ''Part E of title III'' and inserting ''Part E of title III of the Public Health Service Act''.

(b) AMENDMENT.—Title III of the Public Health Service Act is amended by inserting after part D of such title (42 U.S.C. 254b et seq.) the following new part E:

''PART E—OPIOID USE DISORDER

''SEC. 341. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

''(a) GRANTS TO STATES.—The Secretary may make grants to States for—

''(1) developing standing orders for pharmacies regarding opioid overdose reversal medication;

''(2) encouraging pharmacies to dispense opioid overdose reversal medication pursuant to a standing order;

''(3) implementing best practices for persons authorized to prescribe medication regarding—

''(A) prescribing opioids for the treatment of chronic pain;

''(B) co-prescribing opioid overdose reversal medication with opioids; and

''(C) discussing the purpose and administration of opioid overdose reversal medication with patients;

''(4) developing or adapting training materials and methods for persons authorized to prescribe or dispense medication to use in educating the public regarding—

''(A) when and how to administer opioid overdose reversal medication; and

''(B) steps to be taken after administering opioid overdose reversal medication; and

''(5) educating the public regarding—

''(A) the public health benefits of opioid overdose reversal medication; and

''(B) the availability of opioid overdose reversal medication without a person-specific prescription.

''(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders regarding opioid overdose reversal medication.

''(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary shall give preference to States that—

''(1) have not issued standing orders regarding opioid overdose reversal medication;

''(2) authorize standing orders that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer opioid overdose reversal medication;

''(3) authorize standing orders that permit police, fire, or emergency medical services agencies to acquire and administer opioid overdose reversal medication;

''(4) have a higher per capita rate of opioid overdoses than other applicant States; or

''(5) meet any other criteria deemed appropriate by the Secretary.

''(d) GRANT TERMS.—

''(1) NUMBER.—A State may not receive more than 1 grant under this section.

''(2) PERIOD.—A grant under this section shall be for a period of 3 years.

''(3) AMOUNT.—A grant under this section may not exceed $500,000.

''(4) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(5).

''(e) APPLICATIONS.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may require, including detailed proposed expenditures of grant funds.

''(f) REPORTING.—Not later than 3 months after the Secretary disburses the first grant payment to any State under this section and every 6 months thereafter for 3 years, such State shall submit a report to the Secretary that includes the following:

''(1) The name and ZIP Code of each pharmacy in the State that dispenses opioid overdose reversal medication under a standing order.

''(2) The total number of opioid overdose reversal medication doses dispensed by each such pharmacy, specifying how many were dispensed with or without a person-specific prescription.

''(3) The number of pharmacists in the State who have participated in training pursuant to subsection (a)(4).

''(g) DEFINITIONS.—In this section:

''(1) OPIOID OVERDOSE REVERSAL MEDICATION.—The term 'opioid overdose reversal medication' means any drug, including naloxone, that—

''(A) blocks opioids from attaching to, but does not itself activate, opioid receptors; or

''(B) inhibits the effects of opioids on opioid receptors.

''(2) STANDING ORDER.—The term 'standing order' means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.

''(h) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $5,000,000 for the period of fiscal years 2017 through 2019.

''(2) ADMINISTRATIVE COSTS.—Not more than 3 percent of the amounts made available to carry out this section may be used by the Secretary for administrative expenses of carrying out this section.''.

SEC. 3. CUT-GO COMPLIANCE.

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by inserting before the period at the end the following: ''(except such dollar amount shall be reduced by $5,000,000 for fiscal year 2017)''.

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.

Mr. Speaker, I rise today in support of H.R. 4586, Lali's Law, introduced by my colleagues in the House, the gentleman from Illinois (Mr. DOLD) and the gentlewoman from Massachusetts (Ms. CLARK).

The rate of overdose for individuals age 24 to 34 has nearly tripled, going from 8.1 overdose deaths per 100,000 to 23.1 overdose deaths per 100,000. Families across the country are losing loved ones to reversible opioid overdose. Naloxone is an opioid antagonist that can prevent opioid overdose deaths by binding to the opioid receptors in the body and preventing the overdose.

H.R. 4586 amends the Public Health Service Act to authorize grants to States for developing standing orders and educating healthcare professionals regarding the dispensing of opioid overdose reversal medication without person-specific prescriptions.

This legislation is a first step in promoting wider access of naloxone or other opioid overdose reversal drugs that may come to market. Standing orders are prescriptions that are not person-specific. If a pharmacy has a standing order, anyone needing the medication may come and fill a prescription for it.

Naloxone, while incredibly effective at stopping opioid overdose, does not have severe side effects if used incorrectly or if used when not needed. Many States have standing order laws in place but need help bridging the gap between law and a functioning program. The grants funded by this legislation will help aid that process.

Mr. Speaker, I urge my colleagues to support this legislation.

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. 4586, Lali's Law.

Mr. Speaker, between 2001 and 2014, there was a threefold increase in prescription drug overdoses and a sixfold increase in heroin overdoses in the United States. We must do more to prevent drug misuse and abuse to avoid these tragedies in the first place. We must also ensure that those suffering from addiction to prescription and nonprescription drugs have access to potentially lifesaving treatments when and where they need it.

Naloxone has proven to be a successful lifesaving intervention for patients presenting with overdose if administered quickly. When used, naloxone helps restore breathing that has been stopped by the overdose and has potential for saving thousands of lives each year.

H.R. 4586 would create a competitive grant program to help States increase access to overdose reversal medications. The primary purpose of the grant is to fund State programs that allow pharmacists to distribute overdose reversal drugs without a person-prescription to qualified individuals or entities.

To be effective, overdose reversal drugs must be given to the patient almost immediately. In an emergency situation, the ability for emergency medical technicians, law enforcement, substance abuse treatment providers, and qualified individuals to have such medications on hand can make the difference between life and death. Qualified individuals and entities often need

to possess treatment before a specific patient is identified.

Many States have established and use these programs to allow local law enforcement officers or emergency medical technicians to carry and use the overdose reversal drug naloxone. H.R. 4586 would expand these programs by helping States develop standing orders and educate healthcare professionals about dispensing these medications without person-specific prescriptions.

I want to thank the bill's sponsors, the gentlewoman from Massachusetts (Ms. CLARK) and the gentleman from Illinois (Mr. DOLD), for introducing this legislation. I urge my colleagues to join me in supporting H.R. 4586.

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

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER), my friend.

Mr. CARTER of Georgia. Mr. Speaker, I rise today in support of H.R. 4586 because it is critical that we educate healthcare professionals about opioid overdose reversal medications.

This bill allows the CDC to authorize grants to States based on their ability to educate healthcare professionals in dispensing opioid reversal medication. Specifically, this opioid reversal medication, called naloxone, can be used in emergency situations to stop an opioid overdose death.

Also, through this bill, pharmacists will be able to dispense naloxone to patients without a prescription, increasing access to this lifesaving antidote. This access will help save lives in emergency situations when patients do not have the time or ability to seek or receive professional medical care. The World Health Organization states that this increased access will save up to 200,000 lives.

As a lifelong pharmacist, I believe it is our duty to always educate Americans about the lifesaving tools available to them. I encourage my colleagues to support H.R. 4586 so more people can be educated and have access to lifesaving medication related to opioid overdose.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentlewoman from Massachusetts (Ms. CLARK), a cosponsor of the bill.

Ms. CLARK of Massachusetts. Mr. Speaker, I thank Representative DOLD for joining me in this legislation, and I also thank the family of Alex Laliberte for sharing their story. We offer our deepest sympathies.

Mr. Speaker, across Massachusetts and the Nation, too many parents are desperately trying to save their child from the deadly grip of the opioid crisis. In the past year alone, this public health crisis has claimed nearly 1,400 lives in the Commonwealth of Massachusetts. The bill before us today, Lali's Law, is a critical part of addressing this crisis.

Naloxone, commonly known as Narcan, is a lifesaving drug. It stops the effect of heroin within minutes after it is administered, and it allows breathing to resume. But it is critical that it is widely available.

Under this bill, States that have authorized a standing order that allows anyone to obtain naloxone from a pharmacist would be eligible for a grant that can be used for public education campaigns and training for healthcare providers and pharmacists.

I want to share the story of a family from my district that illustrates the difference training and the availability of Narcan can make.

One night, a 911 call came in, a desperate and frantic new mother with a very young baby who was unresponsive. The first responders arrived at the scene, but despite their best efforts, this baby was not reviving. A responding firefighter relied on his training and quick thinking to save this child's life by administering Narcan. It worked.

Even though the mom had not revealed that she was addicted to prescription painkillers, the first responder knew the symptoms and made the right guess and saved this child's life. If he had not been trained to administer Narcan and not had the lifesaving drug with him that night, that baby would not be alive. But the man was, and now the baby and mom have a future.

This crisis presents an urgent calling for all of us, Democrats and Republicans alike, to put aside our differences and do what we can to save lives. That is what we are talking about here: increasing the availability of Narcan will save lives.

I am happy to join with my friend from Illinois to offer this important bill. I urge all of my colleagues to support this legislation.

Mr. GUTHRIE. Mr. Speaker, I yield 5 minutes to the gentleman from Illinois (Mr. DOLD), my good friend.

Mr. DOLD. Mr. Speaker, I want to thank my good friend for yielding. I want to thank my friend from Massachusetts for her work on this legislation. Representative CLARK sharing that story is extremely powerful.

In the suburbs of Chicago, Mr. Speaker, somebody dies from using heroin every 3 days. Nationally, that statistic is 1 every 19 minutes. Every single one of them leaves behind a family in grief.

Today, Mr. Speaker, I am joined in the Chamber by Chelsea Laliberte, Jody Daitchman, and Gary Laliberte, the family of a young man from Buffalo Grove named Alex.

Alex graduated from Stevenson High School. He played sports. He got good grades and made a lot of friends. He was a typical teenager who had his whole life ahead of him. But behind his happy exterior, Alex was sick. He was struggling with escalating drug abuse.

During Alex's sophomore year in college, he came down with an unknown illness. He would go to the hospital, and he would get better—at least for a while. But then a few months later he would get sick. He would be admitted to the hospital and again would repeat the cycle. His family didn't know it then, but Alex was dependent on prescription drugs and was suffering from withdrawal.

Alex continued this pattern until just a few days before his final exams. At that point in time, Alex actually overdosed on prescription drugs and heroin and, at the age of 20, passed away. His family never even had the chance to seek help for his dependency.

Unfortunately, this story is far too common across our country.

As a father, I can't even imagine the pain of losing a child to a drug overdose; but sadly, too many families like the Lalibertes have experienced this loss. Heroin and heroin abuse have become an epidemic in our country.

During my work as the co-chair of the Suburban Anti-Heroin Task Force, I have met countless families who have been affected by drug abuse—literally torn apart. This is not an isolated issue. It affects every community, every ZIP Code, regardless of your socioeconomic status, regardless of your educational status.

I talk to parents who say, ''It is not in my community.'' It is. It is in your community, let me just assure you.

My work with Live4Lali and the Lake County Opioid Initiative inspired me to introduce this law with Representative CLARK. Our bipartisan bill is named in Alex Laliberte's memory.

Lali's Law increases access to a lifesaving antidote called naloxone, which, in Lake County, Illinois, has already saved nearly 100 lives since first responders and the police force requested the opportunity to be able to use this lifesaving antidote. The police officers actually would respond, would get there before the paramedics—often 5 to 7, sometimes 9 minutes faster—and refused to sit by idly as they watched these young people die from an overdose.

When used properly, naloxone helps restore breathing that has been stopped by an overdose. You have heard the statistics, but the World Health Organization predicts that increased access to naloxone could save another 20,000 lives each and every year.

Lali's Law is a decisive step to not only save young people like Alex Laliberte from falling victim to drug abuse, but also to help those in our communities struggling to get their lives back on track. Our bill—and, frankly, the work that has been done here in this body today, and I think we have got some 18 different bipartisan bills coming together to try to solve this prescription drug epidemic, this heroin epidemic that is sweeping our country—is proof of what is possible when we set aside partisanship and get to work for the people that we all represent.

Lali's Law has already brought Alex's story to the United States Congress and has amplified the lifesaving

benefit of Live4Lali's amazing work. Now, by passing this overwhelming bipartisan bill, we can ensure that Alex's lasting legacy includes helping countless others get a second chance at recovery and saving their families from the unbearable heartbreak.

Mr. Speaker, together, we truly can save lives.

Again, I want to thank Representative CLARK. I want to thank the Laliberte family. I want to thank the first responders, the stakeholders back in Lake County, and all those here in this body who are working to try to create an environment, create the opportunity for us to be able to take a huge step forward in combating this prescription drug and heroin epidemic.

I thank the gentleman for yielding the time.

□ 1815

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

Mr. GUTHRIE. Mr. Speaker, I encourage my colleagues to vote for H.R. 4586.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4586, also known as Lali's Law.

Sadly, Lali's Law was named after Alex Laliberte: a Buffalo Grove, Illinois resident who tragically passed away seven years ago from a drug overdose.

Alex was a good kid. He was an athlete during high school, and also did well academically.

During his sophomore year in college, he began being hospitalized for a mysterious illness.

Unknown to his friends and family, Alex soon developed an addiction to the prescription drugs and was being hospitalized for withdrawal.

He would stay in the hospital until his symptoms subsided only to leave the hospital and repeat the cycle.

Alex continued this cycle until he died of an opioid overdose a few days before his final exams.

He was only 20 years old.

Our lack of education on opioids and harm reduction contributed to Alex's early death, and we must act to prevent a repeat of this tragedy.

Lali's Law is an important piece of legislation that would authorize grants to states to develop standing orders and educate health care professionals about the dispensing of opioid overdose reversal medication without person-specific prescriptions.

In addition, this bill would encourage pharmacies to dispense opioid overdose reversal medication pursuant to a standing order.

According to the National Institute on Drug Abuse, 2.1 million people nationwide abuse opioids.

Mr. Speaker, Lali's Law is instrumental in helping these victims reverse their addiction.

Lali's Law would also implement the following guidelines and practices for those people authorized to prescribe the medication:

Only prescribe opioids for chronic pain

Opioid overdose reversal medication must be co-prescribed with opioids; and

the purpose and administration of opioid overdose reversal medication must be discussed with the patients.

Furthermore, H.R. 4586 would require the development and adaptation of training materials and methods for the people authorized to prescribe or dispense the medication to use in educating the public, which includes:

When and how to administer opioid overdose reversal medication, and

The steps that should be taken after administering the opioid overdose reversal medication.

Lastly, Lali's Law would educate the public regarding the health benefits of the opioid reversal medication and the availability of the medication without a person-specific prescription.

In 2014, rates of opioid overdose deaths jumped significantly, from 7.9 per 100,000 in 2013 to 9.0 per 100,000, which is a 14 percent increase.

Mr. Speaker, I join my colleagues in support of H.R. 4586.

This legislation is vital for reducing opioid-related deaths across our nation, protecting the lives of those at risk to opioid abuse.

It is our job to make sure that Alex's lasting legacy includes helping others get a second chance at recovery and a second chance at life.

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. 4586, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. GUTHRIE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

REDUCING UNUSED MEDICATIONS ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4599) to amend the Controlled Substances Act to permit certain partial fillings of prescriptions, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4599

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 ''Reducing Unused Medications Act of 2016''.

SEC. 2. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

''(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.—

''(1) PARTIAL FILLS.—

''(A) IN GENERAL.—A prescription for a controlled substance in schedule II may be partially filled if—

''(i) it is not prohibited by State law;

''(ii) the prescription is written and filled in accordance with the Controlled Substances Act (21 U.S.C. 801 et seq.), regulations prescribed by the Attorney General, and State law;

''(iii) the partial fill is requested by the patient or the practitioner that wrote the prescription; and

''(iv) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

''(B) OTHER CIRCUMSTANCES.—A prescription for a controlled substance in schedule II may be partially filled in accordance with section 1306.13 of title 21, Code of Federal Regulations (as in effect on the date of enactment of the Reducing Unused Medications Act of 2016).

''(2) REMAINING PORTIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 30 days after the date on which the prescription is written.

''(B) EMERGENCY SITUATIONS.—In emergency situations, as described in subsection (a), the remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 72 hours after the prescription is issued.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Attorney General to allow a prescription for a controlled substance in schedule III, IV, or V of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) to be partially filled.

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.

Mr. Speaker, I rise in support of H.R. 4599, the Reducing Unused Medications Act of 2016, introduced by Ms. CLARK of Massachusetts and Mr. STIVERS of Ohio.

The number of prescriptions for opioids has significantly increased in recent years. While opioids can benefit patients when used appropriately, once their pain is subsided, there may be unused pills that could be misused and diverted.

Several States have considered enabling pharmacies to partially fill such prescriptions to minimize the number of pills in circulation while continuing to address the patient needs. However, current DEA regulations are not entirely clear about when such partial fills are permitted.

H.R. 4599 amends the Controlled Substances Act to clarify when schedule II controlled substances, including opioid pain medications, can be partially filled. This is a commonsense, bipartisan bill that will help save lives.

I urge my colleagues to join me in support.

I reserve the balance of my time.

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

Mr. Speaker, I rise to voice my support for H.R. 4599, Reducing Unused Medications Act.

Opioid abuse in the United States is rising at alarming rates. In 2014, nearly 2 million Americans abused or were addicted to prescription opioids. Opioids are now one of the most prescribed classes of medications, and the National Institute on Drug Abuse estimates that over 70 percent of adults who misuse prescription opioids get them from a friend or relative.

A promising step to reduce the number of prescription opioids is a permanent partial filling of these prescriptions. Current Drug Enforcement Administration regulations allow pharmacists to partially fill prescriptions for schedule III, IV, and V substances, however, only allow partial fulfillment of schedule II substances in long-term-care settings or to terminally ill patients and when the full prescription cannot be supplied.

While these regulations do not explicitly prohibit a pharmacist from partially filling prescriptions for schedule II substances outside of these certain limited circumstances, DEA recognizes that the regulations lack clarity as to when partial filling of schedule II substances is permitted. This bill would provide clarity.

The Reducing Unused Medications Act would allow pharmacists, at the request of patients or doctors, to partially fill prescriptions for schedule II drugs, such as opioids, meaning that a patient or doctor can request to receive a 10-day supply of a 30-day prescription initially and then return later to receive the remaining portion, if needed. This flexibility may help reduce the number of unused pills in circulation and reduce the risk of substance misuse, diversion, and overdose.

The bipartisan bill before us reflects a careful compromise that holds the potential to reduce the amount of unused opioid medications in circulation and is an important step in helping curb a growing opioid epidemic.

I want to thank Representatives CLARK and STIVERS for their leadership in sponsoring this bill.

I urge my colleagues to support the Reducing Unused Medications Act.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Massachusetts (Ms. CLARK), the sponsor of this bill.

Ms. CLARK of Massachusetts. Mr. Speaker, I thank the gentleman from Texas for yielding.

Mr. Speaker, over the last decade, we have seen a staggering increase of opioid overdose deaths. In 2015, this epidemic claimed 125 lives in my district alone. There are a lot of different causes of this crisis, but the number of prescription opioids in circulation is a critical factor.

Over the last 15 years, the amount of prescription painkillers has quadrupled and generic Vicodin is now the most prescribed drug to Medicare beneficiaries.

Now, we know that often patients don't use all the opioids they are prescribed. According to the National Institute on Drug Abuse, over 70 percent of adults who misuse prescription drugs get them from friends or relatives.

Millions of half-filled bottles of unused and unwanted prescription drugs line our families' medicine cabinets, and too often that is where opioid addiction begins.

One promising way to reduce the amount of unused and unwanted painkillers that are fueling this public health crisis is by allowing patients and doctors to only partially fill opioid prescriptions.

By allowing pharmacists to partially fill a prescription for opioids at the request of a patient or doctor, we can reduce the number of unused pills and help stop pill diversion and misuse.

Currently, the DEA allows partial filling of prescriptions for many drugs, but the regulations are narrower and less clear for opioid drugs. That is why I, along with Representative STIVERS, have introduced the Reducing Unused Medications Act.

This legislation will resolve any ambiguity and clearly establish that a prescription for schedule II substances, like opioid painkillers, may be partially filled upon the request of a patient or doctor.

We have all heard the stories. Just last weekend I ran into a dad whose son had been given a 30-day prescription of opioid painkillers for having a wisdom tooth taken out, and he had just received an unwanted prescription, also for 30 days, after having minor surgery.

This bill will empower patients to manage their prescriptions and can be a critical tool in an effort to address the opioid epidemic. This is a commonsense bill that will help us stop the misuse of prescription drugs that has fueled the use of heroin and this opioid epidemic.

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

Mr. GUTHRIE. Mr. Speaker, I encourage all my colleagues to vote for H.R. 4599, and I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I rise to voice my support for H.R. 4599, commonsense legislation that offers the potential to reduce the number of unused and unwanted prescription opioids that have been misused or diverted as a part of the opioid epidemic.

The number of prescription opioids dispensed in the U.S. has nearly quadrupled in the last 15 years, and over 70 percent of adults who misuse prescription opioids get them from a friend or a relative. This is often due to the fact that many patients fill legitimate prescriptions for opioids and for one reason or another do not use the entirety of the prescription.

One way to help reduce the amount of unused opioid medications in home medicine cabinets is to permit the partial filling of Schedule II prescriptions. Partial fill policies allow providers, pharmacists, and patients the option to dispense a portion of a prescription with the option of filling the total amount of the prescription at a later time. For example, a patient or practitioner could request that 10 or 15 days of a 30-day prescription be dispensed initially with the remaining portion available later if needed. It is hoped that this additional flexibility would reduce the number of unused pills in circulation and ultimately reduce misuse and diversion of these prescription opioids.

Current Drug Enforcement Administration regulations allow pharmacists to partially fill prescriptions for Schedule III, IV, and V substances, however, Schedule II substances can only be partially filled in long term care settings, for terminally ill patients, or when the full prescription cannot be supplied. While these regulations do not prohibit partially filling prescriptions for Schedule II substances in other situations, the DEA has acknowledged that the regulations may need to be amended to provide clarity as to when partial fill of Schedule II substances is allowable.

The Reducing Unused Medications Act of 2015 was introduced in the House by Representatives KATHERINE CLARK (D–MA) and STEVE STIVERS (R–OH) to do just that—provide additional clarity regarding when Schedule II prescriptions may be partially filled under the Controlled Substances Act.

In addition to the circumstances outlined in current DEA regulations, H.R. 4599 would also allow partial fill of Schedule II substances if requested by a doctor or patient, as long as the prescription is written and dispensed according to federal and state law. It further makes clear that remaining portions of a partially filled prescription for a Schedule II substance may not be filled later than 30 days after the date the prescription is written.

Partial fills would also be allowed in emergency situations, with the remaining portion to be filled not later than 72 hours after the prescription is issued. This legislation does not impact the ability of Schedule III, IV, or V prescriptions to be partially filled.

H.R. 4599 is the result of careful compromise among the authors of this legislation, the stakeholders, and our Committee members, and I urge my colleagues to support it.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4599 the ''Reducing Unused Medication Act of 2016''.

This bill is an important measure that will decrease the number of unused medications available for misuse to the public by setting limitations on the most frequent avenues used to secure unused medication.

As we know, many times patients are prescribed medication far beyond their needs.

Unused prescription medication creates a lethal danger to households and communities across America, and failing to properly dispose of unfinished medications can have dire consequences on the environment and our ecosystem.

According to a new study conducted by Geisinger Health System and published in the Journal of the American Pharmacists Association just 11 percent of unused prescription drugs were disposed of via drug take-back programs, while 55 percent were left in the

medicine cabinet, 14 percent were thrown in the trash, and 9 percent were flushed down the toilet.

As we have heard many unfortunate stories as we bring greater awareness to this issue, we know that abuse of medicine among teenagers is a growing problem.

Easy access to parents' and grandparents' leftover medications is just throwing gasoline on the fire.

Meanwhile, more than 60,000 young children are taken to the emergency room each year after ingesting a family member's medication.

With respect to the environment, the FDA no longer recommends flushing drugs down the toiler because sewage treatment plants lack the capacity to remove pharmaceuticals and personal care products' residue.

H.R. 4599 will amend the Controlled Substances Act to permit certain fillings of prescriptions—such that a prescription for a controlled substance may be partially filled if:

It is not prohibited by state law;

The prescription is written and filled in accordance with the Controlled Substances Act, regulations prescribed by the Attorney General, and State law;

The partial fill is requested by the patient or the practitioner that wrote the prescription; and

The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

Mr. Speaker, enacting this legislation will work to not only combat a number of prescription drug abuses, but also deal a debilitating blow to the mounting opioid abuse epidemic.

The SPEAKER pro tempore (Mr. ZINKE). 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. 4599, 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.

EXAMINING OPIOID TREATMENT INFRASTRUCTURE ACT OF 2016

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4982) to direct the Comptroller General of the United States to evaluate and report on the in-patient and outpatient treatment capacity, availability, and needs of the United States, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4982

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 ''Examining Opioid Treatment Infrastructure Act of 2016''.

SEC. 2. STUDY ON TREATMENT INFRASTRUCTURE.

Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall initiate an evaluation, and submit to Congress a report, of the inpatient and outpatient treatment capacity, availability, and needs of the United States, which shall include, to the extent data are available—

(1) the capacity of acute residential or inpatient detoxification programs;

(2) the capacity of inpatient clinical stabilization programs, transitional residential support services, and residential rehabilitation programs;

(3) the capacity of demographic specific residential or inpatient treatment programs, such as those designed for pregnant women or adolescents;

(4) geographical differences of the availability of residential and outpatient treatment and recovery options for substance use disorders across the continuum of care;

(5) the availability of residential and outpatient treatment programs that offer treatment options based on reliable scientific evidence of efficacy for the treatment of substance use disorders, including the use of Food and Drug Administration-approved medicines and evidence-based nonpharmacological therapies;

(6) the number of patients in residential and specialty outpatient treatment services for substance use disorders;

(7) an assessment of the need for residential and outpatient treatment for substance use disorders across the continuum of care;

(8) the availability of residential and outpatient treatment programs to American Indians and Alaska Natives through an Indian health program (as defined by section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)); and

(9) the barriers (including technological barriers) at the Federal, State, and local levels to real-time reporting of de-identified information on drug overdoses and ways to overcome such barriers.

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.

Mr. Speaker, I rise today in support of H.R. 4982, Examining Opioid Treatment Infrastructure Act of 2016, introduced by my colleagues, the ranking member of the Energy and Commerce Committee, Mr. PALLONE of New Jersey, and Mr. FOSTER of Illinois.

H.R. 4982 directs the Government Accountability Office to evaluate and report on the inpatient and outpatient treatment capacity, availability, and needs of the United States. It is important to have the data necessary to assess the opioid infrastructure in our country.

Mr. Speaker, I urge my colleagues to support this bill.

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. 4982, Examining Opioid Treatment Infrastructure Act.

Opioid use disorder is a chronic disease that can be effectively treated, but it requires ongoing management. As the current epidemic has drawn sharply into focus, significantly more resources are needed to ensure availability of and access to evidence-based treatment.

A public health-based approach to drug abuse and addiction requires having broad-based treatment services available for those with opioid use disorders, including both behavioral therapies and proven medication-assisted treatment and insurance coverage for such treatment.

Medication-assisted treatment is often in combination with behavioral treatment, which has been shown to be highly effective in the treatment of opioid addiction.

However, many patients in need of treatment face significant barriers. Physicians cite barriers finding and placing patients in addiction treatment and recovery programs.

Current capacity of treatment and recovery programs is inadequate to meet the population's needs. There are too few physicians and programs offering treatment and recovery services.

In order to address these shortages, better information and data is needed for our existing opioid treatment infrastructure. H.R. 4982, the Examining Opioid Treatment Infrastructure Act, will direct the GAO to conduct a study on the inpatient and outpatient treatment capacity of the United States.

It instructs the agency to examine the capacity of acute residential or inpatient detoxification programs, inpatient clinical stabilization programs, transitional residential support services, and residential rehabilitation programs.

The GAO is directed to report on geographic differences in the availability of treatment and recovery programs for substance abuse disorders; the availability of programs that offer evidence-based treatment options, including the use of FDA-approved medications; and the number of patients' different treatment settings.

Finally, the agency would include an assessment of the need for residential and outpatient treatment for substance use disorders across the continuum of care.

We must face this crisis head-on and address the serious gaps in evidence-based treatment. The Examining Opioid Treatment Infrastructure Act will help us do this.

I want to thank the bill's sponsor, Representative BILL FOSTER, for introducing this legislation.

I urge my colleagues to support the act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. CARTER), my friend.

Mr. CARTER of Georgia. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 4599 because treatment of addiction to opioid painkillers and heroin

is vital in fighting the U.S. drug abuse epidemic.

H.R. 4982 requires the Government Accountability Office to report on inpatient and outpatient treatment capacities, detoxification programs, rehabilitation programs, and treatment programs for pregnant women and adolescents.

Inpatient and outpatient treatment centers are usually one of the biggest obstacles communities face when trying to help people who are fighting addiction. Unfortunately, for most communities, local treatment facilities are few and far between and many of them are full.

As a lifelong healthcare professional, I believe the only way we will be able to adequately fight this opioid abuse epidemic is if we work together.

□ 1830

We need to adequately understand the treatment services that are available to people with addiction across the country so we can use these tools to their fullest extent. That is why I am supporting H.R. 4982. By understanding all the tools the community can use, we can begin to fight this epidemic.

I encourage my colleagues to support this bill so we can begin to leverage our resources to help our communities fight opioid abuse.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. FOSTER), a cosponsor of the bill.

Mr. FOSTER. Mr. Speaker, I thank Mr. GREEN for yielding me the time.

My bill, H.R. 4982, the Examining Opioid Treatment Infrastructure Act of 2016, is straightforward, and it is bipartisan.

If we are ever going to get a handle on the heroin and opioid epidemic tearing through our communities, we have to know what we are dealing with. We need data, and we need to know what capacity we have in place and what capacity we need to treat this epidemic so that we can make smart and adequate investments, which is why we need this bill.

This important bill directs a study of the inpatient and outpatient addiction treatment capacity and availability throughout the U.S., as well as an assessment of the needed types and numbers of treatment options.

It seems simple, but there is no better place to start than at the beginning, with an understanding of the addiction treatment infrastructure that we have versus the need for that infrastructure.

When I was first elected to Congress, I was not prepared to hear the stories from family members who had lost a loved one due to substance abuse. My office often gets calls from parents wanting to share their stories of the children they have lost to addiction.

While opioid addiction may start in many ways, it ends with a scientifically understood, increasingly treatable medical condition in which the biochemical pathways necessary to normal decisionmaking in the brain have been hijacked, and the chemistry of the brain permanently altered.

The more we learn about the science of addiction, the more convinced we become that the best path forward is treating addiction like the medical, biochemical condition that it is. To do this successfully, we need the correct number and types of addiction treatment facilities.

That is why I introduced the Examining Opioid Treatment Infrastructure Act of 2016, with my friend from New Jersey (Mr. PALLONE).

We know that opioid use and abuse has become an epidemic, and now let's make sure that we know the real numbers we are dealing with so we can allocate the necessary resources.

I urge support of the Examining Opioid Treatment Infrastructure Act of 2016.

Mr. GENE GREEN of Texas. Mr. Speaker, having no further speakers, I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I encourage my colleagues to vote for H.R. 4982.

I yield back the balance of my time.

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. 4982, 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.

OPIOID USE DISORDER TREATMENT EXPANSION AND MODERNIZATION ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4981) to amend the Controlled Substances Act to improve access to opioid use disorder treatment, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4981

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 ''Opioid Use Disorder Treatment Expansion and Modernization Act''.

SEC. 2. FINDING.

The Congress finds that opioid use disorder has become a public health epidemic that must be addressed by increasing awareness and access to all treatment options for opioid use disorder, overdose reversal, and relapse prevention.

SEC. 3. OPIOID USE DISORDER TREATMENT MODERNIZATION.

(a) IN GENERAL.—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended—

(1) in subparagraph (B), by striking clauses (i), (ii), and (iii) and inserting the following:

''(i) The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

''(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary—

''(I) all schedule III, IV, and V drugs, as well as unscheduled medications approved by the Food and Drug Administration, for the treatment of opioid use disorder, including such drugs and medications for maintenance, detoxification, overdose reversal, and relapse prevention, as available; and

''(II) appropriate counseling and other appropriate ancillary services.

''(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclause (II), the applicable number is 30.

''(II) The applicable number is 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients.

''(III) The Secretary may by regulation change such total number.

''(IV) The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.

''(iv) If the Secretary by regulation increases the total number of patients which a qualifying practitioner is permitted to treat pursuant to clause (iii)(II), the Secretary shall require such a practitioner to obtain a written agreement from each patient, including the patient's signature, that the patient—

''(I) will receive an initial assessment and treatment plan and periodic assessments and treatment plans thereafter;

''(II) will be subject to medication adherence and substance use monitoring;

''(III) understands available treatment options, including all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including their potential risks and benefits; and

''(IV) understands that receiving regular counseling services is critical to recovery.

''(v) The practitioner will comply with the reporting requirements of subparagraph (D)(i)(IV).'';

(2) in subparagraph (D)—

(A) in clause (i), by adding at the end the following:

''(IV) The practitioner reports to the Secretary, at such times and in such manner as specified by the Secretary, such information and assurances as the Secretary determines necessary to assess whether the practitioner continues to meet the requirements for a waiver under this paragraph.'';

(B) in clause (ii), by striking ''Upon receiving a notification under subparagraph (B)'' and inserting ''Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B)''; and

(C) in clause (iii)—

(i) by inserting ''and shall forward such determination to the Attorney General'' before the period at the end of the first sentence; and

(ii) by striking ''physician'' and inserting ''practitioner'';

(3) in subparagraph (G)—

(A) by amending clause (ii)(IV) to read as follows:

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall address—

''(aa) opioid maintenance and detoxification;

''(bb) appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;

''(cc) initial and periodic patient assessments (including substance use monitoring);

''(dd) individualized treatment planning; overdose reversal; relapse prevention;

''(ee) counseling and recovery support services;

''(ff) staffing roles and considerations;

''(gg) diversion control; and

''(hh) other best practices, as identified by the Secretary.''; and

(B) by adding at the end the following:

''(iii) The term 'qualifying practitioner' means—

''(I) a qualifying physician, as defined in clause (ii); or

''(II) during the period beginning on the date of the enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act and ending on the date that is three years after such date of enactment, a qualifying other practitioner, as defined in clause (iv).

''(iv) The term 'qualifying other practitioner' means a nurse practitioner or physician assistant who satisfies each of the following:

''(I) The nurse practitioner or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

''(II) The nurse practitioner or physician assistant satisfies 1 or more of the following:

''(aa) Has completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

''(bb) Has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

''(III) The nurse practitioner or physician assistant is supervised by or works in collaboration with a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may review and update the requirements for being a qualifying other practitioner under this clause.''; and

(4) in subparagraph (H)—

(A) in clause (i), by inserting after subclause (II) the following:

''(III) Such other elements of the requirements under this paragraph as the Secretary determines necessary for purposes of implementing such requirements.''; and

(B) by amending clause (ii) to read as follows:

''(ii) Not later than one year after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.''.

(b) RECOMMENDATION OF REVOCATION OR SUSPENSION OF REGISTRATION IN CASE OF SUBSTANTIAL NONCOMPLIANCE.—The Secretary of Health and Human Services may recommend to the Attorney General that the registration of a practitioner be revoked or suspended if the Secretary determines, according to such criteria as the Secretary establishes by regulation, that a practitioner who is registered under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is not in substantial compliance with the requirements of such section, as amended by this Act.

(c) OPIOID DEFINED.—Section 102(18) of the Controlled Substances Act (21 U.S.C. 802(18)) is amended by inserting ''or 'opioid' '' after ''The term 'opiate' ''.

(d) REPORTS TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and not less than over every 5 years thereafter, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration and experts in opioid use disorder research and treatment, shall—

(A) perform a thorough review of the provision of opioid use disorder treatment services in the United States, including services provided in opioid treatment programs and other specialty and nonspecialty settings; and

(B) submit a report to the Congress on the findings and conclusions of such review.

(2) CONTENTS.—Each report under paragraph (1) shall include an assessment of—

(A) compliance with the requirements of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), as amended by this Act;

(B) the measures taken by the Secretary of Health and Human Services to ensure such compliance;

(C) whether there is further need to increase or decrease the number of patients a waivered practitioner is permitted to treat, as provided for by the amendment made by subsection (a)(1);

(D) the extent to which, and proportions with which, the full range of Food and Drug Administration-approved treatments for opioid use disorder are used in routine health care settings and specialty substance use disorder treatment settings;

(E) access to, and use of, counseling and recovery support services, including the percentage of patients receiving such services;

(F) changes in State or local policies and legislation relating to opioid use disorder treatment;

(G) the use of prescription drug monitoring programs by practitioners who are permitted to dispense narcotic drugs to individuals pursuant to a waiver under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2));

(H) the findings resulting from inspections by the Drug Enforcement Administration of practitioners described in subparagraph (G); and

(I) the effectiveness of cross-agency collaboration between Department of Health and Human Services and the Drug Enforcement Administration for expanding effective opioid use disorder treatment.

SEC. 4. SENSE OF CONGRESS.

It is the Sense of Congress that, with respect to the total number of patients that a qualifying physician (as defined in subparagraph (G)(iii) of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) can treat at any one time pursuant to such section, the Secretary of Health and Human Services should consider raising such total number to 250 patients following a third notification to the Secretary of the need and intent of the physician to treat up to 250 patients that is submitted to the Secretary not sooner than 1 year after the date on which the physician submitted to the Secretary a second notification to treat up to 100 patients.

SEC. 5. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

''(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.—

''(1) PARTIAL FILLS.—

''(A) IN GENERAL.—A prescription for a controlled substance in schedule II may be partially filled if—

''(i) it is not prohibited by State law;

''(ii) the prescription is written and filled in accordance with the Controlled Substances Act (21 U.S.C. 801 et seq.), regulations prescribed by the Attorney General, and State law;

''(iii) the partial fill is requested by the patient or the practitioner that wrote the prescription; and

''(iv) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

''(B) OTHER CIRCUMSTANCES.—A prescription for a controlled substance in schedule II may be partially filled in accordance with section 1306.13 of title 21, Code of Federal Regulations (as in effect on the date of enactment of the Reducing Unused Medications Act of 2016).

''(2) REMAINING PORTIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 30 days after the date on which the prescription is written.

''(B) EMERGENCY SITUATIONS.—In emergency situations, as described in subsection (a), the remaining portions of a partially filled prescription for a controlled substance in schedule II—

''(i) may be filled; and

''(ii) shall be filled not later than 72 hours after the prescription is issued.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Attorney General to allow a prescription for a controlled substance in schedule III, IV, or V of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) to be partially filled.

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.

Mr. Speaker, I rise in support of H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, introduced by the gentleman from Indiana (Mr. BUCSHON) and the gentleman from New York (Mr. TONKO).

More than 2 million Americans are living with a substance use disorder. Evidence strongly suggests that medication-assisted treatment can have a significant impact on combating this epidemic.

H.R. 4981 would amend the Controlled Substance Act to expand access to medication-assisted treatment for patients with substance use disorders while improving the quality of care provided and minimizing the potential for drug diversion.

For the first time, this bill would authorize nurse practitioners and physician assistants to prescribe maintenance treatment in an office-based setting after meeting certain training requirements.

H.R. 4981 would improve the training that all qualifying practitioners receive, and it would maintain the critical role counseling and other recovery support services play in the provision of quality medication-assisted treatment.

Further, the bill would require HHS to perform a thorough review of opioid use disorder so we know what is working well and where there is a need for further improvement.

H.R. 4981 is the product of extensive bipartisan discussion at the Energy and Commerce Committee, and I urge my colleagues to join me in supporting it.

I reserve the balance of my time.

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

Mr. Speaker, I rise in support of H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act.

Despite the fact that we are in the middle of an unprecedented opioid and heroin crisis, we know that treatment gaps continue to limit our ability to address the growing crisis. Only 1 in 10 people struggling with addiction receive any form of treatment, despite the fact that we have evidence-based, medication-assisted treatment for those struggling with prescription drug or heroin addiction.

One available treatment is buprenorphine. The medication is safely prescribed from an office setting similar to any other medication a patient might take.

Unfortunately, in the midst of our current opioid epidemic, currently, physicians are restricted to how many patients they are allowed to treat with this medication, and nurse practitioners and physician assistants are not allowed to treat patients with this medication at all.

As a result, many patients are placed on prolonged waiting lists with addiction specialists as they await access to this treatment. This is not acceptable.

We must significantly increase the cap of the number of patients a physician can treat, as well as permanently allow nurse practitioners and physician assistants to treat patients with this medication.

Today's legislation is not perfect, but it is the first step toward reaching bicameral, bipartisan agreement on a package that meets these goals. I remain committed to working with my colleagues to expand access to this important evidence-based treatment as we move to conference with the Senate.

I want to thank the bill's sponsors, fellow members of the Committee on Energy and Commerce, Representative PAUL TONKO and Representative LARRY BUCSHON, for introducing this legislation. I urge my colleagues to support the Opioid Use Disorder Treatment Expansion and Modernization Act.

I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 5 minutes to the gentleman from Indiana (Mr. BUCSHON), a cosponsor of this piece of legislation.

Mr. BUCSHON. Mr. Speaker, H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act, is the product of months of stakeholder engagement, expert input, and bipartisan negotiation.

The opioid epidemic has left no area of this Nation untouched. Day in and day out, we hear from our constituents and see in the news the direct impact this has on the everyday lives of our fellow citizens.

The evidence is clear that this epidemic is growing and it will continue to grow unless immediate action is taken.

As a doctor, a father, and a public policymaker, I want to do my part to help our communities overcome this challenge. That is why I am proud to offer H.R. 4981, the Opioid Use Disorder Treatment Expansion and Modernization Act today with my colleague from New York (Mr. TONKO).

We have worked together over the past several months to find common ground and move forward with a well-crafted policy solution. Our final bill represents months of stakeholder engagement and bipartisan work to improve access and quality treatment for opioid use disorder while limiting diversion of treatment medications for abuse themselves.

H.R. 4981 targets four main areas:

Increase access to opioid use disorder treatment where it is most needed;

Empower physicians through education, training, and quality-of-care measures;

Encourage a multi-pronged approach to opioid use disorder treatment;

Deter bad actors and reduce diversion, as previously was mentioned.

This is a positive step toward increasing access for treatment for opioid use disorder while raising the quality of care and reducing diversion.

Again, I want to thank Mr. TONKO and all those who have worked with us throughout this process. I urge my colleagues to support H.R. 4981's passage, and I look forward to productive discussions with the Senate to get critical opioid legislation to the President's desk.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentleman from New York (Mr. TONKO), a fellow member on the Committee on Energy and Commerce.

Mr. TONKO. Mr. Speaker, I thank the gentleman from Texas for yielding.

I rise in support of H.R. 4981, Opioid Use Disorder Treatment Expansion and Modernization Act, which I have had the honor of working on with my colleague and friend, Representative LARRY BUCSHON, in introducing.

At the outset, I would like to thank Representative BUCSHON and his staff, as well as the hard work of individuals on the committee staff, and our committee leaders, Chairman UPTON and Ranking Member PALLONE, to get this bill to this point.

I would also like to praise my colleague and fellow New Yorker, Representative BRIAN HIGGINS, for his introduction and leadership on the TREAT Act, without which we would not be making this progress today.

It is no hyperbole to announce that we are in a crisis when it comes to the opioid epidemic sweeping our Nation. More than 47,000 people have died of drug overdoses in 2014—family members, friends, and neighbors within that 47,000, for each and every one of us—a vast majority of which were opioid-related.

It is a sign of the times that when you drive down the thruway in my district in upstate New York, instead of billboards advertising for McDonald's or Taco Bell, you see billboards advising to you call 911 in case of an opioid overdose.

It is disturbing how quickly this has become the new normal. This crisis has affected our neighbors, our families, and our beloved communities.

Having worked with the addiction recovery community, I know that one of the most important things we can do as policymakers is to ensure that when an individual struggling with addiction cries out for help, that there is someone there to answer the call. That is what this bill endeavors to do.

Right now, treatment capacity for those seeking help for opioid use disorder in an office-based setting is artificially capped at 100 patients. What this means in reality is that if you are patient 101 or 102, you get a closed door and have to wait weeks, if not months, for treatment. Expectedly, these delays can be deadly.

The legislation before us will support the goal of raising the caps for qualified physicians to 250, expanding existing opioid treatment capacity by some 150 percent, all while ensuring the care that individuals receive is high quality and minimizes the risk of diversion.

In addition, this legislation will, for the first time, expand buprenorphine-prescribing authority to nurse practitioners and physician assistants who meet certain training requirements and comply with applicable State laws.

By bringing these practitioners into the fold, we can expand treatment capacity, especially in rural areas where physicians oftentimes might be few and far between.

Importantly, this bill expands access to high-quality addiction treatment, promoting the full range of psychosocial services that makes recovery possible, and providing HHS with new tools to remove bad actors from the system.

Any Member interested in decreasing the unlawful diversion of buprenorphine should support this legislation.

This legislation is not perfect, and I would still like to see a higher patient limit for the top class of physicians.

In the midst of this crisis, ensuring access for all needs to be our utmost top priority. No matter where we ultimately land on this arbitrary number, we will still be closing the door on someone who needs our help. We would not accept this in any other field of medicine, so we all need to think long and hard about why we are allowing this situation to persist in the field of addiction.

In addition, I would like to draw attention to two changes made to this bill before floor consideration. First, instead of statutorily lifting the DATA 2000 caps, this legislation includes a sense of Congress, if you will, that the caps should be lifted.

Secondly, this legislation would time-limit the expansion of prescribing authority to nurse practitioners and physician assistants to some 3 years.

Both of these temporary changes were made to bring the bill into compliance with PAYGO procedures for floor consideration and must be fixed as we move this bill into conference.

□ 1845

I would just ask, Mr. Speaker, are we firm in our commitment to combat the addiction to heroin? Are we firm in our efforts to assist those who struggle with the illness of addiction? Do we stand for providing true hope to individuals who count on us to provide the resources along with the legislation to make life available to them?

I would suggest that this House and the Senate look hard and fast at providing resources that are real and that provide for an effective outcome. If we fail to find a path forward for a meaningful expansion of the physician caps and certainly the nurse practitioners' and physician assistants' prescribing authority, then we are rationing care, pure and simple.

The starting point for any conference discussion should be the bill as reported out of the House Energy and Commerce Committee. In any final legislation, we must include a statutory lifting of the DATA 2000 caps as well as full authority for our NPs and PAs. I would ask for the commitment of my colleagues on the other side of the aisle in continuing to work toward these goals.

Notwithstanding these issues, I believe it is critically important to keep up the momentum and to pass this bill. Even in its imperfect form, this bill will make a huge difference in the lives of those who struggle with this disease. If we cannot find a way to get a bill to the President's desk that will provide needed relief in the midst of this epidemic, shame on us.

While this legislation is not a cure-all for the opioid epidemic, I believe the Opioid Use Disorder Treatment Expansion and Modernization Act will go far in helping to alleviate our acute treatment capacity issues and put more people on the path to recovery. I ask my colleagues in this House and down the hall in the Senate to support a bill—this bill—so that we can bring hope, truly bring hope into the lives of those individuals, those families, and those communities who grapple with this crisis on a daily basis.

Mr. GUTHRIE. Mr. Speaker, as I said earlier, people come here to the people's House from all walks of life. We are blessed to have a pharmacist amongst us. The only pharmacist here. These are difficult issues. Legal prescription drugs are diverted and abused, and heroin is illegal. It is great to have his expertise.

Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. I thank the gentleman from Kentucky for yielding and for his efforts, along with Dr. BUCSHON and others across the aisle, Congressman GENE GREEN and all those who have been involved in this. This is a very important subject.

Mr. Speaker, I rise today in support of H.R. 4981 because making sure modern treatments are available for opioid addiction should be one of our top priorities in the fight against opioid drug abuse.

H.R. 4981 makes reforms to the Controlled Substances Act that would modernize the way doctors approach opioid addiction and how patients obtain treatment. These reforms, which make treatment tools more available to patients, are one more step we can take to improve treatment services for patients. With these reforms, more patients will receive higher quality care, increasing the success of overall treatment.

As a lifelong healthcare professional, I have witnessed patients firsthand who have struggled with receiving care for their addiction. We must stop the cycle of failing to provide patients with proper care because the system is not adequately structured to provide it.

The only way we are able to provide the appropriate care is if we continue to support the evolution of treatment and care for this ever-changing opioid abuse epidemic. That is why I am supporting H.R. 4981. By reforming the way treatment is provided, we can begin to truly help all patients with opioid addiction.

Mr. Speaker, I encourage my colleagues to support this bill.

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

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

Mr. GUTHRIE. Mr. Speaker, I encourage and urge my colleagues to support this very important bill, H.R. 4981.

I yield back the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I rise in support of H.R. 4981 the "Opioid Use Disorder Treatment Expansion and Modernization Act".

This bill highlights the abuse of opioids that has become a public health epidemic.

Opioids are drugs with effects similar to opium, such as heroin and certain pain medications.

H.R. 4981 would encourage and train health care providers to prescribe overdose reversal drugs, such as Naloxone, when they prescribe common opioids-like pain medication to patients at risk of addiction.

The plague of opioid overdose deaths across the nation is disturbing, but there are ways to combat this trend.

Any party receiving treatment assessments under this legislation will be privy to the following.

1. A treatment plan and periodic assessments.

2. Will also be subject to medication adherence and substance use monitoring.

3. Treatment options, including all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including their potential risks and benefits.

4. Receiving regular counseling services is critical to recovery.

The Centers for Disease Control and Prevention reports that nearly 259 million opioid prescriptions were written in 2012, more than enough for every adult in the United States.

Enacting this legislation will implement a diversion control plan that contains specific measures to reduce the likelihood of the diversion of controlled substances prescribed by the physician for the treatment of opioid use disorder.

In 2013 nearly 4.5 million people in the United States without a valid medical need were using prescription painkillers.

Both states and the federal government have begun responding to this growing public health crisis.

The Obama administration has awarded $94 million to community health centers to improve and expand the delivery of substance abuse services.

Mr. Speaker, the mounting number of people adversely affected and the over 25,000 lives lost expressly demonstrates the need for this type of legislation.

H.R. 4981 is a positive step in the right direction and I urge all members to support this important legislation.

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. 4981, 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.

VICTIMS OF GUN VIOLENCE

(Mr. PETERS asked and was given permission to address the House for 1 minute.)

Mr. PETERS. Mr. Speaker, Akron, Ohio, April 18, 2013:

Kem Delaney, 23 years old.
Kiana Welch, 19.
Maria Nash, 19.

Kalamazoo, Michigan, February 20, 2016:

Dorothy Brown, 74 years old.
Barbara Hawthorne, 68.
Mary Lou Nye, 62.
Mary Jo Nye, 60.
Richard Smith, 53.
Tyler Smith, 17.

Lakeland, Florida, January 6, 2016:

Eneida Branch, 31 years old.
David Washington, 24.
Angelica Guadalupe Castro, 23.

Pelzer, South Carolina, March 5, 2014:

Victor Vandegrift, 48 years old.
Wanda Renee Anderson, 43.
Hank Eaton, 32.

Kansas City, Kansas, March 7, 2016:

Randy J. Nordman, 49 years old.
Mike Capps, 41.
Austin Harter, 29.
Clint Harter, 27.

Jackson, Tennessee, April 28, 2016:

Dartalin Pharmer, 32 years old.
Delandis Cortez Clark, 31.
Brian Jontez Banes, 31.
Tashonda Davis, 22.

Wilmington, Delaware, February 11, 2016:

Steven Rinehart, 50 years old.
Laura Elizabeth Mulford, 47.
Officer Michael Manley, 42.
Christine Belford, 39.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 1252. An act to authorize a comprehensive strategic approach for United States foreign assistance to developing countries to reduce global poverty and hunger, achieve food and nutrition security, promote inclusive, sustainable, agricultural-led economic growth, improve nutritional outcomes, especially for women and children, build resilience among vulnerable populations, and for other purposes; to the Committee on Foreign Affairs.

S. 1352. An act to increase Federal Pell Grants for the children of fallen public safety officers, and for other purposes; to the Committee on Education and the Workforce; in addition, to the Committee on the Budget; and to the Committee on the Judiciary for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

Mr. PETERS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 6 o'clock and 52 minutes p.m.), under its previous order, the House adjourned until tomorrow, Thursday, May 12, 2016, at 10 a.m. for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XIV, executive communications were taken from the Speaker's table and referred as follows:

5322. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's direct final rule — Standard Preparations, Limits of Potency, and Dating Period Limitations for Biological Products [Docket No.: FDA-2016-N-1170] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5323. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule — Standards for the Growing, Harvesting, Packing, and Holding of Produce for Human Consumption; Technical Amendment [Docket No.: FDA-2011-N-0921] (RIN: 0910-AG35) received May 9, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5324. A letter from the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, Department of Justice, transmitting the Department's final order — Schedules of Controlled Substances: Temporary Placement of Butyryl Fentanyl and Beta-Hydroxythiofentanyl into Schedule I [Docket No.: DEA-434F] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5325. A letter from the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, Department of Justice, transmitting the Department's interim final rule — Schedules of Controlled Substances: Placement of Brivaracetam into Schedule V [Docket No.: DEA-435] received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Energy and Commerce.

5326. A letter from the Secretary, Department of the Treasury, transmitting a six-month periodic report on the national emergency with respect to Sudan that was declared in Executive Order 13067 of November 3, 1997, pursuant to 50 U.S.C. 1641(c); Public Law 94-412, Sec. 401(c); (90 Stat. 1257) and 50 U.S.C. 1703(c); Public Law 95-223, Sec 204(c); (91 Stat. 1627); to the Committee on Foreign Affairs.

5327. A letter from the Assistant Secretary, Legislative Affairs, Department of State, transmitting a report to Congress on the status of the Government of Cuba's compliance with the United States-Cuba September 1994 ''Joint Communique'' and the treatment by the Government of Cuba of persons returned to Cuba in accordance with the United States-Cuba May 1995 ''Joint Statement'', together known as the Migration Accords, pursuant to Public Law 105-277, Sec. 2245; (112 Stat. 2681-824); to the Committee on Foreign Affairs.

5328. A letter from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting the FY 2015 No FEAR Act report, pursuant to Public Law 107-174, 203(a); (116 Stat. 569); to the Committee on Oversight and Government Reform.

5329. A letter from the Regulations Coordinator, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting the Department's interim final rule — Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program [CMS-9933-IFC] (RIN: 0938-AS87) received May 10, 2016, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); jointly to the Committees on Energy and Commerce and Ways and Means.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BISHOP of Utah: Committee on Natural Resources. H.R. 1621. A bill to modify the boundary of Petersburg National Battlefield in the Commonwealth of Virginia, and for other purposes; with an amendment (Rept. 114–562, Pt. 1). Referred to the Committee of the Whole House on the state of the Union.

Mr. BISHOP of Utah: Committee on Natural Resources. H.R. 3211. A bill to provide for the addition of certain real property to the reservation of the Siletz Tribe in the State of Oregon (Rept. 114–563). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEE

Pursuant to clause 2 of rule XIII, the Committee on Armed Services discharged from further consideration H.R. 1621 referred to the Committee of the Whole House on the state of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mrs. LOVE:

H.R. 5188. A bill to amend title XVIII of the Social Security Act to promote physician training in newly recognized primary medical specialties, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. KUSTER:

H.R. 5189. A bill to address the opioid abuse crisis; to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Veterans' Affairs, Education and the Workforce, Ways and Means, Armed Services, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. COSTELLO of Pennsylvania:
H.R. 5190. A bill to amend title 38, United States Code, to provide greater flexibility to States in carrying out the Disabled Veterans' Outreach Program and employing local veterans' employment representatives, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. DOLD:
H.R. 5191. A bill to amend the Internal Revenue Code of 1986 to provide incentives for employers to establish student loan repayment programs and to make contributions to qualified tuition programs on behalf of children of employees; to the Committee on Ways and Means.

By Mr. BISHOP of Utah:
H.R. 5192. A bill to amend title 49, United States Code, to provide for overflights of national recreation areas where the primary recreational activities involve motorized watercraft, and for other purposes; to the Committee on Transportation and Infrastructure.

By Ms. JENKINS of Kansas:
H.R. 5193. A bill to amend the Internal Revenue Code of 1986 to make improvements in the rules related to qualified tuition program sand qualified ABLE programs; to the Committee on Ways and Means.

By Mr. BLUMENAUER:
H.R. 5194. A bill to amend the Internal Revenue Code of 1986 to allow a credit against tax for costs incurred by certain businesses for drug disposal programs; to the Committee on Ways and Means.

By Ms. DELAURO (for herself, Mr. VAN HOLLEN, Ms. WASSERMAN SCHULTZ, Mr. FARR, Mr. DAVID SCOTT of Georgia, Ms. MOORE, Ms. JUDY CHU of California, Mr. TAKANO, Mr. ENGEL, Mr. GRIJALVA, Mr. RYAN of Ohio, Mrs. NAPOLITANO, Mr. PAYNE, Mr. HIGGINS, Ms. PINGREE, Ms. BORDALLO, Mr. SCHIFF, Mr. LANGEVIN, Ms. KAPTUR, Mr. NADLER, Mr. HASTINGS, Ms. TSONGAS, Mr. LARSON of Connecticut, Ms. LEE, Mr. SHERMAN, Mr. POCAN, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Ms. SLAUGHTER, Mr. RANGEL, Mr. SWALWELL of California, Ms. CASTOR of Florida, Mr. YOUNG of Alaska, Ms. SCHAKOWSKY, Mr. HINOJOSA, Mr. PRICE of North Carolina, Ms. JACKSON LEE, Mr. CONNOLLY, Mr. YARMUTH, and Mr. LEVIN):
H.R. 5195. A bill to require that health plans provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations; to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ISRAEL (for himself and Mr. PETERS):
H.R. 5196. A bill to amend the Internal Revenue Code of 1986 to provide an income tax credit for eldercare expenses; to the Committee on Education and the Workforce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KENNEDY (for himself, Mr. GIBSON, Mr. ASHFORD, Mr. GARAMENDI, and Mr. PETERS):
H.R. 5197. A bill to provide assistance to foreign countries to interdict or seize shipments of items in contravention of United Nations Security Council Resolution 1701 or 2231, and for other purposes; to the Committee on Armed Services, and in addition to the Committee on Foreign Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. CAROLYN B. MALONEY of New York (for herself, Mr. BLUMENAUER, Ms. JUDY CHU of California, Mr. ISRAEL, Mrs. LOWEY, Mr. MCGOVERN, Ms. NORTON, Mr. RYAN of Ohio, Ms. SCHAKOWSKY, Mr. SERRANO, Ms. SLAUGHTER, Ms. TSONGAS, Mr. SHERMAN, Mr. CAPUANO, Ms. MOORE, Mr. ELLISON, and Mr. FOSTER):
H.R. 5198. A bill to amend the Truth in Lending Act to establish fair and transparent practices related to the marketing and provision of overdraft coverage programs at depository institutions, and for other purposes; to the Committee on Financial Services.

By Mr. MEADOWS:
H.R. 5199. A bill to amend title 41, United States Code, to improve the manner in which Federal contracts for construction and design services are awarded, and to prohibit the use of reverse auctions for design and construction services procurements; to the Committee on Oversight and Government Reform.

By Mr. POMPEO (for himself and Mr. LIPINSKI):
H.R. 5200. A bill to direct the Secretary of Defense to submit to Congress a report on cooperation between Iran and the Russian Federation; to the Committee on Armed Services, and in addition to the Committee on Foreign Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SWALWELL of California (for himself, Ms. LOFGREN, Mr. BEN RAY LUJÁN of New Mexico, Ms. ESHOO, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Ms. LEE, Mr. HONDA, Mr. PERLMUTTER, Mrs. WATSON COLEMAN, Mr. DESAULNIER, Mr. CÁRDENAS, Ms. JUDY CHU of California, Mr. FATTAH, and Mr. LANGEVIN):
H.R. 5201. A bill to amend the Higher Education Act of 1965 to expand eligibility for public service student loan forgiveness to certain contractor employees of national laboratories; to the Committee on Education and the Workforce.

By Ms. MAXINE WATERS of California (for herself, Ms. BASS, Mr. BECERRA, Ms. BROWNLEY of California, Mr. CÁRDENAS, Ms. JUDY CHU of California, Ms. HAHN, Mr. TED LIEU of California, Mr. LOWENTHAL, Mrs. NAPOLITANO, Ms. ROYBAL-ALLARD, Ms. LINDA T. SÁNCHEZ of California, Mr. SCHIFF, Mr. SHERMAN, and Mrs. TORRES):
H.R. 5202. A bill to require the Department of Housing and Urban Development to fill all asset management positions located at non-core office locations of the Office of Multifamily Housing, and for other purposes; to the Committee on Financial Services.

By Mr. GRIFFITH:
H. Res. 723. A resolution expressing the support of the House of Representatives for the designation of a National Day of Recognition for the centennial of the Convention Between the United States and Great Britain (for Canada) for the Protection of Migratory Birds, and for other purposes; to the Committee on Natural Resources.

By Ms. EDDIE BERNICE JOHNSON of Texas (for herself, Ms. BROWN of Florida, Mr. PETERS, Mr. THOMPSON of Mississippi, Ms. CLARKE of New York, Mr. PAYNE, Mrs. CAPPS, Ms. EDWARDS, Ms. MOORE, Mr. ELLISON, Mr. RUSH, Mr. JOYCE, Ms. SCHAKOWSKY, Mrs. ELLMERS of North Carolina, Mr. GRIJALVA, Mr. LARSEN of Washington, Mr. MICHAEL F. DOYLE of Pennsylvania, Mr. LEWIS, Ms. BORDALLO, Ms. BONAMICI, Ms. NORTON, Mr. LYNCH, Mr. BLUMENAUER, Mr. SABLAN, Mr. RUIZ, Mrs. DINGELL, Mr. RODNEY DAVIS of Illinois, Mr. POCAN, Mr. CARSON of Indiana, Mr. MCKINLEY, and Mrs. BLACK):
H. Res. 724. A resolution supporting the goals and ideals of National Nurses Week on May 6, 2016, through May 12, 2016; to the Committee on Energy and Commerce.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of rule XII of the Rules of the House of Representatives, the following statements are submitted regarding the specific powers granted to Congress in the Constitution to enact the accompanying bill or joint resolution.

By Mrs. LOVE:
H.R. 5188.
Congress has the power to enact this legislation pursuant to the following:
The Constitutional authority in which this bill rests is in the power of the Congress To regulate Commerce as enumerated by Article 1, section 8 of the United States Constitution as applied to providing for the general Welfare of the United States through the Center for Medicare and Medicaid Services.

By Ms. KUSTER:
H.R. 5189.
Congress has the power to enact this legislation pursuant to the following:
Article I, Section 8

By Mr. COSTELLO of Pennsylvania:
H.R. 5190.
Congress has the power to enact this legislation pursuant to the following:
Article 1, Section 8 of the United States Constitution.

By Mr. DOLD:
H.R. 5191.
Congress has the power to enact this legislation pursuant to the following:
Article I, Section 8, Clause I

By Mr. BISHOP of Utah:
H.R. 5192.
Congress has the power to enact this legislation pursuant to the following:
Article IV, Section 3, Clause 2 and Article I, Section 8

By Ms. JENKINS of Kansas:
H.R. 5193.
Congress has the power to enact this legislation pursuant to the following:
Article 1, Section 8

By Mr. BLUMENAUER:
H.R. 5194.
Congress has the power to enact this legislation pursuant to the following:
The Constitution of the United States provides clear authority for Congress to pass tax legislation. Article I of the Constitution, in detailing Congressional authority, provides that ''Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises . . .'' (Section 8, Clause 1). This legislation is introduced pursuant to that grant of authority.

By Ms. DELAURO:
H.R. 5195.
Congress has the power to enact this legislation pursuant to the following:
Article I, Section 8, Clause 3 of the United States Constitution and Article I, Section 8, Clause 1 of the United States Constitution.

By Mr. ISRAEL:
H.R. 5196.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8 of the United States Constitution.

By Mr. KENNEDY:

H.R. 5197.

Congress has the power to enact this legislation pursuant to the following:

Article I Section 8 of the United States Constitution

By Mrs. CAROLYN B. MALONEY of New York:

H.R. 5198.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause 3, the Commerce Clause

By Mr. MEADOWS:

H.R. 5199.

Congress has the power to enact this legislation pursuant to the following:

The Congress enacts this bill pursuant to Clause 1 of Section 8 of Article I of the United States Constitution, which provides Congress with the ability to enact legislation nessecary and proper to effectuate its purpose in taxing and spending.

By Mr. POMPEO:

H.R. 5200.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8 of the Constitution of the United States

By Mr. SWALWELL of California:

H.R. 5201.

Congress has the power to enact this legislation pursuant to the following:

Article I, Sections 8 and 9

By Ms. MAXINE WATERS of California:

H.R. 5202.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause 5 and Clause 18 of the United States Constitution

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions, as follows:

H.R. 24: Mr. CHAFFETZ and Mr. MEEHAN.
H.R. 167: Mr. DUFFY.
H.R. 183: Mr. WESTERMAN.
H.R. 187: Mr. YOUNG of Iowa.
H.R. 239: Miss RICE of New York.
H.R. 265: Mr. SCOTT of Virginia.
H.R. 303: Mr. O'ROURKE.
H.R. 329: Mr. KILMER.
H.R. 335: Mr. QUIGLEY and Mr. RUPPERSBERGER.
H.R. 379: Mr. HARPER and Mr. LARSEN of Washington.
H.R. 428: Ms. STEFANIK.
H.R. 448: Mr. WALZ.
H.R. 540: Mr. SMITH of Nebraska.
H.R. 563: Ms. DEGETTE.
H.R. 611: Mr. WALKER, Mr. AUSTIN SCOTT of Georgia, Mr. WITTMAN, and Mr. WILSON of South Carolina.
H.R. 649: Ms. CASTOR of Florida.
H.R. 706: Mr. O'ROURKE.
H.R. 716: Mr. VARGAS.
H.R. 835: Mr. CUMMINGS, Ms. ROYBAL-ALLARD, Mr. ASHFORD, and Mr. KENNEDY.
H.R. 836: Mr. PITTENGER.
H.R. 840: Ms. VELÁZQUEZ.
H.R. 863: Mr. HUELSKAMP.
H.R. 923: Mr. YODER and Mr. LUETKEMEYER.
H.R. 953: Ms. BROWNLEY of California.
H.R. 973: Mrs. LOWEY.
H.R. 986: Mr. UPTON.
H.R. 1139: Mr. PASCRELL.
H.R. 1141: Mr. PETERS.
H.R. 1197: Mr. ROSKAM.
H.R. 1221: Mr. ALLEN and Mr. WALZ.
H.R. 1247: Mr. CRAMER and Ms. CASTOR of Florida.
H.R. 1274: Mr. CONYERS.
H.R. 1401: Mr. CARTWRIGHT.
H.R. 1519: Mr. VARGAS.
H.R. 1559: Mr. WENSTRUP and Mr. HARDY.
H.R. 1602: Mr. CICILLINE.
H.R. 1655: Mr. DESAULNIER.
H.R. 1686: Mr. KILMER.
H.R. 1736: Mr. POCAN.
H.R. 1752: Mr. MASSIE.
H.R. 1814: Mr. BRADY of Pennsylvania.
H.R. 1877: Mr. GIBSON.
H.R. 1911: Mrs. KIRKPATRICK.
H.R. 1940: Mr. HECK of Washington and Mr. WELCH.
H.R. 1943: Mr. CUMMINGS and Mr. CARSON of Indiana.
H.R. 1981: Mr. THORNBERRY.
H.R. 2056: Mr. SABLAN.
H.R. 2076: Mr. GRIJALVA.
H.R. 2144: Ms. DUCKWORTH.
H.R. 2156: Mr. TAKANO, Mr. BRADY of Pennsylvania, Mr. AGUILAR, and Mr. BYRNE.
H.R. 2173: Mr. LOEBSACK, Mr. DESAULNIER, Mr. KILMER, Ms. KAPTUR, Mr. CICILLINE, and Mr. SEAN PATRICK MALONEY of New York.
H.R. 2227: Ms. STEFANIK.
H.R. 2260: Mr. DESAULNIER.
H.R. 2274: Mrs. DINGELL.
H.R. 2285: Ms. JACKSON LEE, Mr. CICILLINE, and Mr. THOMPSON of Mississippi.
H.R. 2350: Mr. BYRNE, Mr. DESAULNIER, Mr. POCAN, Mr. DUFFY, Mr. BRADY of Pennsylvania, Ms. SINEMA, Mr. HASTINGS, Mrs. WAGNER, and Mr. ASHFORD.
H.R. 2434: Ms. WASSERMAN SCHULTZ, Mr. DESJARLAIS, and Ms. DUCKWORTH.
H.R. 2450: Ms. KUSTER.
H.R. 2500: Mr. COSTA and Mr. COLE.
H.R. 2513: Mr. SENSENBRENNER.
H.R. 2519: Mr. BRENDAN F. BOYLE of Pennsylvania and Mr. ASHFORD.
H.R. 2622: Mrs. WALORSKI.
H.R. 2627: Mr. AGUILAR.
H.R. 2658: Mr. BOUSTANY.
H.R. 2669: Mr. BEYER.
H.R. 2694: Mr. CARSON of Indiana, Mr. DEFAZIO, Mr. KIND, and Mr. SERRANO.
H.R. 2737: Mr. BERA, Mr. GRIJALVA, Mrs. LOWEY, Mr. CÁRDENAS, and Mr. MEEKS.
H.R. 2739: Mrs. BROOKS of Indiana and Ms. WASSERMAN SCHULTZ.
H.R. 2799: Mr. CURBELO of Florida and Mr. KILMER.
H.R. 2805: Mrs. HARTZLER.
H.R. 2844: Ms. ROYBAL-ALLARD, Mr. BISHOP of Georgia, and Ms. DELAURO.
H.R. 2889: Mr. GRAYSON, Mr. BEYER, Mr. SARBANES, Mr. GARAMENDI, Mr. LOWENTHAL, Ms. DELAURO, Ms. SCHAKOWSKY, and Mr. POCAN.
H.R. 2894: Mr. LOEBSACK.
H.R. 2896: Mr. SIMPSON.
H.R. 2948: Ms. JUDY CHU of California, Mr. PETERS, and Mr. EMMER of Minnesota.
H.R. 2980: Mr. KATKO and Mr. CARTWRIGHT.
H.R. 3011: Mr. POSEY.
H.R. 3012: Mr. CICILLINE and Mr. ROHRABACHER.
H.R. 3084: Mr. GIBSON, Mr. DENHAM, and Mr. WHITFIELD.
H.R. 3088: Mr. GRAVES of Georgia.
H.R. 3095: Mr. MEEHAN and Mr. CARTWRIGHT.
H.R. 3096: Mrs. WATSON COLEMAN.
H.R. 3105: Ms. DUCKWORTH.
H.R. 3222: Mrs. WAGNER and Mr. MEADOWS.
H.R. 3225: Mr. DESJARLAIS.
H.R. 3229: Mr. MURPHY of Pennsylvania, Mr. DEFAZIO, Mr. MARINO, Mr. RUSH, Mr. THOMPSON of Mississippi, and Mr. YOUNG of Iowa.
H.R. 3250: Mr. PAULSEN.
H.R. 3266: Ms. LOFGREN and Ms. ESHOO.
H.R. 3294: Mrs. CAROLYN B. MALONEY of New York.
H.R. 3299: Mr. MESSER and Mr. RUPPERSBERGER.
H.R. 3323: Mr. RUSH, Ms. MENG, Mr. BLUMENAUER, Mr. COFFMAN, Mr. BOUSTANY, Mrs. KIRKPATRICK, Mr. LOBIONDO, and Mr. TIPTON.
H.R. 3355: Mr. PASCRELL.
H.R. 3471: Mr. HONDA.
H.R. 3690: Mr. GRAYSON.
H.R. 3706: Mr. COOK, Mr. GRAYSON, Mr. THOMPSON of Mississippi, Mr. RUSH, Mr. HASTINGS, Mr. HIMES, and Mr. ROUZER.
H.R. 3742: Mr. RUPPERSBERGER and Ms. BROWNLEY of California.
H.R. 3799: Mr. PALMER, Mr. OLSON, and Mr. GENE GREEN of Texas.
H.R. 3817: Ms. STEFANIK.
H.R. 3846: Mr. RICHMOND and Mr. COURTNEY.
H.R. 3870: Ms. DELAURO.
H.R. 3882: Ms. MOORE, Ms. NORTON, and Mr. ISRAEL.
H.R. 3957: Mr. SCHWEIKERT.
H.R. 4007: Mr. KING of Iowa.
H.R. 4019: Ms. DELAURO and Mr. CONNOLLY.
H.R. 4059: Mr. MULLIN, Mr. LUCAS, and Mr. OLSON.
H.R. 4062: Mr. GRIFFITH.
H.R. 4137: Mr. AL GREEN of Texas.
H.R. 4146: Mr. PASCRELL and Mr. CAPUANO.
H.R. 4147: Mr. PASCRELL and Mr. CAPUANO.
H.R. 4247: Ms. STEFANIK, Mr. BILIRAKIS, and Mr. MCCAUL.
H.R. 4266: Mr. HASTINGS.
H.R. 4301: Mr. VALADAO, Mr. LANCE, Mr. LAMALFA, Mrs. BLACK, Mr. RATCLIFFE, and Mr. OLSON.
H.R. 4333: Ms. FRANKEL of Florida and Mr. BRENDAN F. BOYLE of Pennsylvania.
H.R. 4365: Mr. COSTELLO of Pennsylvania, Mr. ROUZER, and Mr. JOYCE.
H.R. 4428: Mr. BILIRAKIS.
H.R. 4442: Mr. GRIFFITH, Mr. MEEHAN, Mr. LOEBSACK, Mr. HUFFMAN, and Mr. BRADY of Pennsylvania.
H.R. 4445: Mr. DEFAZIO.
H.R. 4448: Mr. TOM PRICE of Georgia.
H.R. 4514: Mr. COSTELLO of Pennsylvania and Ms. MCSALLY.
H.R. 4575: Mr. HUIZENGA of Michigan and Mrs. BEATTY.
H.R. 4592: Mr. POSEY, Mr. SIRES, Ms. WILSON of Florida, Mrs. BUSTOS, Mr. HASTINGS, Mrs. DINGELL, Mr. DELANEY, Mr. PERLMUTTER, Ms. BROWNLEY of California, Mr. RUSH, Mr. QUIGLEY, Mr. FOSTER, Mr. COOPER, Mr. ASHFORD, Mr. BRENDAN F. BOYLE of Pennsylvania, Mrs. CAPPS, Mr. CONNOLLY, Ms. KAPTUR, Mr. BEN RAY LUJÁN of New Mexico, Mr. NORCROSS, Mrs. KIRKPATRICK, Mr. SWALWELL of California, and Mr. BISHOP of Georgia.
H.R. 4602: Mr. JEFFRIES.
H.R. 4625: Mr. ZELDIN.
H.R. 4626: Mr. RUIZ, Mr. ZINKE, Ms. SEWELL of Alabama, Mr. FLEISCHMANN, Mr. CAPUANO, Ms. GRAHAM, Mr. HECK of Washington, and Mr. CRENSHAW.
H.R. 4636: Mr. LOUDERMILK and Mr. WESTERMAN.
H.R. 4658: Mrs. LOVE.
H.R. 4662: Mr. HARPER.
H.R. 4684: Ms. GABBARD.
H.R. 4696: Mr. LOWENTHAL.
H.R. 4703: Mr. ROKITA.
H.R. 4760: Mr. BRIDENSTINE and Ms. JENKINS of Kansas.
H.R. 4768: Mr. WEBER of Texas, Mrs. MIMI WALTERS of California, Mr. POE of Texas, Mr. GIBBS, and Mr. RIBBLE.
H.R. 4770: Mr. BOUSTANY.
H.R. 4773: Mr. GUINTA, Mr. HARPER, Mr. PALMER, Mr. KINZINGER of Illinois, and Mr. GRAVES of Missouri.
H.R. 4782: Mr. O'ROURKE.
H.R. 4792: Mr. CONNOLLY.
H.R. 4818: Mr. GRAVES of Georgia.
H.R. 4819: Mr. ROSKAM and Mrs. BLACK.
H.R. 4828: Mr. ROSKAM.
H.R. 4830: Mr. RUSH and Mr. ROKITA.
H.R. 4867: Mr. MEEHAN.

H.R. 4905: Mr. DESAULNIER.
H.R. 4907: Mrs. NOEM and Mr. TIPTON.
H.R. 4913: Mrs. WAGNER.
H.R. 4926: Mr. SESSIONS and Mr. JODY B. HICE of Georgia.
H.R. 4928: Mr. STUTZMAN, Mr. WEBER of Texas, Mr. PITTENGER, and Mr. YOHO.
H.R. 4933: Mr. DESAULNIER.
H.R. 4942: Ms. LEE.
H.R. 4956: Mr. BISHOP of Utah.
H.R. 4959: Mr. ROE of Tennessee and Mr. TOM PRICE of Georgia.
H.R. 4960: Mr. PERLMUTTER.
H.R. 4963: Mr. DESAULNIER.
H.R. 4965: Ms. JUDY CHU of California.
H.R. 4966: Ms. JUDY CHU of California.
H.R. 4994: Mr. PETERS.
H.R. 4999: Mr. CONNOLLY and Mr. LAMBORN.
H.R. 5001: Mr. SENSENBRENNER and Mr. SESSIONS.
H.R. 5015: Mrs. HARTZLER and Ms. MCSALLY.
H.R. 5025: Mr. GUTIÉRREZ, Mr. FATTAH, and Mr. CUELLAR.
H.R. 5044: Mr. CUMMINGS, Mr. COURTNEY, Mr. SHERMAN, Mr. LEVIN, Ms. DEGETTE, Mr. POCAN, Mr. SWALWELL of California, Mr. WELCH, Mr. RYAN of Ohio, and Mr. CUELLAR.
H.R. 5064: Mr. KATKO.
H.R. 5073: Mr. RIBBLE.
H.R. 5082: Mr. CHABOT.
H.R. 5090: Mr. CARSON of Indiana, Mr. JOHNSON of Georgia, Mr. DOGGETT, Mr. PERLMUTTER, Ms. FRANKEL of Florida, Mr. BLUMENAUER, Ms. KUSTER, Mr. MOULTON, Mr. LANGEVIN, Mr. PETERS, Ms. SCHAKOWSKY, Ms. JUDY CHU of California, Mr. MCGOVERN, Mr. RUIZ, Mr. STIVERS, Mr. BRIDENSTINE, and Mr. SERRANO.
H.R. 5100: Mr. ASHFORD.
H.R. 5111: Mr. CÁRDENAS.
H.R. 5112: Mr. BARR and Mr. MULVANEY.
H.R. 5119: Mr. HILL.
H.R. 5124: Mr. CICILLINE and Ms. JACKSON LEE.
H.R. 5130: Ms. JUDY CHU of California, Ms. LEE, Ms. ADAMS, Ms. MENG, and Mrs. WATSON COLEMAN.
H.R. 5146: Mr. RICHMOND and Ms. BROWNLEY of California.
H.R. 5164: Mr. HUELSKAMP.
H.R. 5172: Mr. REED.
H.R. 5183: Mr. RYAN of Ohio, Mr. RUPPERSBERGER, Miss RICE of New York, and Mr. KILMER.
H.R. 5187: Mr. NEAL.
H. Con. Res. 40: Mr. COSTA, Mr. DESAULNIER, Ms. MATSUI, Mr. BRADY of Pennsylvania, Ms. SPEIER, Mr. FARENTHOLD, Mr. MCCAUL, and Mr. HULTGREN.
H. Con. Res. 100: Mr. PEARCE.
H. Con. Res. 122: Mr. GRIJALVA and Mrs. KIRKPATRICK.
H. Con. Res. 128: Mr. ADERHOLT and Mr. KINZINGER of Illinois.
H. Res. 14: Mr. SHERMAN, Ms. LEE, and Ms. SPEIER.
H. Res. 28: Mr. YOUNG of Iowa and Ms. MCCOLLUM.
H. Res. 521: Mr. CICILLINE.
H. Res. 565: Mrs. WALORSKI.
H. Res. 571: Mr. HARRIS.
H. Res. 683: Mr. LEWIS, Mr. MCGOVERN, Mr. POCAN, and Mr. GRIJALVA.
H. Res. 712: Mr. LUETKEMEYER.
H. Res. 722: Mr. MCGOVERN.