

MEMBER DAY: TESTIMONY AND PROPOSALS ON THE OPIOID CRISIS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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WEDNESDAY, OCTOBER 11, 2017

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:17 a.m., in room 2322, Rayburn House Office Building, Hon. Michael C. Burgess (chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Guthrie, Barton, Upton, Shimkus, Lance, Bilirakis, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Butterfield, Matsui, Luján, Kennedy, Eshoo, and Pallone (ex officio).

Staff present: Adam Buckalew, Professional Staff Member, Health; Kelly Collins, Staff Assistant; Zack Dareshori, Staff Assistant; Jordan Davis, Director of Policy and External Affairs; Paul Eddatell, Chief Counsel, Health; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Communications Director; Katie McKeogh, Press Assistant; Alex Miller, Video Production Aide and Press Assistant; Christopher Santini, Counsel, Oversight and Investigations; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Counsel, Health; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Jourdan Lewis, Minority Staff Assistant; Jessica Martinez, Minority Outreach and Member Services Coordinator; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Member Services, and Outreach; Kimberlee Trzeciak, Minority Senior Health Policy Advisor; and C.J. Young, Minority Press Secretary.

Mr. BURGESS. Subcommittee will come to order, and I will recognize myself for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

United States of America is in the midst of a fierce battle against an epidemic brought to us by opioids. It does not matter where you live. This crisis has touched every corner of American society.

While New England and the Ohio Valley regions represent States hardest hit by the epidemic, health officials from the South and reaching across the West all report a growing number of overdose deaths in those counties.

The latest figures from the Center for Disease Control and Prevention are astounding. Ninety-one Americans die every day from an overdose.

Now, more than ever, we must come together and strengthen our commitment to fight this malady. I expect today's Members Day will bring to the forefront key insights and potential solutions on this critical issue.

In the previous Congress, the Energy and Commerce Committee led several bipartisan initiatives to help address the opioid epidemic.

The Comprehensive Addiction Recovery Act and the 21st Century Cures Act are now law and providing resources at the State and local levels.

Much-needed policy changes are being implemented the passage of both CARA—with the passage of both CARA and Cures.

In fact, as a result of CARA, patients suffering from substance abuse now have greater access to evidence-based treatment, addiction treatment services, and overdose reversal therapies.

Cures, on the other hand, provided \$1 billion in grants for States to support an array of prevention treatment and recovery services. I believe these initiatives are making a significant difference.

At the same time, other issues have emerged in this fight. Earlier this year, our committee responded to reports of people overdosing on heroin laced with synthetic opioids—fentanyl, carfentanyl—which are 100 to 10,000 times more potent than morphine.

The ready availability of these synthetic opioids have become a public health threat and illegal online pharmacies, primary operating in foreign countries, are exacerbating this epidemic every day for our State and Federal officials.

Today's hearing will allow us to gain Member perspective on potential ways to complement existing policies and Federal regulations to combat the opioid epidemic.

Representatives both on and off the Energy and Commerce Committee will testify about the opioid epidemic, share their stories, and propose legislative solutions for our consideration.

In advance, I want to thank House Members for participating in this important discussion, and we look forward to hearing from everyone who's going to be before us today.

Let me yield what little time I have left to the vice chairman of the Health Subcommittee, Mr. Guthrie.

Mr. GUTHRIE. Thank you very much. Obviously, I am going to be brief.

So many families have been devastated by this, and in "Dreamland," which is a book that I read about the opioid crisis—an important book that I read about the opioid crisis—had all these different scenarios.

But when you see it in reality, I was in Owensboro one evening and met a mom. The mom was the mother of an athletic student—an athlete and an honor student—who had her ACL torn playing soccer, was prescribed painkillers.

After her recovery she was addicted to pain killers. Since she couldn't have access to them, turned to heroin, and passed away due to an overdose.

This is a sad story that is repeated through all groups and all areas and it's something that I am looking forward to hearing all the testimony today to look for ideas to further do what Congress has done through CARA and moving forward as well.

So I thank you, Mr. Chairman, for yielding and I yield back the balance of my time.

Mr. BURGESS. The Chair now recognizes the ranking member of the subcommittee, Mr. Green, 3 minutes for an opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman.

The Centers for Disease Control and Prevention has called for prescription drug overdose abuse in the United States an epidemic, has found drug overdose to be the leading cause of injury death in the United States.

Between 1999 and 2010, the death rate from prescription painkillers more than quadrupled and only continues to rise. In 2015, more than 52,000 people died of drug overdoses in America and about two-thirds of those were linked to opioids.

The toll is only rising. The New York Times' analysis of preliminary data found that 59,000 to 65,000 likely died from overdoses in 2016.

Today, it's estimated that more than 2 million have use disorder and too few of these people are in treatment. The rate of heroin overdoses had increased dramatically in recent years.

Its rise is directly linked to the opioid epidemic. In 2010, approximately 3,000 drug-poisoning deaths were connected to heroin. In 2013, the number jumped to a total of 8,000 overdose deaths and only continues to rise.

There is no community that has not been touched by this crisis and some have been ravaged by it. This committee has taken steps to address the crisis but so much is needed to combat it when families and communities across the country are being torn apart.

Included in the 21st Century Cares, or the State-targeted response to the opioid crisis grant program, it provided a billion dollars over 2017 to 2018 to States to address the opioid epidemic.

Extending this money is a crucial part of any continued Federal efforts to respond to the epidemic. We need an approach that employs proven health—public health strategies and spans the entire spectrum from prevention to treatment and recovery.

These include robust funding to support prevention, crisis response and expanded access to treatment and long—lifelong recovery tools.

The Affordable Care Act is a vital part of our efforts to fight against the opioid epidemic. More than 1.5 million Americans with substance abuse use disorders have access to treatment through Medicaid that doesn't—that didn't before the ACA, thanks to the Medicaid expansion.

Unfortunately, Americans fighting addiction that live in States that refuse to expand their Medicaid programs like Texas were left out in the cold.

For those in the individual market, all plans must include services for substance abuse disorders and mental health, and consumers cannot be denied coverage because of a history of substance abuse, all thanks to the ACA.

This is not a small feat. Prior to the ACA, roughly a third of all individual market policies didn't cover substance abuse treatment.

Repealing the mental substance abuse disorder coverage provision of the ACA will remove at least \$5.5 billion annually from the treatment of low-income people with mental and substance abuse disorders.

Going even further is to gut the traditional Medicaid or scrap the Medicaid expansion in States that took the money would be absolutely devastating to our fight against prescription drug and heroin addiction crisis.

We are in the midst of the largest public health crisis that our country has known and this is not time to cut health care safety nets that serve those in recovery.

I am pleased that we have the opportunity to hear from our colleagues about their proposals and to combat the prescription drug epidemic.

We need a comprehensive solution to the crisis that includes real dollars and targets the entire spectrum of addiction, prevention, crisis response for those who fall through the cracks, and expanding access to treatment and proving support for recovery.

We must be guided by science and avoid stigmas and not fall into traps, misconceptions about proven treatment strategies.

I thank the chairman for having this conversation and look forward to advancing new strategies and funding to turn the side of this growing crisis and really help families and communities that desperately need it.

And I yield back my time.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman. I will just make an organizational note before we move to our first panel.

We are going to be hearing from Energy and Commerce members at the outset. Energy and Commerce members are welcome to give their testimony from the witness table or from the dais, whichever they prefer.

We are going to move to our first panel, which will consist of Chairman Walden, Ranking Member Pallone, Chairman Upton, Ms. Eshoo, and Chairman Latta, and again, you are welcome to testify either from the table or from the dais.

So, with that, the Chair recognizes the chairman of the full committee, Mr. Walden.

STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. I thank the chairman.

I come here today on behalf of my constituents like I do every day, but I think especially today, with our opportunity for all Members to make their case to the Energy and Commerce Committee, first we want to welcome them.

And I think as our colleagues on both sides of the aisle have already said, all of us in all of our communities face these challenges related to drug overdoses.

I held a round table the day before yesterday in Bend, Oregon, where I learned a lot about the problems they're facing and some of the successes they are having, and the importance of the work that we are doing here.

It is a heartbreaking epidemic that has been featured on the front pages of our local newspapers, on national television, as part of the stories from our friends and family members, and with good reason.

Conservative estimates forecast that more than 90 Americans die from opioid abuses overdoses each day—90 a day, Mr. Chairman, while more than a thousand are treated each day for abusing opioids.

In 2016 alone, more than 64,000 Americans died from drug overdoses and in Oregon alone, more people died last year from drug overdoses than from car accidents.

I recently held round tables in southern and central Oregon to discuss how we can better combat this crisis. Meeting with the people on the front lines of this fight in our communities to find out what is working, what more can be done, is crucial to our efforts to end this scourge.

The Energy and Commerce Committee has led a number of bipartisan initiatives to help address the opioid epidemic, from groundbreaking initiatives that are now law like the Comprehensive Addiction and Recovery Act—CARA—and the 21st Century Cures Act.

Resources are become available and important policy changes are being implemented to stem the tide of opioids.

CARA established a comprehensive strategy for improving evidence-based treatment for patients with substance abuse disorders and it made significant changes to expand access to addiction treatment and services and overdose reversal medications.

The new law also included criminal justice and law enforcement-related provisions. The 21st Century Cures Act provided a billion dollars in grants for States, the first half of which was made available in April of 2017 to be administered by the Substance Abuse and Mental Health Services Administration, or SAMHSA.

My State of Oregon received \$6.5 million in grants to help combat the epidemic that has plagued our great State. However, so much more work needs to be done.

Since the passage of CARA and the 21st Century Cures Act, other issues have emerged in the fight against opioids such as the proliferation of fentanyl and its analogs, and then there are allegations of pill dumping and the practice of patient brokering.

In my own district, I've heard the all-too-familiar tale of the mother whose oldest son was first prescribed opioids after injuring his ankle playing basketball. It didn't take long for him to become addicted.

Another parent shared with me the story of his sister and nurse who died of an overdose after years of suffering from addiction and bounding between pharmacies, passing off forged prescriptions.

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 the—she was only caught because two pharmacies in the small town happen to check with each other. You see, by then it was too late, though.

These two stories may have come from Oregon, but they're not exclusive to the Beaver State. They're why we are here today.

Addressing the opioid epidemic requires an all hands on deck effort. Today we'll be hearing testimony and stories from our colleagues both on and off the Energy and Commerce Committee about what more can be done and I am looking forward to hearing feedback and input from both sides of the aisle to hear about what is working and what is not and find ways to complement our existing law and to address emerging issues.

So with that, Mr. Chairman, I appreciate everyone here today with us, taking time to participate. I look forward to hearing from all my colleagues, and together we must continue to fight this opioid crisis in America, and I yield back.

[The prepared statement of Mr. Walden follows]:

PREPARED STATEMENT OF HON. GREG WALDEN

It's great to see so much activity in our hearing room today. While there are a lot of familiar faces, there are plenty that we don't see in here on a regular basis. For those folks, I'd like to say welcome to Energy and Commerce. I'm glad you could join us for this important opportunity to highlight the opioid crisis.

The heartbreaking epidemic has been featured on the front pages of our local newspapers, on national television, and as part of stories from our friends and family members. And with good reason—conservative estimates forecast more than 90 Americans die from opioid overdoses each day, while more than 1,000 are treated each day for abusing opioids. In 2016 alone, more than 64,000 Americans died from drug overdoses, and in Oregon alone, more people died last year from drug overdoses than from car accidents.

I recently held roundtables in southern and central Oregon to discuss how we can better combat the crisis. Meeting with the people on the front lines of this fight in our communities to find out what is working, and what more can be done, is crucial to our efforts to end this scourge.

The Energy and Commerce Committee has led a number of bipartisan initiatives to help address the opioid epidemic. From groundbreaking initiatives that are now law, like the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, resources are becoming available and important policy changes are being implemented to stem the tide of opioids.

CARA established a comprehensive strategy for improving evidencebased treatment for patients with substance-use disorders and made significant changes to expand access to addiction treatment services and overdose reversal medications. The new law also included criminal justice and law enforcement-related provisions.

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However, more work needs to be done.

Since the passage of CARA and the 21st Century Cures Act, other issues have emerged in the fight against opioids, such as the proliferation of fentanyl and its analogues, allegations of pill dumping, and the practice of patient brokering.

In my own district, I've heard the all too familiar tale of the mother whose oldest son was first prescribed opioids after injuring his ankle playing basketball. It didn't take long for him to become addicted. Another parent shared with me the story of his sister, a nurse, who died of an overdose after years of suffering from addiction and bouncing between pharmacies passing off forged prescriptions. 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.

Those two stories may have come from Oregon, but they're not exclusive to my home State. And they're why we're here today.

Addressing the opioid epidemic requires an all-hands-on-deck effort. Today we will be hearing testimony and stories from our colleagues both on and off the Energy and Commerce Committee about what more can be done. I'm looking forward to hearing feedback and input from both sides of the aisle—to hear about what's working and what's not, find ways to complement existing law, and to address emerging issues.

I appreciate everyone here with us today taking the time to participate, and I look forward to hearing from my colleagues on both side of the aisle. Together, we must continue to fight to combat the opioid crisis.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman.

And again, just to reiterate the format for today, members on the Energy and Commerce Committee are invited to either give testimony from the witness table or from the dais, whichever they prefer.

So at this time I will recognize the ranking member of the full committee, Frank Pallone from New Jersey, for 5 minutes, please.

STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Burgess.

Today's Member Day provides us the opportunity to hear from our colleagues about how the epidemic is uniquely affecting their districts as well as to hear their ideas of additional efforts and funding that is needed to help individuals, families, and communities affected by this crisis.

Like all communities across the country, the opioid epidemic is having devastating consequences in my home State. Drug overdoses are the leading causes of accidental death in New Jersey.

According to the Centers for Disease Control and Prevention, there were—there was a 16 percent increase in drug overdose deaths in New Jersey between 2014 and 2015, and last year drug overdose deaths topped more than 2,000.

And unfortunately, we are continuing to see increased deaths from this tragic epidemic. I am proud of the steps this committee has taken to respond to this tragic epidemic that is taking the lives of 91 Americans every day.

I am pleased that we worked together in a bipartisan fashion to pass the Comprehensive Addiction and Recovery Act, or CARA. We also worked together to create the State-targeted response to the opioid crisis grant program as part of the 21st Century Cures Act and this grant program provides a billion to States to address the opioid epidemic.

There were positive and—well, these were positive and bipartisan laws that we produced in 2016 during the last year of the Obama administration. That was 2016. Two thousand seventeen has been much different.

Congressional Republicans have spent much of this year trying to repeal the Affordable Care Act, which would have prevented millions of Americans from getting the help that they need to treat opioid use disorders and the repeal legislation passed here in the House would have allowed insurers to once again discriminate

against people with preexisting conditions such as opioid use disorders.

The Republican-passed bill would also have allowed States to waive essential health benefits including mental health and substance use treatment.

But, thankfully, those repeal efforts have failed to date. So as we move forward, what is clear is that individuals with substance use disorder, their families, and their communities need us to work together to do more.

Despite some progress here in Washington, the epidemic has shown no signs of relenting and that is why we must continue to support and increase funding for proven health—public health approaches spanning the entire spectrum from crisis to recovery, including expanding access to medication-assisted treatment.

Those efforts should include more funding and we should extend the State-targeting response to the opioid crisis grant program so that we can expand even further people's access to opioid abuse treatment, prevention, and recovery support services.

So I look forward to hearing from my House colleagues and continuing to work together in a bipartisan fashion to help our country respond to this crisis.

I yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you Chairman Burgess. Today's Member Day provides us the opportunity to hear from our colleagues about how the epidemic is uniquely affecting their districts as well as to hear their ideas of additional efforts and funding that is needed to help individuals, families, and communities affected by this crisis.

Like all communities across the country, the opioid epidemic is having devastating consequences in my home State. Drug overdoses are the leading cause of accidental death in New Jersey. According to the Centers for Disease Control and Prevention, there was a 16 percent increase in drug overdose deaths in New Jersey between 2014 and 2015. Last year, drug overdose deaths topped more than 2,000. And unfortunately, we are continuing to see increased deaths from this tragic epidemic.

I am proud of steps this committee has taken to respond to this tragic epidemic that is taking the lives of 91 Americans every day. I am pleased that we worked together in a bipartisan fashion to pass the Comprehensive Addiction and Recovery Act (CARA). We also worked together to create the State Targeted Response to the Opioid Crisis grant program as part of the 21st Century CURES Act. This grant program provides \$1 billion to States to address the opioid epidemic.

These were positive and bipartisan laws that we produced in 2016 during the last year of the Obama administration. That was 2016—2017 has been much different. Congressional Republicans have spent much of this year trying to repeal the Affordable Care Act, which would have prevented millions of Americans from getting the help that they need to treat opioid use disorders.

The repeal legislation passed here in the House would have allowed insurers to once again discriminate against people with preexisting conditions, such as opioid use disorders. The Republican passed bill would also have allowed States to waive essential health benefits, including mental health and substance use treatment. Thankfully, repeal efforts have failed to date.

As we move forward, what's clear is that individuals with substance use disorder, their families, and their communities need us to work together to do more. Despite some progress here in Washington, the epidemic has shown no signs of relenting. That is why we must continue to support and increase funding for proven public health approaches spanning the entire spectrum from crisis to recovery, including expanding access to medication-assisted treatment. Those efforts should include more funding. We should extend the State Targeting Response to the Opioid Crisis grant program so that we expand even further people's access to opioid abuse treatment, prevention, and recovery support services.

I look forward to hearing from my House colleagues and continuing to work together in a bipartisan fashion to help our
I yield back.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman.

Chair recognizes the chairman of the Energy Subcommittee, Mr. Upton, for 3 minutes.

**STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MICHIGAN**

Mr. UPTON. Well, thank you, Mr. Chairman.

This is very important, this Member Day, as we are able to all share our personal experiences on a crisis that has been plaguing our Nation over the last couple of years—opioid addiction and abuse.

This silent epidemic has for sure torn through families, neighbourhoods, and communities, both certainly in my home State of Michigan. But we know across the country as well.

In fact, in 2015, there were nearly 2,000 opioid abuse-related deaths in Michigan alone. Even more tragically, more than 22,000 babies are born every year across the country with neonatal opioid withdrawal syndrome.

This terrible epidemic has hit home both in my community and, yes, even in my extended family. So this is very personal to me as it is with so many throughout our communities.

In the last couple of years, I have been meeting with first responders, crisis center employees, advocacy groups, and yes, individuals suffering.

All of these folks have said that, tragically, the death toll continues to rise. That is why we have been taking concrete steps here in this committee to combat the widespread epidemic.

Just last year, the President signed into his sweeping package aimed at attacking the opioid epidemic from all sides.

As part of 21st Century Cures, a bill that every one of our committee members supported, an additional \$1 billion was allocated to the States like Michigan to address opioid addiction, treatment and prevention.

This year the first round of funding was delivered. We received \$16 million and that grant funding will make a real difference. It will.

To those suffering I just say help is on the way, and as a result of this legislation as well as administrative action, NIH Director Francis Collins is helping to lead the charge.

This summer, the NIH started meeting with experts in academia and the biopharmaceutical industry to talk about innovative ways in which Government and industry can work together to address the crisis.

I strongly support that work and look forward to seeing the results of the research that NIH is doing with its industry partners.

There are also things that we in Congress can help NIH with in these endeavors. First, we need the NIH to develop more options for overdose reversals.

Second, we need the evidence that the NIH can develop an effective therapy for addiction, and finally, we must accelerate the development of nonaddictive pain medicines.

The sooner that we in Congress supply the resources necessary to conduct that work, the sooner that we can supply powerful new tools for every community.

These efforts can't happen fast enough and these are some of the many reasons that I continue to support robust NIH funding.

There is more work to be done, and here in Congress we will continue to take steps to address that epidemic and in this committee we are on the front lines to advance meaningful bipartisan legislation that indeed will make a difference. Together, we will bring it out of the shadows.

I yield back.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Mr. Chairman, thank you for holding this very important Member Day hearing on a crisis that has been plaguing our Nation over the last several years—opioid addiction and abuse. This silent epidemic has torn through families, neighborhoods, and communities both in my home State of Michigan and indeed across the entire country. In fact, in 2015, there were nearly 2,000 opioid abuse related deaths in Michigan alone.

In the last few years I have been meeting with first responders, crisis center employees, advocacy groups, and yes—individuals suffering. All of these folks have said that, tragically, the death toll continues to rise.

This is why we have been taking concrete action here in the Energy and Commerce Committee to combat this widespread epidemic. Just last year, the president signed into law a sweeping package aimed at attacking the opioid epidemic from all sides.

As part of my landmark, bipartisan 21st Century Cures Act, an additional \$1 billion was allocated to States, like Michigan, to address opioid addiction treatment and prevention. Just this year, the first round of that funding was delivered.

Michigan received more than \$16 million. This grant funding will make a real difference. To those suffering, I just say this: Help is on the way.

As a result of my legislation as well as administrative action, my good friend Dr. Francis Collins is helping to lead the charge in his position as director of the National Institutes of Health. This summer, the NIH started meeting with experts in academia and the biopharmaceutical industry to talk about innovative ways in which Government and industry can work together to address this crisis. I strongly support this work and look forward to seeing the results of the research NIH is doing with its industry partners.

There are also things we in Congress can help NIH with in these endeavors. First, we need NIH to develop more options for overdose reversal. Second, we need the evidence NIH can develop on effective therapies for addiction. And finally, we must accelerate the development of nonaddictive pain medicines. The sooner we in Congress supply the resources necessary to conduct this work, the sooner we can supply powerful new tools for our communities. These efforts can't happen fast enough, and these are some of the many reasons that I continue to support robust NIH funding.

There is more work to be done. Clearly. And here in Congress we will continue to take steps to address this epidemic. Here in this committee, we're on the front lines in advancing meaningful, bipartisan legislation that will make a difference. Together, we can take this "silent epidemic" and bring it out of the shadows.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

Chair recognizes the gentleman from New Jersey, Mr. Lance, 3 minutes, please.

**STATEMENT OF HON. LEONARD LANCE, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. LANCE. Thank you, Mr. Chairman, and I must say this is the first time I've been on this side of the dais and what a fine looking group.

Mr. GREEN. It is more fun being over here, as you know.

Mr. BURGESS. If it makes the gentleman more comfortable, we can swear you in.

[Laughter.]

Mr. LANCE. That means I would be under oath.

Mr. BURGESS. Yes.

Mr. LANCE. Thank you, Chairman Burgess, for organizing this conversation today. The opiate crisis is devastating families and communities across New Jersey, the State I represent.

In 2015, the Garden State's death rate was two and a half times the skyrocketing U.S. rate. We are making progress with the implementation of the Comprehensive Addiction Recovery Act of 2016, but more work needs to be done.

I acknowledge the efforts of one of my constituents, Basking Ridge resident Clodette Sabatelle. Clodette has done critical work and has made a positive difference in the lives of those suffering from drug addiction.

Her advocacy group, Community in Crisis, helps equip the loved ones of those in pain. None of the progress we have made so far in this fight against drug addiction and opiate abuse would have been possible without the work of people like Clodette and organizations like Community in Crisis. Their efforts are efforts that we should make sure Congress understands and applauds.

I worked closely with Clodette on the issue of over prescription. In 2012, health care providers wrote 259 million prescriptions for opiates.

The CARA provisions I authored addressed that issue by reforming and improving the medical drug approval and label process at the Food and Drug Administration.

For the first time, Congress has required the agency to work closely with expert advisory committees before making critical product approval and labeling decisions and to make recommendations regarding educational programs for prescribers of extended release and long-acting opiates.

CARA also encourages the development and approval of opiates with abuse-deterrent properties. We also have to make sure resources such as the State-targeted response to the opiate crisis grants administered by the Substance Abuse and Mental Health Services Administration continue to give States the tools they need to experiment and test best practices.

New Jersey recently secured a \$13 million Federal grant from the Substance Abuse and Mental Health Services Administration to focus on this crisis.

The Drug-Free Community Support program in the White House Office of National Drug Control Policy also recently awarded Community in Crisis and two other able organizations Hunterdon Prevention Resource and EmPoWER Somerset, each with a \$125,000 grant to assist addressing the problem of opiate and heroin abuse, provide education, and implement prevention measures.

Community in Crisis Hunterdon Prevention Resource and EmPOWER Somerset are great partners in connecting people with the resources and support they need.

These investments are not only the right thing to do but help lessen the significant strain on law enforcement resources. I commend each group on its important work.

Mr. Chairman, I stand ready to work with you and colleagues on both sides of the aisle to continue this work. Thank you for calling this hearing today.

[The prepared statement of Mr. Lance follows:]

PREPARED STATEMENT OF HON. LEONARD LANCE

Thank you, Chairman Burgess, for organizing this conversation today.

The Energy and Commerce Committee has done a lot right in the fight against drug addiction. Last year's landmark legislation set up lanes for success but it is going to be up to this committee to make sure the administration, the respective agencies and all stakeholders continue this effort to implement the Comprehensive Addiction and Recovery Act of 2016 and do all we can for those in need. I think today's Member Day demonstrates we are committed to doing that.

The opioid crisis is devastating families and communities across the Garden State. In 2015, New Jersey's heroin death rate was two-and-one-half times the skyrocketing U.S. rate. We are making progress with CARA's implementation but there is much more work to be done. Too often we are hearing about another life cut short from the scourge of drug addiction. This is not just a New Jersey problem, but an epidemic facing the entire country. We need to be working together and empowering the groups and organizations that are succeeding in turning the tide against drug abuse.

I would like to acknowledge the efforts of one of my constituents, Basking Ridge resident Clodette Sabatelle. Clodette has done critical work and has made a difference in the lives of those suffering from drug addiction. Her advocacy group, Community in Crisis, helps empower and equip the loved ones of those in pain. None of the progress we have made so far in this fight against drug addiction and opioid abuse would have been possible without the work of people like Clodette and organizations like Community in Crisis. Their efforts equipped Congress to act and helped craft and champion the CARA legislation.

I worked closely with Clodette on the issue of over prescription. In 2012, health care providers wrote 259 million prescriptions to people for opioids. The CARA provisions I authored address that issue by reforming and improving the medical drug approval and label process within the Federal Food and Drug Administration. For the first time, Congress has required the agency to work closely with expert advisory committees before making critical product approval and labeling decisions and to make recommendations regarding education programs for prescribers of extended-release and long-acting opioids. CARA also encourages the development and approval of opioids with abuse-deterrent properties.

We also have to make sure resources such as the State Targeted Response to the Opioid Crisis Grants administered by the Substance Abuse and Mental Health Services Administration continue to give States the tools they need to experiment and test best practices. New Jersey recently secured a \$13 million Federal grant from the Substance Abuse and Mental Health Services Administration to prioritize five specific strategies: strengthening public health surveillance, advancing the practice of pain management, improving access to treatment and recovery services, targeting availability and distribution of overdose-reversing drugs and supporting cutting-edge research.

The Drug-Free Communities Support Program the White House Office of National Drug Control Policy also recently awarded Community in Crisis and two other very able organizations, Hunterdon Prevention Resource and Empower Somerset, each with a \$125,000 grant to assist addressing the problem of opioid and heroin abuse, provide education and implement prevention measures. Community in Crisis, Hunterdon Prevention Resource and Empower Somerset are great partners in connecting people with the resources and support they need. These investments are not only the right thing to do, but help lessen the significant strain on law enforcement resources. I commend each group on its important work.

Mr. Chairman, I stand ready to work with you and colleagues on both sides of the aisle to continue this work. Thank you for calling this hearing today.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back. And the Chair wants to thank this panel.

We will move to our second panel. Members identified wishing to speak in the second panel: Mr. Butterfield of North Carolina, Ms. Matsui in California, and Mr. Bilirakis of Florida.

Again, Members are advised they may either speak from the witness table or from the dais, whichever is their preference.

So the Chair recognizes Ms. Matsui of California for 3 minutes.

**STATEMENT OF HON. DORIS O. MATSUI, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. MATSUI. Thank you, Mr. Chairman, for inviting us today to testify about proposals to address our Nation's opioid epidemic.

We all have heartbreaking stories of constituents whose lives were lost too soon to an opioid overdose. In my home district of Sacramento, they have experienced a particularly deadly overdose crisis last year due to pills contaminated with fentanyl, which is as much as 50 times stronger than heroin.

Addiction is a devastating disease that knows no bounds and we must come together to provide solutions in a comprehensive manner. In this committee, we took a step forward by passing the Comprehensive Addiction and Recovery Act into law last year.

We need to build on these efforts. Understanding addiction and its consequences are multipronged and we need a multipronged solution.

I look at this problem as I do any other health care problem, which means I examine it holistically across the spectrum from prevention to early intervention to treatment.

In the case of the opioid epidemic there is a lot we can do at each of these stages, all of which rest on truly building up our Nation's mental health system and integrating behavior health care with physical health care.

Historically, mental health and addiction have been treated as character flaws and therefore not addressed with evidence-based medical treatment. We can reverse that course by making treatment more available, bolstering our mental health work force, and reducing stigma.

In 2012, Representative Lance and Senators Stabenow, Blunt, and I passed the Excellence in Mental Health Demonstration Project into law. This project is allowing States to demonstrate that building up Community-Based Behavioral Health Clinics improves access to care.

Last week, we introduced legislation to extend the years of the program and expand it to more States. We should strongly consider this as one way to help address the opioid crisis.

We also need to enforce mental health parity laws to make sure health insurers are offering mental health benefits equal to physical health benefits.

However, this work on parity is irrelevant if mental health benefits are not offered in the first place. There have been proposals which included provisions that allow States to waive essential health benefits, meaning insurance once again not be required to cover mental health and addiction treatments. That's not good.

Cutting billions from the Medicaid program would also mean loss of coverage from millions suffering from substance use disorder. We cannot take these steps backward.

I am encouraged by steps being taken across the health care sector to address the crisis including the limiting of opioid prescriptions for prescribers and insurers.

We need to build on these efforts. That includes considering proposals in Congress to provide resources and training for State and local enforcement and bolstering a mental health workforce, educating the public, addressing availability of a range of treatment options from outpatient to inpatient to residential care and more.

And I do look forward to continuing to work with the committee on these policy proposals to address this pressing issue.

Thank you, and I yield back.

[The prepared statement of Ms. Matsui follows:]

PREPARED STATEMENT OF HON. DORIS O. MATSUI

Thank you, Mr. Chairman, for inviting us to testify today about proposals to address our Nation's opioid epidemic. We all have heartbreaking stories of constituents whose lives were lost too soon to an opioid overdose. In my home district of Sacramento, we experienced a particularly deadly overdose crisis last year due to the introduction of pills contaminated with fentanyl, which is as much as 50 times stronger than heroin.

Addiction is a devastating disease that knows no bounds and impacts us all, and we must come together to provide solutions in a comprehensive manner.

In this committee, we took a first step by passing the Comprehensive Addiction and Recovery Act, or CARA, into law last year. We need to build on those efforts; understanding addiction and its consequences are multipronged, we need a multipronged solution.

I look at this problem as I do any other health care problem or disease, which means I examine it holistically across the spectrum from prevention to early intervention to treatment.

In the case of the opioid epidemic, there is a lot we can do at each of these stages, all of which rest on truly building up our Nation's mental health system and integrating behavioral health care with physical health care.

If people are able to get behavioral health treatment when they need it in their communities, we can start to address the root causes of addiction and prevent and catch issues earlier. Historically, mental health and addiction have been treated as character flaws and therefore not addressed with evidence-based medical treatment. We can reverse that course by making treatment more available, bolstering our mental health workforce, and reducing stigma.

In 2012, Rep. Lance and Senators Stabenow, Blunt, and I passed the Excellence in Mental Health Demonstration project into law. This project is allowing States and local communities to demonstrate that building up Community-Based Behavioral Health Clinics, in coordination with physical health clinics and community resources, will improve access to care. This project is currently in eight States, and last week we introduced the Excellence in Mental Health and Addiction Treatment Expansion Act to extend the years of the demo and expand it to more States. We should strongly consider this project and legislation as a way to build up community care to address the opioid crisis.

We also need to ensure that mental health parity is truly achieved. When an insurance company offers mental health benefits, they should be equal to physical health benefits offered. We need to ensure that this rule is being followed across the country. However, the rule is irrelevant if mental health benefits are not offered in the first place. Trumpcare proposals have included provisions that allow States to waive essential health benefits, meaning insurers would once again not be required to cover mental health and addiction treatment. Cutting billions of dollars from the Medicaid program would also mean loss of coverage for millions of Americans suffering from substance use disorder. We cannot take these steps backward.

I am encouraged by steps that are being taken across the health care sector to address the crisis. Prescribers and insurers are limiting opioid prescriptions, such as for pain following a surgery, to seven days. This prevents bottles of extra unused

pills from sitting in people's medicine cabinets, as do prescription drug "take back" days where people can turn in unused pills to the DEA.

We need to build on these efforts and work together across the system. That includes considering proposals in Congress that provide resources and training for State and local law enforcement, bolstering our mental health workforce, educating the public on what they can do to prevent or react to a crisis, addressing the availability of a range of treatment options from outpatient to inpatient to residential care, and more. I look forward to continuing to work with the committee on policy proposals to address this pressing issue.

Mr. BURGESS. Chair thanks the gentlelady. Gentlelady yields back.

Chair recognizes the gentleman from Florida, Mr. Bilirakis, for 3 minutes, please.

**STATEMENT OF HON. GUS M. BILIRAKIS, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF FLORIDA**

Mr. BILIRAKIS. Thank you, Mr. Chairman.

The United States is in the midst of an opioid overdose epidemic. Sadly, 91 Americans die every day due to opioid overdoses. Nearly half of all opioid overdose deaths involve a prescription opioid.

In 2010, in response to the opioid crisis in Florida's pill mill problem, Florida's legislature enacted statewide tracking of painkiller prescriptions coupled with law enforcement using drug trafficking laws to prosecute providers caught over prescribing. Within 3 years, Florida saw a decrease of more than 20 percent in overdose deaths.

Despite this positive trend, opioid abuse continues to plague my district. In fact, my district had the second-highest prescription drug death rate in Florida in 2014.

In response, I worked last Congress to ensure that Pasco County was included as a high-intensity drug trafficking area, enabling law enforcement to receive additional resources to combat the spread of drug-related crime.

I want to applaud the committee for including my bills, the Medicare Patient Safety and Drug Abuse Prevention Act and the Promise Act in CARA, which passed last Congress.

The Medicare Patient Safety and Drug Abuse Prevention Act created a pharmacy and physician block-in program within the Medicare Advantage and Medicare Part D, giving CMS the tools to crack down on this abuse in the Medicare program and it's important for us to maintain oversight, of course, as you know, on this program as CMS is developing the rules.

The Promise Act will increase safety for opioid therapy and pain management by requiring the VA and DoD to update their clinical practice guidelines for managing of opioid therapy for chronic pain, requiring the VA opioid prescribers to have the enhanced pain management and safe opioid prescribing education and training and encourage the VA to increase information sharing with State licensing boards. I think that is critical.

As part of the 21st Century Cures Act, Florida has received over \$27 million in grants to help fight the opioid epidemic by increasing access to treatment and recovery services, strengthening public health surveillance, and improving pain management practices.

These critical funds are supporting Florida's all-hands-on-deck approach across the State to curb opioid abuse and save lives.

I am pleased the administration and this committee are leading the charge on this critical issue and I look forward to working together to help save lives and prevent addiction.

I yield back, Mr. Chairman. Thank you.

[The prepared statement of Mr. Bilirakis follows:]

PREPARED STATEMENT OF HON. GUS M. BILIRAKIS

Thank you Mr. Chairman for hosting today's Member Day to discuss the impact of opioid abuse in our communities.

The United States is in the midst of an opioid overdose epidemic. According to the Centers for Disease Control and Prevention, more citizens died from drug overdoses in 2015 than any other year on record. Of those deaths, six out of ten involve opioids. Last year, an estimated 60,000 Americans died due to drug overdoses, more than all the Americans who died in the Vietnam War. Sadly, 91 Americans die every day due to opioid overdoses. Nearly half of all opioid overdose deaths involve a prescription opioid.

Florida has been in the crosshairs of this epidemic. In 2010, in response to the opioid crisis and Florida's 'pill mill' problem, Florida's legislature enacted statewide tracking of painkiller prescriptions coupled with law enforcement using drug trafficking laws to prosecute providers caught overprescribing. Within 3 years, Florida saw a decrease of more than 20 percent in overdose deaths.

Despite this positive trend, opioid abuse continues to plague my district—Florida's 12th District. Pasco and Pinellas counties had some of the highest oxycodone-caused deaths—almost 200 in 2014. In fact, my district had the second-highest prescription drug death rate in Florida in 2014. In response, I worked last Congress to ensure that Pasco County was included as a High Intensity Drug Trafficking Area (HIDTA), which has enabled law enforcement to receive additional resources to combat the spread of drug-related crime.

Additionally, I invited the head of the Office of National Drug Control Policy to visit my district last year. We toured local facilities and met with law enforcement, key health care providers, patients, and experts to determine the next steps in addressing this problem. I want to applaud the committee for including my bills, the Medicare Patient Safety and Drug Abuse Prevention Act and PROMISE Act in the Comprehensive Addiction and Recovery Act which passed last Congress. The Medicare Patient Safety and Drug Abuse Prevention Act created a pharmacy and physician lock-in program within Medicare Advantage and Medicare Part D. Private insurance was already using this strategy against doctor and pharmacy shopping, and States had adopted it as part of the Medicaid program. This gives CMS the tools to crackdown on this abuse in the Medicare program, and it's important for us to maintain oversight on this program as CMS is developing the rules. Furthermore, the PROMISE Act will increase safety for opioid therapy and pain management by requiring the VA and DOD to update their Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain, requiring VA opioid prescribers to have enhanced pain management and safe opioid prescribing education and training, and encourages the VA to increase information sharing with State licensing boards.

As part of the 21st Century Cures Act this Congress, Florida has received over \$27 million in grants to help fight the opioid epidemic by increasing access to treatment and recovery services, strengthening public health surveillance, and improving pain management practices. These critical funds are supporting Florida's all-hands-on-deck approach across the State to curb opioid abuse and save lives.

Now the rise in fentanyl and its various derivatives have presented new challenges to my State. However, we remain optimistic with Florida's recent legislative initiatives including:

- Requiring doctors to log prescriptions in a statewide painkiller database by the end of the next business day to curb 'doctor shopping';
- And setting aside State funds for medications that can help reduce opioid dependency, most of which will be spent in the State prison system.

We need to continue to work closely with local law enforcement, medical professionals, addiction treatment specialists, and those impacted by addiction. I am pleased the administration and this committee are leading the charge on this critical issue, and I look forward to working together to help save lives and prevent addiction. Thank you and I yield back the remaining balance of my time, Mr. Chairman.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman.

Chair recognizes the gentleman from North Carolina, Mr. Butterfield, for 3 minutes, please.

**STATEMENT OF HON. G.K. BUTTERFIELD, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF NORTH CAROLINA**

Mr. BUTTERFIELD. Thank you very much, Mr. Burgess, and to my fellow colleagues. Thank you for opportunity to address the committee today about the state of the opioid epidemic in my home State of North Carolina.

And let me just begin, Mr. Chairman, by crediting my friend and our former colleague, Mary Bono, who was also up from Florida—Mr. Bilirakis, who talked so incessantly about this issue because it was very dear to her and she knew the impact that it was having on her State.

Ms. Mack brought this important topic to the forefront of our subcommittee some years ago. She was the chairman of the subcommittee, and I was the ranking member.

At first, Mr. Chairman, I thought Mary was a little bit overreacting to the opioid crisis in Florida because it had touched her family personally.

But after we had hearings and after I looked into it, I came to the conclusion that she was not overreacting—that it was indeed an epidemic not just in Florida but all across the country.

Just last year, I worked with many of my colleagues in this room on the Comprehensive Addiction and Recovery Act that was passed into law. That bill included, roughly, 20 different legislative proposals to help slow the epidemic. As part of the 21st Century Cures Act, this committee approved \$500 million.

The American people need to know that, Mr. Chairman. We approved \$500 million in supplemental funding to address opioid abuse.

Despite the investments and attention from Congress, we are still feeling the opioid crisis very close to home. During the August work period I saw the effects of the epidemic on my small community in Wilson, North Carolina. Just in August alone, there were two deaths because of the opioid abuse in the community.

According to reports in the Wilson Times—and I have a copy of that with me today—medics in Wilson County administered the appropriate drug in response to opioid crisis 28 times by mid-August, when they usually administered the treatment 30 times per quarter.

According to Chris Parker with the Wilson County Emergency Medical Services, there is a definite increase in opioid use and abuse in our county.

North Carolina has a real problem on its hands. America has a real problem on its hands. By July of this year, there were more than 500 diagnoses for emergency department visits, up from 410 at the same point last year.

Regrettably, Mr. Chairman, in my humble opinion, the administration is not taking this situation seriously. The budget offered by the current administration cuts HHS funding by 16 percent, the

CDC by 17 percent, the National Institutes of Health by 19 percent.

I am also very concerned about the proposals to get the Medicaid program that we have considered in this committee. The Center for Budget and Policy Priorities estimates that nearly 100,000 people with an opioid use disorder have gained coverage through Medicaid expansion under ACA.

Congress must do all that it can to help stop this epidemic from devastating more lives, more families, and communities.

Congress should provide certainty—certainty and funding to combat this epidemic, which is why I am the original cosponsor of H.R. 3495, the Opiate and Heroin Abuse Crisis Investment Act of 2017 that was introduced by Mr. Luján.

We must also protect existing fundings for research in opioid use disorder coverage, provide tools to communities to address this epidemic, and reduce the stigma for those needing treatment.

So I want to thank you for convening this hearing. I want to thank Mr. Latta, Mr. Bucshon, Mr. Bilirakis, and all of you for your time, your attention, and your energy to this issue because it is an emergency in our country.

Thank you. I yield back.

[The prepared statement of Mr. Butterfield follows:]

PREPARED STATEMENT OF HON. G.K. BUTTERFIELD

Chairman Burgess, thank you for the opportunity to address the committee today about the state of the opioid epidemic in North Carolina.

I credit my friend and colleague Mary Bono Mack with bringing this important topic to the forefront of this committee's work to protect public health. As ranking member of the subcommittee previously known as Subcommittee on Commerce, Manufacturing and Trade, I worked closely with Representative Bono Mack to ensure the supply chain for potentially dangerous narcotics is airtight.

Just last year, I worked with many of my colleagues in this room on the Comprehensive Addiction and Recovery Act that was passed into law. That bill included roughly twenty different legislative proposals to help slow the opioid epidemic. As part of the 21st Century Cures Act, this committee approved \$500 million in supplemental funding to address opioid abuse.

Despite the investments and attention from Congress, we are still feeling the opioid crisis close to home in North Carolina. During the August work period, I saw the effects of the epidemic on my community in Wilson, North Carolina.

Just in August alone, there were two deaths because of opioid abuse in Wilson. According to reports in The Wilson Times, medics in Wilson County administered Naloxone in response to opioid crises 28 times by mid-August, when they usually administer the treatment 30 times per quarter. According to Chris Parker with Wilson County Emergency Medical Services, "there is a definite increase in opiate use in Wilson County."

North Carolina has a real problem on its hands. By July of this year, there were more than 500 opioid diagnoses for emergency department visits, up from 410 at the same point in 2016.

Clearly, the administration is not taking this situation seriously. The budget offered by the Trump administration cuts HHS by 16 percent, the CDC by 17 percent, and that National Institutes of Health by 19 percent. I am also very concerned about the proposals to gut the Medicaid program that we have considered in this very committee. The Center for Budget and Policy Priorities estimates that nearly 100,000 people with an opioid use disorder have gained coverage through Medicaid Expansion under the ACA.

Congress must do all it can to help stop this epidemic from devastating more lives, families, and communities. Congress should provide certainty in funding to combat this epidemic, which is why I am original cosponsor of H.R. 3495, the Opioid and Heroin Abuse Crisis Investment Act of 2017, that was introduced by my friend Ben Ray Luján. We must also protect existing funding for research and opioid use

disorder coverage, provide tools to communities to address this epidemic, and reduce stigma for those needing treatment.

I ask unanimous consent to submit two articles from The Wilson Times for the record. I yield back.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Chair recognizes the gentleman from Indiana, Mr. Bucshon, for 3 minutes, please.

**STATEMENT OF HON. LARRY BUCSHON, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF INDIANA**

Mr. BUCSHON. Chairman Burgess, Ranking Member Green, thank you for holding this important hearing today.

Opioid abuse disorder has ravaged our communities, and while it is important to look forward and address what else needs to be done to combat this terrible disease, we need to ensure the legislation we have already passed is being properly implemented and is working as Congress intended.

In July 2016, the Comprehensive Addiction and Recovery Act—CARA—landmark legislation addressing the opioid abuse crisis was passed into law. I spent months convening stakeholder round tables and working on bipartisan language which became Section 303 of CARA.

Section 303 updates the Controlled Substances Act and office-based opioid addiction treatment laws by ensuring that patients are offered and physicians are trained on all FDA-approved treatments.

Under previous law, prior to CARA millions of opioid-addicted patients had their treatment determined based on their setting of care.

With the passage of CARA, patients in these settings must now be offered a full range of treatment options based on their individual clinical needs and individualized treatment plan.

Unfortunately, 15 months after the legislation was signed into law, Section 303 still has not been implemented. I urge the committee to conduct strong oversight to ensure SAMHSA will be properly implementing the law.

Every day that this law goes unimplemented is one more day that our family members, friends, and colleagues are battling a disease with fragmented and incomplete treatment options.

Specifically, SAMHSA should send a dear colleague letter to notify physicians that they must offer all anti-addiction medicines based on a patient's clinical needs.

Additionally, curriculum for doctors, PAs, and nurse practitioners should be updated to include training on all FDA-approved opioid addiction medications.

Moreover, all of SAMHSA's public-facing material, including their Web site, should be modernized to reflect this patient-centered approach.

According to the Evansville Courier and Press, 55 people in Vanderburgh County, Indiana, have died of a drug overdose in the first nine months of this year, which is more than all of 2016.

The availability of all medication-assisted treatments regardless of where a patient chooses to seek them will help to stem the tide of these unnecessary deaths.

It is vital that as the committee moves forward in the fight against opiate abuse disorder that we ensure CARA is properly implemented and helping people combat this terrible disease.

Mr. Chairman, again, thank you for this hearing, and I yield back my time.

[The prepared statement of Mr. Bucshon follows:]

PREPARED STATEMENT OF HON. LARRY BUCSHON

Chairman Burgess and Ranking Member Green, thank you for holding this important hearing today. Opioid abuse disorder has ravaged our communities. and while it is important to look forward and address what else needs to be done to combat this terrible disease. we also need to ensure that the legislation we have already passed is being properly implemented. and is working as intended by Congress,

In July, 2016, the Comprehensive Addiction and Recovery Act, landmark legislation addressing the opioid abuse crisis, was passed into law,

I spent months convening stakeholder roundtables and tweaking language on a bipartisan agreement, which became section 303 of CARA,

In particular, Section 303 updates the Controlled Substances Act and Office-Based Opioid Addiction Treatment laws by ensuring that patients are offered, and physicians are trained, on all FDA-approved treatments, Under previous law, prior to CARA, millions of opioidaddicted patients had their treatment determined based on their setting of care, With the passage of CARA, patients in these settings must now be offered the full range of treatment options based on their individualized clinical needs,

Unfortunately, 15 months after the legislation was signed into law, Section 303 still has not been implemented. I urge the committee to conduct strong oversight to ensure SAMHSA will be properly implementing the law, Every day that this law goes unimplemented, is one more day that our family members, friends, and colleagues are battling a disease with fragmented and incomplete treatment options,

Specifically, SAMHSA should send a Dear Colleague letter to notify physicians that they must offer all anti-addiction medicines based on a patient's clinical needs, Additionally, curriculum for doctors, PAs, and nurse practitioners should be updated to include training on all FDA-approved opioid addiction medications, Moreover, all of SAMHSA's public facing material should be modernized to reflect this patient-centered approach,

According to the Evansville Courier and Press, 55 people in Vanderburgh County, IN have died of a drug overdose in the first nine months of this year, which is more than all of 2016. The availability of all medication-assisted treatments, regardless of where a patient chooses to seek them, will help to stem the tide of these unnecessary deaths.

It's vital that as the committee moves forward in the fight against opioid abuse disorder that we ensure the hard work that the committee has already accomplished is implemented and working.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman and recognizes the gentleman from Ohio, Mr. Latta, for 3 minutes, please.

STATEMENT OF HON. ROBERT E. LATTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. LATTA. Well, thank you, Mr. Chairman, and again, thank you for holding this hearing today.

Opioid abuse and addiction has caused devastation in every community across our Nation and Ohio has been especially hard hit. In Ohio, in 2015, 3,050 people lost their lives from unintentional drug overdose.

In 2016, that number increased to 4,050. That's a 32 percent increase from the previous year and that means 11 deaths a day. For comparison, in 2016, there were 1,133 traffic fatalities in Ohio.

That means that drug overdoses cause nearly four times as many deaths compared to traffic accidents. These figures are heart-breaking and sad to know that this problem isn't getting any better.

Many county coroners in Ohio say that 2017's overdose fatalities are outpacing 2016's. This problem knows no limits and has affected husbands, wives, children, brothers, sisters, fathers, and mothers. It has destroyed marriages, ruined careers, and cut too many lives short.

When I read through the obituaries in my local newspapers over the past year or two I have noticed more younger individuals without a cause of death being listed.

Unfortunately, in too many of instances it is because of drug overdoses. Across my district in northwest and west central Ohio, I have heard how opioid addiction impacts our communities.

I have toured businesses and met with community leaders and spoke with families to hear how substance use disorders have directly affected their lives.

It is because of these stories that I plan to introduce legislation that would direct the Department of Health and Human Services to create a public electronic database of information relating to nationwide efforts to combat the opioid crisis.

The database would serve as a central location of information for the public and others to track Federal funding allocations made available for research and treatment of opioid abuse, find research relating to opioid abuse from all Federal agencies, State, local, and Tribal governments as well as nonprofits, law enforcement, medical experts, public health educators, and research institutes.

Furthermore, the legislation would charge HHS to evaluate a myriad of issues relating to pain management, addiction, prescription guidelines, treatments, trends and patterns, and effective solutions to problems used across the country.

These findings would be available on the database as well and HHS would be instructed to offer recommendations for targeted areas of improvement.

I believe that with the help of HHS and other relevant agencies this database will allow for easier access of information, funding streams, and relevant data that can help to combat the opioid abuse epidemic across our Nation.

With 11 people dying every day in Ohio and over 91 Americans dying nationwide every day, we have run out of time to find a solution to this crisis. We need action now.

I appreciate the committee for holding this forum to express creative ideas and solutions and hope it leads to more lives being saved.

Mr. Chairman, I appreciate the opportunity to be here, and I yield back the balance of my time.

[The prepared statement of Mr. Latta follows:]

PREPARED STATEMENT OF HON. ROBERT E. LATTA

Opioid abuse and addiction has caused devastation in every community, and Ohio has been hit especially hard.

In 2016, Ohio lost at least 4,050 people from unintentional drug overdose. That's a 32 percent increase from the previous year and 11 deaths a day.

For comparison, in 2016, there were 1,133 traffic fatalities in my State. That means drug overdoses caused nearly 4 times as many deaths compared to traffic accidents.

These figures are heartbreaking and it's sad to know that this problem isn't getting any better. Many coroners say that 2017's overdose fatalities are outpacing 2016's.

This problem knows no limits and has affected husbands, wives, children, brothers, sisters, fathers, and mothers. It has destroyed marriages, ruined careers, and cut lives far too short.

I frequently read obituaries in my local newspaper, and over the past year or two I started to notice a pattern of younger individuals without a cause of death. I soon realized that no cause was listed because they had died from a drug overdose. This happens far too often.

All across my district in Northwest and West Central Ohio, I've heard how opioid addiction impacts our communities. I've toured businesses, met with community leaders, and spoke with families to hear how substance use disorders have directly affected their lives.

It's because of these stories that I plan to introduce a bill that will direct the Department of Health and Human Services to create a public electronic database of information relating to nationwide efforts to combat the opioid crisis.

The database would serve as a central location of information for the public and others to:

- Track Federal funding allocations made available for research and treatment of opioid abuse; and,
- Find research relating to opioid abuse from all Federal agencies, State, local, and Tribal governments, as well as nonprofits, law enforcement, medical experts, public health educators, and research institutes.

Furthermore, my bill would charge HHS to evaluate a myriad of issues relating to pain management, addiction, prescription guidelines, treatments, trends and patterns, and effective solutions and programs used across the country.

These findings would be available on the database as well and HHS would be instructed to offer recommendations for targeted areas of improvements.

I hope that with the experts at HHS, and other relevant agencies, this database will allow for easier access of information, funding streams, and relevant data that can help to combat the opioid abuse epidemic across our country.

With 11 people dying every day in my home State of Ohio, and over 91 Americans dying every day nationwide, we have run out of time to find a solution to this crisis. We need action now.

I appreciate the committee for holding this forum to express creative ideas and solutions, and hope it leads to lives being saved.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

The Chair wants to thank all the Members on this panel for your testimony. You are now excused, and we will seek the next panel, and I—

Mr. BUTTERFIELD. Mr. Chairman, a parliamentary inquiry. Did—

Mr. BURGESS. The gentleman will state his parliamentary inquiry.

Mr. BUTTERFIELD. I am not sure that is the right terminology. But I wanted to include into the record two newspaper articles that I referenced.

Have I lost my right to do that?

Mr. BURGESS. Is the gentleman asking unanimous consent?

Mr. BUTTERFIELD. I am. Yes, sir.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BUTTERFIELD. Thank you.

Mr. BURGESS. And the Chair now would ask that the next panel, which is Mr. Johnson, Mr. Welch, Leader Pelosi, and Mrs. Brooks.

And, again, members of the committee are welcome to provide their testimony from their seated position on the dais or from the witness table, whichever is your preference.

And, Mr. Johnson, I will recognize you for 3 minutes.

**STATEMENT OF HON. BILL JOHNSON, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF OHIO**

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate this discussion about an issue that is so vitally important.

It is no secret that America is in the midst of an opioid crisis. Last year, in my home State of Ohio alone, about 86 percent of overdose deaths involved an opioid.

This epidemic can be felt in virtually every community across the country and today I want to share a story that will shed some light on some of the good work being done by people in my district to help combat the opioid epidemic and to perhaps let everyone know about some of the positive things that are taking place.

Recently, I had the honor of visiting Field of Hope, a faith-based nonprofit treatment facility in southeastern Ohio that assist area families ravaged by poverty and drug abuse.

Field of Hope Recovery House was founded by a man named Kevin Dennis after he witnessed his own daughter become addicted to opioids after she had knee surgery from a high school athletic injury.

Her prescriptions ran out before her pain was managed. But, unfortunately, by that point, she was addicted. She ended up in prison several times for theft and checked into numerous rehab facilities before she fully recovered from addiction.

She is now a recovery counselor at Field of Hope and is happily married with a child. I heard some incredibly powerful and touching stories during my visit to the Field of Hope Campus and I witnessed the good work they are doing firsthand.

We, in Congress, and especially in this committee have an important role to play in supplementing and enabling the work being done by organizations like Field of Hope.

On the front end, we need to develop prevention policies that steer people like Kevin's daughter away from opioids in the first place. Innovative nonopioid nonaddictive treatments exist today and more are on the way. But this—these innovative treatments are not always covered by Federal programs like Medicare and Medicaid.

We should closely examine the reimbursement policies in place to ensure that patients have access to effective alternatives for pain management without the risk of addiction.

I've also been encouraged by recent efforts by private payers, providers, pharmacists, and patient groups to address the addiction crisis through increased awareness, prescribing guidelines, and new treatment options. I believe Congress can play a role in ensuring that all prescribers are equipped with education in pain man-

agement so they can provide effective pain treatments for patients and timely intervention for those who are addicted.

I look forward to continuing to work with my colleagues on the committee and in the House to find effective solutions to this scourge.

Mr. Chairman, it is a national crisis. We need to act, and, with that, I yield back the balance of my time.

[The prepared statement of Mr. Johnson follows:]

PREPARED STATEMENT OF HON. BILL JOHNSON

It is no secret that the United States is in the midst of an opioid epidemic. Last year, in my home State of Ohio alone, about 86 percent of overdose deaths involved an opioid. This epidemic can be felt in virtually every community across the country; and today, I want to share a story that will shed some light on some of the good work being done in my district to help combat the opioid epidemic, and to let people know about some of the positives taking place.

I had the honor of visiting Field of Hope, a faith-based, nonprofit, treatment facility in Southeastern Ohio that assists area families ravaged by poverty and drug abuse. Field of Hope recovery house was founded by a man named Kevin Dennis, after he witnessed his own daughter become addicted to opioids after she had knee surgery from a high school athletic injury. Her prescriptions ran out, but she was addicted. She ended up in prison several times for theft, and checked into numerous rehab facilities before she fully recovered from addiction. She is now a recovery counselor at Field of Hope, and is happily married with a child. I heard some incredibly powerful and touching stories during my visit to the Field of Hope campus, and I witnessed the good work they are doing firsthand.

We in Congress, and especially in this committee, have an important role to play in supplementing and enabling the work being done by organizations like Field of Hope. On the front end, we need to develop prevention policies that steer people, like Kevin's daughter, away from opioids in the first place. Innovative nonopioid treatments exist today, and more are on the way, but are not always covered by Federal programs like Medicare and Medicaid. We should closely examine the reimbursement policies in place to ensure that patients have access to effective alternatives for pain management without the risk of addiction.

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I look forward to continuing to work with my colleagues on the committee and in the House to find effective solutions to this scourge.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

The Chair is then pleased to recognize the entire Vermont delegation. Mr. Welch, you are recognized for 3 minutes.

STATEMENT OF HON. PETER WELCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT

Mr. WELCH. We don't have the numbers of Texas, but I appreciate the recognition.

First of all, Dr. Burgess, thank you, and Mr. Green, thank you—your taking time to focus attention and demonstrate the urgency of this challenge.

Second, this so affects us all. I mean, it's heartbreaking and it doesn't matter whether it's a red district or a blue district. It doesn't matter what your view is on the size and scope of Government. This is hurting people in your district, Dr. Burgess and Mr. Green, and in my district and my colleagues' here.

In Vermont, our Governor dedicated his entire State of the State Address to this epidemic in 2014, and I remember at that time many of my colleagues asked the question, “Peter, isn’t this going to do bad things for the reputation of Vermont,” but then acknowledged that what he was saying was true in their own State—in their own districts.

So you focussing attention on it, Mr. Chairman, thank you. That is step number one. I can give you some statistics in Vermont but they would be very similar to Mr. Johnson.

I mean, our prescription drug problems with individuals increased from 2,477 in 2012 by 80 percent. Heroin went from 913 in 2012 and increased to 3,488—a 380 percent increase. Every one of those stories is a story of family heartache.

I mean, I got a letter from a mom whose 27-year-old son became addicted to heroin and just the story about him being homeless, him going from being a full time working person to being out on the street, him—her having to call her daughters, saying that their brother may soon be dead—all of that is real and all to vivid.

So this is an enormous challenge. Our job in Congress is to come up with some policies that are going to help people help themselves and I would like to make a few suggestions of things that we need to do.

Number one, we do have to have funding. We have to have full funding for the Comprehensive Addiction and Recovery Act, and we’ve got to find the money in order to allow our communities to do that work.

Two, we have to have more research into alternative treatment. I am working with Mr. McKinley to try to get the Comprehensive Addiction and Recovery Act to find better alternatives to treat pain.

Three, let us allow for partial filling of opioid subscriptions. Many of us have signed letters that would allow that to happen.

Four, let’s support the recent action by Commissioner Gottlieb. He has done some good things. Immediate release—he is trying to get immediate release opioid manufacturers to follow a more stringent set of REMS requirements which includes training doctors to safely prescribe these drugs.

So this hearing is tremendous—focusing attention. The next step is to put this into legislative action.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Welch follows:]

PREPARED STATEMENT OF HON. PETER WELCH

First of all, Dr. Burgess, thank you, and Mr. Green, thank you, you’re taking time to focus attention and demonstrate the urgency of this challenge. Second, this so affects us all, I mean it’s heartbreaking, and it doesn’t matter if it is a red district or a blue district, it doesn’t matter what your view is on the size and scope of Government. This is hurting people in your district Dr. Burgess and Mr. Green, and in my district and my colleagues’ here.

In Vermont, our Governor dedicated his entire State of the State address to this epidemic in 2014, and I remember at that time many of my colleagues asked the question ‘Peter, isn’t this going to do bad things for the reputation of Vermont?’ but then acknowledged that what he was saying was true in their own State, in their own districts. So you focusing attention on it Mr. Chairman, thank you, that is step number one.

I can give you some statistics in Vermont, they would be very similar to Mr. Johnson. I mean our prescription drug problems with individuals increased from 2,477

in 2012 by 80 percent, heroin went from 913 in 2012 and increased to 3,488, a 380 percent increase. Every one of those stories is a story of family heartache. I mean, I got a letter from a mom whose 27-year-old son became addicted to heroin, and just the story about him being homeless, him going from being a full time working person to being out on the street, her having to call her daughters saying that their brother may soon be dead. All of that is real and all too vivid. So this is an enormous challenge.

Our job in Congress is to come up with some policies that will help people help themselves. And I'd like to make a few suggestions of things that we need to do. Number one, we do have to have funding. We have to have full funding for the Comprehensive Addiction and Recovery Act. And we have got to find the money to in order allow our communities to do that work. Two, we have to have more research into alternative treatment. I'm working with Mr. McKinley to try to get the Comprehensive Addiction and Recovery Act to find better alternatives to treat pain. Three, let's allow for partial filling of opioid prescriptions. Many of us have signed letters that would allow that to happen. Four, let's support the recent action by commissioner Gottlieb. He's done some good things. He is trying to get immediate release opioid manufacturers to follow a more stringent set of REMS requirements, which includes training doctors to safely prescribe these drugs. So, this hearing is tremendous, focusing attention. The next step is to put this into legislative action.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

The Chair recognizes the gentlelady from Indiana, Mrs. Brooks, for 3 minutes, please.

**STATEMENT OF HON. SUSAN W. BROOKS, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF INDIANA**

Mrs. BROOKS. Thank you, Mr. Chairman, and thank you, Ranking Member Green, for hosting this incredibly important hearing.

Too many Americans are struggling with the crippling effects of drug abuse and addiction and the statistics, as we know, are devastating.

According to the Indiana State Department of Health, every 2 1A½ hours, a Hoosier is sent to the hospital for an opioid overdose.

Across our State there are enough bottles of painkillers in circulation for nearly every Hoosier to have their own and the number of infants born addicted to opioids is increasing at an alarming rate with health care costs for these babies costing Indiana more than \$64 million in 2014 alone.

And as we know, like so many other States, Hoosiers are now more likely to die from a drug overdose than a car accident.

When I came to Congress in 2013, I had been very focussed on our communities and families that this epidemic has swept up. And like so many of my colleagues, we have held round tables. We have held meetings. We have met with addicted individuals' families. We have been on the front line with prescribers, health care workers. We all agree this is a Federal problem and a local problem.

Last year, we passed CARA, which included my bill to establish an interagency task force to review, modify, and update the best practices for pain management and prescribed pain medicine.

HHS has already taken steps informing this task force, but more needs to be done. In my view, it is critical to ensure that the medical professionals have continuing medical education for the prescribing of DEA-controlled substances that have such a high risk of abuse.

I am exploring options to ensure that physicians and other medical professionals who prescribe these schedule drugs have more

and better education linked to the application and renewal of their DEA licenses.

Professionals who prescribe and dispense opioid medications must have better training so that they fully understand those patients who, sadly, have gotten the onset of addiction due to what they've been prescribed and now they need even better education to help prevent that onset and then to help them with the addiction.

Indiana is tackling our problems head on and in fact just yesterday Indiana University announced a new initiative called Responding to the Addictions Crisis. It is being led by IU's Dean of Nursing, Robin Newhouse. IU is committing \$50 million over the next 5 years to collaborate with State and community partners to tackle this crisis.

It is going to be one of the most comprehensive State-based responses and every IU campus in the State is going to be involved.

It is going to focus on training and education, data collection and analysis, policy analysis and development, addiction sciences, community and workforce development.

So major steps are being taken across our State because everyone has a role to play, from our prescribers to our medical, to our higher ed institutions.

And I want to remind folks that DEA has a national prescription drug take-back day. It is approaching on October 28th.

It provides that safe, convenient, responsible way to dispose of excess prescriptions drugs so that people can get those drugs out of their medicine cabinets and out of our kids' reach. And not just kids—to adults. So there are going to be locations all across the country and I really encourage everyone because everyone has a role to play. And so October 28th is National Take-Back Day and I hope that we get that word out.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Mrs. Brooks follows:]

PREPARED STATEMENT OF HON. SUSAN W. BROOKS

Thank you, Mr. Chairman.

Too many Americans are struggling with the crippling effects of drug addiction and abuse and too many families are grieving the loss of a loved one to an overdose. Since I joined Congress in 2013, I have been committed to helping people overcome this sweeping epidemic. According to the Indiana State Department of Health, every 2 1A½ hours, a Hoosier is sent to the hospital for an opioid overdose. Across the State there are enough bottles of painkillers in circulation for nearly every Hoosier to have their own. The number of infants born addicted to opioids is increasing at an alarming rate, costing Indiana more than \$64 million in 2014 alone. Hoosiers are now more likely to die from a drug overdose than a car accident; Indiana is one of four States where the fatal drug overdose rate has quadrupled since 1999, ranking us 15th in the country in overdose fatalities.

At home in the district, I have pursued answers to this epidemic through roundtables and meetings with individuals and families on the front lines of this crisis, prescribers and health workers and first responders, and community leaders. I have visited the neonatal intensive care unit (NICU) at Saint Vincent's Hospital in Indianapolis to see firsthand the devastating effects of infants born addicted to opioids and who must already fight for survival through withdrawal in their very first days on this earth. I meet with juvenile court judges and social workers whose caseloads have doubled as more and more children are being removed from their parents' care because their parents are more concerned about where to find their next high than the welfare of their child and it is no longer safe for them in their

home. Indiana first responders tell me they are overwhelmed with the unprecedented increase in drug overdoses.

Last year Congress passed the Comprehensive Addiction and Recovery Act which included significant resources and reforms to combat this crisis; the measure included my bill to establish an inter-agency task force to review, modify, and update best practices for pain management and prescribe pain medicine. Although we've made great strides to turn the tide of the epidemic, we need to do more to bring prescribers in as part of the solution and help educate people struggling with substance abuse and their families.

Just a few months ago, I met with the Grant County Substance Abuse Task Force at Marion General Hospital and heard from community leaders how important it is to fight this crisis at a Federal AND local level. In order to do this, it is critical that our first responders have the equipment they need to safely respond to situations where toxic substances are present. We must also educate the youngest members of our communities of the dangers of substance abuse, and ensure our kids do not have access to harmful prescription drugs. As part of my ongoing effort to combat this crisis, I will be participating in the DEA's National Prescription Drug Take Back Day on October 28. This provides a safe, convenient, and responsible way to dispose of excess prescription drugs, while also providing an opportunity to raise awareness of the opioid crisis and to educate our friends, family members, and neighbors about the potential for abuse of medications.

Indiana is tackling the problem head-on. I trust our State and local partners to do what's necessary to address this crisis and it is a priority for Governor Holcomb. He recently established a Commission to Combat Opioid Abuse and, just yesterday, Indiana University announced it committing an investment of \$50 million to collaborate with State and community partners to tackle this crisis, making it one of the Nation's largest and most comprehensive State-based responses. Major steps are being taken across the State, proving that it will take everyone—from the Federal Government to individuals in our communities—do their part to combat this crisis.

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

Mr. BURGESS. Very well, and of course, I thank the gentlelady for providing the date. This hearing is being streamed on Facebook Live, so your information now has been distributed to everyone who's been tuning in this morning. So that is a good thing, and perhaps we can each individually try to make that date part of our discussions as we go through the rest of the month.

I want to thank this panel for being here. You all are excused. I have a panel identified of Mr. Luján, Markwayne Mullin of Oklahoma, Mr. Tonko, Mr. Hudson, and Mr. Kennedy.

Again, Energy and Commerce members are advised that they may present from the dais or from the witness table, whichever is your preference.

If you are seated at the table, we will provide a name tag for you. So, whenever you are ready, Mr. Luján, you are recognized for 3 minutes, please.

STATEMENT OF HON. BEN RAY LUJÁN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. LUJÁN. Thank you, Mr. Chairman. I thank the chairs and ranking members for the opportunity to discuss how New Mexico has been impacted by the opioid crisis.

Five hundred and one New Mexicans died of drug overdose deaths in 2015. Across this country, there were 52,404 deaths in 2015 and more than 560,000 deaths between 1999 and 2015—a half a million people who missed Thanksgiving dinner or their daughter's softball game, who weren't able to help their son with math homework or kiss their spouse good night.

That's brothers and sisters, parents and friends and children that we have lost too soon because in part Congress has not responded forcefully enough to the crisis.

Last Congress, we did important work by passing the Comprehensive Addiction and Recovery Act—CARA—and 21st Century Cures Act. These were steps in the right direction but these efforts alone are not enough.

I have heard from my community that the funding passed in Cures is helpful but hard to use. In part, this is because of the short funding period which impacts communities' ability to plan for the long-term and expand capacity.

We know that in two many areas like New Mexico there are simply not enough people and resources. Many want help and can't get it.

I am reminded of a story relayed to me by one of my constituents, Jay, who have stopped using heroin on his own—who felt as if he was going into relapse and sought help at a local treatment facility.

Jay was told, come back when you are using. He was turned away and told to come back only if he started using again because they lacked the capacity to treat patients who were not active drug users. That's simply not right.

To really expand the treatment prevention and wraparound services that our constituents need, we must increase funding and create stability. We need to give local governments and organizations the ability to plan and not fear losing vital support from Congress.

Most of all, we need to give constituents like Jay a place to go after he's fought a tough fight on his own. That's why I introduced the Opioid and Heroin Abuse Crisis Investment Act to continue the funding to combat the opioid epidemic we passed in 21st Century Cures for an additional 5 years.

I would welcome my colleagues' support because we absolutely must extend this funding for an additional 5 years and beyond.

However, this still isn't enough, which is why we must look at new efforts to drive vital investments to help those in need and address the barriers to appropriate quality and accessible treatment.

These barriers include a decaying rural mental health and substance abuse treatment infrastructure, lack of regional coordination of treatment resources, lack of support for rural physicians providing substance abuse treatment, administrative barriers against the most effective form of opioid abuse treatment, and a shortage of rural physicians who provide medication-assisted treatment.

We as a committee must recognize that hoping for the best is not valid public policy—there is a quick fix to solve the opioid crisis. That is simply not true.

We need to advance serious legislation that takes into account long-term planning for the Federal Government and for States and communities. We need to bring it to the floor of the House, send it to the Senate, get it passed, and to the president's desk.

I fear that until we recognize this fact we will continue to lose brother's and sisters, parents and friends, and children.

Mr. Chairman, I thank you for holding this important hearing and finding a way for us to work in a bipartisan fashion to address this important issue.

Thank you, Mr. Chairman. I yield back.
[The prepared statement of Mr. Luján follows:]

PREPARED STATEMENT OF HON. BEN RAY LUJÁN

I thank the chairs and ranking members for the opportunity to discuss how New Mexico has been impacted by the opioid crisis.

Five hundred and one New Mexican died of drug overdoses deaths in 2015.

Across this county, there were 52,404 deaths in 2015 and more than 560,000 deaths between 1999 and 2015.

A half million people who missed Thanksgiving dinner, or their daughter's softball game. Half-a-million who weren't able to help their son with their math homework or kiss their spouse goodnight.

That's brothers, sisters, parents, friends, and children that we lost too soon because, in part, Congress has not responded forcefully enough to this crisis.

Last Congress, we did important work by passing the Comprehensive Addiction and Recovery Act (CARA), and 21st Century Cures Act.

These were steps in the right direction, but these efforts alone are not enough.

I've heard from my community that the funding passed in 21st Century Cures is helpful, but hard to use. In part, this is because of the short funding period, which impacts communities' ability to plan for the long-term and expand capacity.

We know that in too many areas like New Mexico, there are simply not enough people and resources. Many want help and can't get it.

I am reminded of a story relayed to me by one of my constituents, Jay, who had stopped using heroin on his own, but felt as if he was going to relapse and sought help at a local treatment facility.

Jay was turned away and told to come back only when he started using again, because they lacked the capacity to treat patients who were not active drug users. That's simply not right.

To really expand the treatment, prevention, and wrap around services that our constituents need, we must increase funding and create stability.

We need to give local governments and organizations the ability to plan—and not fear losing vital support from Congress. Most of all we need to give Jay a place to go after he's fought a tough fight on his own.

That is why I introduced the Opioid and Heroin Abuse Crisis Investment Act to continue the funding to combat the opioid epidemic we passed in 21st Century Cures for an additional 5 years. I would welcome my colleagues support because we absolutely must extend this funding for an additional 5 years and beyond.

However, this still isn't enough, which is why we must look at new efforts to drive vital investments to help those in need and address the barriers to appropriate, quality, and accessible treatment.

These barriers include a decaying rural mental health and substance abuse treatment infrastructure, lack of regional coordination of treatment resources, lack of support for rural physicians providing substance abuse treatment, administrative barriers against the most effective form of opioid abuse treatment, and a shortage of rural physicians who provide Medication Assisted Treatment.

We as a committee must recognize that 'hoping for the best' is not valid public policy. There is no quick-fix to solve this opioid epidemic.

We need to advance serious legislation that takes into account long-term planning for the Federal Government, and for States and communities. We need to bring it to the floor of the House, and we need to send it to the President's desk.

I fear that until we recognize this fact, we will continue to lose brothers, sisters, parents, friends, and children.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

Mr. Mullin, you are going to be recognized for 3 minutes. After that, we will allow the Minority Leader to be seated at the table and hear her testimony.

But Mr. Mullin, go ahead for 3 minutes, please.

Mr. MULLIN. OK. Mr. Chairman, I have no problem with letting Ms. Pelosi go next, if she would like to.

Mr. BURGESS. If the Minority Leader is ready, then, yes, we will recognize you for—you are recognized.

**STATEMENT OF HON. NANCY PELOSI, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. PELOSI. Thank you, Mr. Chairman. Thank you, Rep. Mullin, for your courtesy. I really came to listen as well as to convey some thoughts.

This is only the second time I've ever testified as Leader or as—in that capacity because this issue rises to the level, as you know, of life and death. And so, with gratitude to you and to the ranking member, Mr. Green, for bringing us together in a bipartisan way on this issue that is a matter of life and death.

Thank you, Mr. Burgess.

The opioid epidemic, again, is taking a savage daily toll on the American people. We know that, and regardless of who they are or where they live, they are in every district in the country, as we know.

The scourge is tearing families apart, have an impact on the well-being of our children, hollowing out communities. It has claimed the lives of tens of thousands of Americans every year, on average robbing 91 people of their lives each day.

Again, just to testify to that—I know it's a matter of your record here. Opioid addiction is a public health catastrophe and is growing more dire and deadly every day.

And I believe that it is really important for us to respond to this national emergency with the seriousness and urgency it requires. Fortunately, we have had bipartisanship in passing legislation—the Comprehensive Addiction and Recovery Act.

We all came together during the bipartisan legislation that was passed—the 21st Century Cures Act that people were so happy that the addiction language was in there. That day we heard the stories of families so affected—break your heart—families who had lost a child, a young teenager or 21-year-old or whatever within a matter of days or weeks before that particular signing.

President Obama signed that legislation. But it had the language. It just hasn't had the money to the adequate extent and that, Mr. Chairman, is my appeal to you for our Democrats and Republicans to work together to have the funding to fund the key initiatives authorized in the bill.

I do want to make a pitch for Medicaid be built on the progress. The ACA's Medicaid expansion has provided a vital lifeline for tens of thousands of Americans struggling with addiction.

As Governor of Ohio, our former colleague, John Kasich, noted, thank God we expanded Medicaid, because that Medicaid money is helping to rehab people.

Yet 19 States have not taken that step. We stand ready to work with you, Mr. Chairman, in good faith with Republicans to update and improve the ACA but we remain vigilant against efforts to gut Medicaid because it will create even more of a problem in terms of opioids, just to name one thing.

The opiate epidemic is a challenge to the conscience of the entire country. We must, again, act urgently and boldly to get America's families the prevention treatment and recovery resources they need, and in that regard I said we must work with providers in the pharmaceutical industry to push effective prevention measures so

we can reduce unnecessary prescriptions and stop this epidemic at the source.

Knowing of your busy schedule, I will submit my entire statement for the record. Again, thank you for the courtesy of being able to testify before your committee and thank you for your leadership on this important issue, and thank you, Mr. Green, as well.

[The prepared statement of Ms. Pelosi follows:]

PREPARED STATEMENT OF HON. NANCY PELOSI

Thank you all for being here to shine a light on the devastating epidemic of opioid addiction.

Opioid addiction is inflicting a savage daily toll on Americans—regardless of who they are, where they live or how much money they make.

This scourge is tearing apart families and hollowing out communities. It is claiming the lives of tens of thousands of Americans every year—robbing an average of 91 people of their lives each day and driving down the national life expectancy.

Opioid addiction is a public health catastrophe. And it is growing more dire and deadly each day.

SERIOUS, URGENT ACTION

We must respond to this national emergency with the seriousness and urgency it requires.

We must increase funding and improve capacity, so that health systems and providers can offer high-quality, evidence-based opioid addiction treatment, including medication-assisted treatment and recovery support services.

It is unacceptable that our Nation lacks the capacity to treat nearly half of the men and women who suffer from opioid use disorders;

We must also improve access to treatment—combatting the stigmas, cost and misperceptions that prevent people from accessing care.

And we must work with providers on effective prevention measures—so we can limit opioid supply, and stop this epidemic at the source.

CARA FUNDING

Fortunately, Congress has already created the tools to improve prevention and expand access to care.

Last year, Democrats and Republicans worked together to pass the Comprehensive Addiction and Recovery Act—a landmark bill to provide the full continuum of care to those suffering from opioid addiction.

But, unfortunately, the Republican Congress has so far failed to adequately fund the key initiatives authorized by this bill.

There is no room for politics in the life-or-death fight against opioid addiction. We cannot shortchange the resources needed to fight the tragedy of opioid addiction in our country.

Congress is appropriating billions to rebuild communities after natural disasters—we must show a similar commitment to rebuilding communities ravaged by opioids.

ACA MEDICAID EXPANSION

We must also build on the progress of the ACA's Medicaid expansion, which has provided a vital lifeline for tens of thousands of Americans struggling with opioid addiction.

As Ohio Governor John Kasich noted, "Thank God we expanded Medicaid, because that Medicaid money is helping to rehab people."

Yet, 19 States still have not taken the step of extending the life-saving benefits of Medicaid coverage. We must work with States to expand Medicaid, so we can bring urgently needed care to men and women fighting for their lives.

Democrats stand ready to work in good faith with Republicans to update and improve the ACA. But we will remain vigilant against any effort to gut Medicaid or create higher costs for less care for families.

CLOSE

The opioid epidemic is a challenge to the conscience of the entire country.

We must act urgently and boldly to get America's families the prevention, treatment and recovery resources they need. Thank you, all, for your leadership in this fight.

Mr. BURGESS. The Chair thanks the Minority Leader for being here today. You are welcome to stay and listen to the testimony of the other Members, but we also respect your schedule, and if you need to leave, that is certainly understandable as well.

But in the meantime, I will recognize Mr. Mullin for 3 minutes.

Ms. PELOSI. Thank you for your hospitality. I will listen. I will listen.

Mr. BURGESS. Well, yes, I will recognize the gentleman from Texas.

Mr. GREEN. Thank you, Leader, for being here. But before Mr. Mullin testifies, Mr. Chairman, I would like to thank him for his work.

Literally, when the water was going down in Houston, you called me and said, "I have some churches in Tulsa who want to partner with your churches."

So we did that, and instead of having one week's worth of your folks from your Cherokee Nation, I think they stayed a month, helping my seniors and disabled clean out their 3 or 4 feet of water in their house, and I didn't realize they had that drywall skills. So thank you.

Ms. PELOSI. As one with a daughter in Houston, and grandchildren, I thank you as well.

Mr. MULLIN. Thank you.

STATEMENT OF HON. MARKWAYNE MULLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Mr. MULLIN. Mr. Green, thank you. Cherokee Nation called us right off the bat and said, "How can we help?," and we had churches reach out to us, and we have been very fortunate to work together on multiple issues here in Congress. It has been a friendship that carried past that and it was a—it was an honor to be able to help your constituents.

Thank you, Mr. Chairman and Mr. Green, for allowing us to talk about such an important epidemic that is going across our Nation. We talk often about the opioid epidemic. But what are we talking about as far as how did we get here and then how do we go back.

We never want to talk about taking medicine backwards. But I stand—I sit in front of you, from a gentleman who's had surgeries since I was a little boy. I was born with my hips out and my feet in club—in the club feet position and I started having surgeries very young. I also built up a very large pain tolerance. And I have never been one to use pain medicine.

Now, my wife says that I am different than most. I think most people in this room would probably agree with that. But I do understand pain, and I understand the need for medicine.

But in '96 when pain became a sense and, in my opinion, we let the genie out of the bottle. We started treating it like it was something that can be treated like a cold or the flu, and all we do is mask it.

And we've seen stronger and stronger drugs coming out. We've seen them become controlled substance—narcotics—that we send

home simply in a bottle with a prescription and say that is—that is controlled.

Now we've seen an epidemic spread from the middle class to the low class to the wealthy and to our mothers and our fathers, to our brothers and our sisters and our coworkers.

When do we put the genie back in the bottle? How do we continue to allow drugs—addictive drugs—continue to be sent home with our loved ones? The highest percentage of death—of accidental opioid deaths—are mothers—middle-age women. Most of them got addicted to them after birth or an elective surgery.

How is that possible? How do we let it continue to move down that path and not say that we have to do something bold about this? When it's a controlled substance, why do we allow it to go home? Wouldn't that be better treated in the hospital?

We talk about a lot of remedies but we have got to go back to where it started, and it started when we started treating it like a sense.

I am very proud to be on this subcommittee. I am very proud that, Chairman Burgess, you are taking a very heavy interest in this and I am proud that Chairman Murphy had took an interest in this, too.

And that is why we are proud to be able to pick up one of his bills. It is H.R. 3545 that will at least allow doctors after surgery to be able to access records to know if that person has an addictive behavior so we are not sending those type of drugs home with them.

I look forward to continuing to work with the committee. I look forward to finally being able to put some type of remedy in bringing this to a closure and quit hurting our families back home, and I hope that we can approach this in a bipartisan approach, put politics aside, and put families first.

Thank you. I look forward to working with you. I yield back.

[The prepared statement of Mr. Mullin follows:]

PREPARED STATEMENT OF HON. MARKWAYNE MULLIN

It's so common to hear from the media about the dysfunction of Washington. It's so uncommon to hear the success stories. As a member of the Energy and Commerce Committee, I've been working on legislation related to opioid abuse since March of 2015, when our committee led a number of bipartisan initiatives to help address the opioid epidemic. That year, we were successful in passing numerous pieces of legislation through committee and through the House.

In July of 2016, President Obama signed the Comprehensive Addiction and Recovery Act, or CARA, into law—which included over a dozen bills passed by the Energy and Commerce Committee. Our committee is a productive one and the legislation passed helps fight the opioid epidemic from the ground up.

The Comprehensive Addiction and Recover Act (CARA) and the 21st Century Cures Act offered a truly comprehensive response to the opioid epidemic and touches on prevention, criminal justice reform, access to treatment, overdose reversal, and recovery. The final bill included an amendment that I offered, which ensures that the Attorney General considers the needs of Native Americans, rural communities, and communities heavily impacted by opioid overdose deaths when awarding grants.

Overprescribing painkillers has been a significant driver in the opioid and heroin epidemic, which is why CARA and CURES created a task force to review best practices for chronic and acute pain management and prescribing pain medication. It improved access to the overdose treatment and the opioid reversal drug naloxone and it expanded NIH opioid research.

Just last week in my district, the Claremore Police Department used the opioid reversal drug, Narcan, for the first time in the field. The victim, who was found un-

conscious and admitted to using opioids, was taken to the hospital for further treatment after police were able to administer the Narcan drug. These success stories are taking place nationwide, thanks to CARA and CURES. I am very proud to have worked on CARA and CURES, but there is still more work that needs to be done.

Oklahoma has been hit hard by the epidemic. Our Attorney General has filed a suit against opioid manufacturers, Cherokee Nation has filed a suit against drug distributors and pharmacies, and our Governor has assembled an Oklahoma Commission on Opioid Abuse. In 2014, Oklahoma had the 10th-highest drug overdose death rate in the Nation. More people died from overdoses than in car crashes. My district also has two of the five counties in the entire State that have the highest rates of unintentional painkiller overdoses—Coal and Muskogee.

We can all agree that more needs to be done to address this crisis, which is why I have worked with my colleague Rep. Katherine Clark to introduced H.R. 3528, the Every Prescription Conveyed Securely (EPCS) Act. The EPCS Act would direct all States to employ electronic prescribing for controlled substances (EPCS) technology for Medicare Part D transactions by 2020. This is a step that seven States have already taken in an effort to combat the crisis and better secure the prescription distribution chain. So far all of our policy has been reactive, and this policy is proactive.

This policy prevents large amounts of opiates from ever reaching the addicts hands and dramatically decreases doctor shopping. The EPCS Act will provide real-time reporting and ensure that the information gathered by electronic medical records can be used in a meaningful way. Electronic prescribing solutions, currently provided by more than 20 companies, are used like an app on the Electronic Health Records and give prescribers feedback on when prescriptions are filled and with what drug.

According to the Department of Justice, most illegally obtained prescription opioids are obtained either through doctor shopping, forged prescriptions, and theft, which can be addressed by an EPCS regime. Another piece of legislation I am supportive of is H.R. 3545, the Overdose Prevention and Patient Safety Act, also known in the Senate as Jessie's Law. This legislation would help put the laws governing the medical records of those struggling with addiction into the 21st Century.

Currently, a law that was passed in 1972 still governs how doctors and health care professionals share alcohol or substance use disorder treatment records. Under this law, when a patient goes to receive treatment at an addiction treatment facility, their medical records will remain segregated from the patient's overall medical record. This puts the patient at tremendous risk because doctors can no longer know their patient's substance use or history of care. In the case of Jessie Grubb, this outdated law was fatal.

Jessie, who was in substance use recovery, went in for routine surgery, and providers were informed by her parents that she should not be given opioids except under strict supervision. However, upon discharge Jessie was prescribed 50 oxycodone pills, and the hospital pharmacy filled the prescription because her substance use disorder treatment history was not in her medical record. That night, she died as the result of an overdose. Doctors cannot safely treat their patients if they don't know the whole story. H.R. 3545 would prevent tragedies like Jessie's and bring the Part 2 law into the 21st century.

Our committee has done good work to combat the opioid epidemic, but our work isn't done. We can do more. We can inspire more success stories, but our work starts here. I urge my colleagues today to support these two bills and continue our dedication on this committee to combating the deadly opioid epidemic. I yield back the remainder of my time.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Chair recognizes the gentleman from New York, Mr. Tonko, for 3 minutes.

STATEMENT OF HON. PAUL TONKO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. TONKO. Thank you, Chair Burgess and Ranking Member Green, and members of the subcommittee.

We are a nation in crisis. The opioid epidemic is wreaking havoc in our communities at an unprecedented scale with CDC esti-

ming 64,000 dead from drug overdoses in 2016—an astonishing 21 percent increase from the previous year.

This public health disaster is costing us more lives annually than at the peak of the AIDS epidemic—as many lives as gun violence and traffic accidents combined.

If this Congress doesn't find additional solutions to turn the tide on the opioid epidemic, we will be complicity in this American tragedy.

I am here today to offer two such legislative solutions. First, I introduced the Addiction Treatment Access Improvement Act—H.R. 3692—with my good friend, Congressman Ben Ray Lujan.

This legislation would expand access to medication-assisted treatment by allowing certified nurse midwives and other advanced practice registered nurses to prescribe buprenorphine and, in addition, this legislation would codify the 2016 rule that allowed physicians to treat up to 275 patients with buprenorphine and eliminate the sunset of a provision that allows nonphysician providers to prescribe MAT.

The Addiction Treatment Access Improvement Act would particularly benefit pregnant and post-partum women who are struggling with addiction and improve outcomes for the over 13,000 infants that are born each year with neonatal abstinence syndrome.

Despite the expansion of medication-assisted treatment in the Comprehensive Addiction and Recovery Act, there is still a significant shortage in treatment capacity, resulting in individuals waiting months, if not years, to receive effective addiction treatment. Only 20 percent of patients who need treatment for opioid use disorder are currently receiving it.

Let me repeat that. Only 20 percent of patients who need treatment for opioid use disorder are currently receiving it. The Addiction Treatment Access Improvement Act would address this treatment gap and save lives.

This committee should act on this bipartisan legislation without delay.

The second bill I'd like to discuss is the Medicaid Reentry Act—H.R. 4005. This legislation is a targeted attempt to address the problem of overdose deaths that occur post-incarceration.

Studies have shown that individuals who are released back into the community post-incarceration are, roughly, eight times more likely to die of an overdose in the first two weeks post-release compared to other times.

The risk of overdose is elevated during this period due to reduced physiological tolerance for opioids amongst the incarcerated population, a lack of effective addiction treatment options while incarcerated, and poor care transitions back into the community.

The Medicaid Reentry Act would grant States flexibility to restart Medicaid coverage for Medicaid-eligible individuals 30 days pre-release.

By allowing the Medicaid benefit to restart prior to release, States would be able to more readily provide effective addiction treatment pre-release and would allow for smoother transitions to community care, reducing the risk of overdose deaths post-release, striking an overall wiser use of scarce Medicaid dollars.

Let me be clear: This legislation that I've introduced would not expand Medicaid eligibility in any way. It would simply grant States new flexibility to restart an individual's Medicaid benefits 30 days earlier than allowed under current law.

This increased flexibility would dovetail with innovative reentry programs already being championed by Republicans and Democrats in States across our country and would give individuals reentering society a fighting chance to live a healthier drug-free life.

Let me just end with an urgent plea for action and bipartisanship. I know that many of the ideas that this committee will hear today would, in normal times, be met with the typical partisan objections and end up stuck in a procedural morass.

These are not normal times. When your house is on fire you don't look to see whether the firefighter is wearing red or blue uniforms before they turn their hoses on.

If we are truly going to make a difference in this crisis and save lives, we have to have a big heart and an open mind.

I thank my colleagues for their time and for their consideration of this legislation that I have presented and, again, to the chair, ranking member, and members of the subcommittee, thank you for offering such, you know, attention to a crisis that has gripped this country in severe measure.

Thank you. I yield back.

[The prepared statement of Mr. Tonko follows:]

PREPARED STATEMENT OF HON. PAUL TONKO

Thank you, Mr. Chairman.

We are a nation in crisis. The opioid epidemic is wreaking havoc in our communities at an unprecedented scale, with the CDC estimating 64,000 dead from drug overdoses in 2016, an astonishing 21 percent increase from the previous year.

This public health disaster is costing us more lives annually than at the peak of the AIDS epidemic—as many lives as gun violence and traffic accidents combined.

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First, I introduced the Addiction Treatment Access Improvement Act, H.R. 3692, with my good friend Congressman Ben Ray Lujan. This legislation would expand access to medication-assisted treatment by allowing certified nurse midwives and other advanced practice registered nurses to prescribe buprenorphine. In addition, this legislation would codify the 2016 rule that allowed physicians to treat up to 275 patients with buprenorphine and eliminate the sunset of a provision that allows nonphysician providers to prescribe MAT.

The Addiction Treatment Access Improvement Act would particularly benefit pregnant and postpartum women who are struggling with addiction and improve outcomes for the over 13,000 infants that are born each year with neonatal abstinence syndrome.

Despite the expansion of medication-assisted treatment in Comprehensive Addiction and Recovery Act, there is still a significant shortage in treatment capacity, resulting in individuals waiting months or years to receive effective addiction treatment. Only 20 percent of patients who need treatment for opioid use disorder are currently receive it.

The Addiction Treatment Access Improvement Act would address this treatment gap and save lives. This committee should act on this bipartisan legislation without delay.

The second bill I'd like to discuss is the Medicaid Reentry Act, which is a targeted attempt to address the problem of overdose deaths that occur post-incarceration.

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carcerated population, a lack of effective addiction treatment options while incarcerated and poor care transitions back into the community.

The Medicaid Reentry Act would grant States flexibility to restart Medicaid coverage for Medicaid-eligible individuals 30-days pre-release. By allowing Medicaid benefits to restart prior to release, States would be able to more readily provide effective addiction treatment pre-release and would allow for smoother transitions to community care, reducing the risk of overdose deaths post-release.

This legislation would not expand Medicaid eligibility in any way, it would simply grant States new flexibility to restart an individual's Medicaid benefits 30-days earlier than allowed under current law. This increased flexibility would dovetail with innovative reentry programs already being championed by Republicans and Democrats in States across the country and would give individuals reentering society a fighting chance to live a healthier, drug-free life.

Let me just end with an urgent plea for action and bipartisanship. I know that many of the ideas that this committee will hear today would, in normal times, be met with the typical partisan objections and end up stuck in a procedural morass.

These are not normal times. When your house is on fire, you don't look to see whether the firemen are wearing red or blue uniforms before they turn the hoses on.

If we are truly going to make a difference in this crisis and save lives we have to have a big heart and an open mind.

I thank my colleagues for their time and for their consideration of the legislation I have presented.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

Chair recognizes the gentleman from North Carolina, Mr. Hudson, for 3 minutes, please.

**STATEMENT OF HON. RICHARD HUDSON, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF NORTH CAROLINA**

Mr. HUDSON. Thank you, Chairman Burgess and Ranking Member Green, for giving me the opportunity to speak on behalf of my constituents.

As has been noted, the opioid epidemic is not an isolated issue. It is a nationwide issue and it deserves our attention. The New York Times noted last month that the opioid epidemic is killing more people per year right now than the HIV epidemic did at its peak in the '90s.

These drugs do not discriminate based on gender, race, social class, or age, and they destroy lives, families, marriages, and careers.

In my home State of North Carolina, the opioid epidemic has really hit hard. North Carolina is home to four cities in the top 25 of worst cities affected by the crisis, one of which is in my district, Fayetteville, North Carolina.

One particularly devastating story that stuck with me from a constituent I met while touring a treatment facility last year in my district, he was a police captain, the son of the police chief in the same town, and he injured his back on the job and was prescribed an opioid following his surgery.

He told me he vividly remembers the moment he became addicted the first time he took one of these medications. Within a year, he was a full-blown heroin addict. He's since recovered and now mentors addicts through treatment.

Unlike many stories, this is a story with a happy ending. Fayetteville has become home to soldiers and veterans—or is the home of soldiers and veterans who have become addicted after being prescribed opioids for injuries sustained in combat or training.

The tragedy is that the VA does not have enough inpatient beds to treat every veteran and so oftentimes veterans go without help and are forced to self-medicate by using opioids found on the black market.

This is outrageous and it is unacceptable. We need to find real solutions so we can put an end to this heartbreak.

I am proud to have worked last Congress with this committee's investigation into opioid addiction which resulted in the passage of both the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act.

These laws have made huge steps forward in the treatment and prevention of opioid addiction but it is clear we have work left to do.

One idea I am working on is expanding access to safe ways to dispose of prescription drugs, particularly opioids. DisposeRX is a company in my district that manufactures a powder that mixes with water inside the pill bottle and renders any unused opioids not only inaccessible and inextricable but also biodegradable.

It is innovation ideas like this that we need to explore and I look forward to working with my colleagues on the committee to help treat and prevent this opioid addiction.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Mr. Hudson follows:]

PREPARED STATEMENT OF HON. RICHARD HUDSON

Thank you, Chairman Walden and Chairman Burgess, for giving me the opportunity to speak on behalf of my constituents. As has been noted, the opioid epidemic is not an isolated issue. It is a nationwide issue and it deserves our attention. The New York Times noted last month that the opioid epidemic is killing more people per year right now than the HIV epidemic did at its peak in the nineties. These drugs do not discriminate based on gender, race, social class, or age and they destroy lives, families, marriages, and careers.

In my home State of North Carolina, the opioid epidemic has really hit hard. North Carolina is home to four cities in the top 25 of worst cities affected by this crisis, one of which is in my district, Fayetteville. One particularly devastating story that has stuck with me was from a constituent I met while touring a treatment facility in my district. He was a police captain—the son of a police chief in the same town—and injured his back on the job and was prescribed an opioid following surgery. He told me he vividly remembers becoming addicted the first time he took one of these medications. Within a year, he was a full blown heroin addict. He's since recovered and now mentors addicts going through treatment, but his story has an unusually happy ending.

Fayetteville is also home to soldiers and veterans who have become addicted after being prescribed opioids for injuries sustained in combat or training. One problem with this epidemic is the VA does not have enough inpatient beds to treat every veteran so oftentimes veterans go without help and are forced to self-medicate by using opioids acquired on the black market. We need to find real solutions so we can put an end to this heartbreak.

I am proud to have worked last Congress on this committee's investigation into the opioid addiction which resulted in the passage of both the Comprehensive Addiction and Recovery Act and the 21st Century Cures act. These laws have made huge steps forward in the treatment and prevention of opioid addiction, but it is clear we have work left to do. One idea I am working on is expanding access to safe ways to dispose of prescription drugs, particularly opioids. DisposeRx, a company in my district, manufactures a powder that mixes with water inside the pill bottle and renders any unused opioids not only inaccessible and inextricable, but also bio-degradable. It is innovative ideas like this that we need to explore and I look forward to working with colleagues on committee to help treat and prevent opioid addiction.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

Chair recognizes the gentleman from Massachusetts, Mr. Kennedy, for 3 minutes, please.

STATEMENT OF HON. JOSEPH P. KENNEDY, III, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. KENNEDY. Thank you, Mr. Chairman, and many thanks to the ranking member, Mr. Green, as well for convening this hearing and for bringing all of us together—our colleagues from across the country.

I also want to thank my colleagues that have testified already. Their comments, I think, are right on. I think they show the depth of this epidemic across the country and how it's affected so many in our districts from around our Nation and the myriad ways in which our Federal Government can help respond to it.

There is no silver bullet to this but there are ideas out there that are, I think, genuine that have widespread support and that I hope will deserve this committee's attention, going forward.

Addiction, as many know, is not a disease that knows congressional districts or State borders or electoral college results. It is not one that cares about how much money is in your bank account or asks how many children you have.

For patients and families on the front lines of this epidemic today it is personal, it is painful, and it is petrifying.

The question, I think, before all of us isn't is there an epidemic. I think you've heard from everybody today saying that there is.

The question is how do we go forward. My colleagues have outlined some of their solutions. I wanted to touch on a couple of broad themes as well.

First and foremost is Medicaid. Medicaid, as of now, covers about 30 percent of all nonelderly adults with an opioid addiction in this country—30 percent—and the 20 percent of opioid addicts that do not have health insurance largely stems from individuals in States that did not take a Medicaid expansion.

This is not enough. We need to strengthen our Medicaid programs to ensure that everybody gets the care that they need when they need it.

That means not just ensuring access to Medicaid and eligibility but it means fleshing out the networks that Medicaid provides so that you don't have the stories that so many of us have heard from folks around the country of even if they are enrolled in Medicaid that there are not providers that will take it, and if providers do take it that they would have wait months in order to get a slot to get into treatment.

There is complex reasons for that but, in my own opinion, a big portion of that comes through low Medicaid reimbursement rates that ends up putting the burden of treatment on the backs of providers rather than making sure that patients get the care that they need.

Second is law enforcement. Folks, we lock people up in this country that are sick and we need to be doing an awful lot more not only to make sure that that safety net for our mental health sys-

tem is not a criminal justice system but supporting our first responders and police officers who end up being on the front lines of this epidemic and addiction epidemic across the country and put in an impossible place of forcing to have to arrest people, forcing to put themselves in danger because our mental health system is not robust enough.

I was a State prosecutor. We threw people in jail that were sick. They would break into homes and cars to try to satiate an opioid epidemic—an opioid addiction because they didn't have anywhere else to go.

Finally—and I will be brief, Mr. Chairman—the medical community. You heard Mrs. Brooks talk about education. We have heard folks talk about prediction of drug monitoring programs. We have heard folks talk about prescription guidelines. All of those need to be on the table.

I, like Mr. Mullin, have had surgery before. I got in an argument with a surgery technician on my hospital bed who was trying to prescribe me pain killers that I wouldn't take because I am so deathly afraid of these things. That part needs to change.

I look forward to working with my colleagues in the weeks and months ahead to try to make sure that our Government does take the step forward we need.

I yield back.

Mr. BURGESS. Chair thanks the gentleman.

Chair thanks everyone on this panel. We will allow you to depart, and we have a panel that will be Mr. Costello of Pennsylvania, Mr. Walberg of Michigan, Mr. Carter of Georgia, and Chairman Goodlatte of Virginia.

And Mr. Walberg, we are doing Energy and Commerce members first. But with your permission, I will go to the Chairman of the Judiciary Committee since he has made time to be with us this morning.

And Chairman Goodlatte, you are recognized for 3 minutes.

**STATEMENT OF HON. BOB GOODLATTE, A REPRESENTATIVE
IN CONGRESS FROM THE COMMONWEALTH OF VIRGINIA**

Mr. GOODLATTE. Mr. Chairman, Ranking Member Green, members of the committee, thank you very much for the opportunity to testify about the opioid crisis in America.

This crisis affects Americans across all socioeconomic levels in all regions of the country, including in my home district in Virginia, and has rightfully gained the attention of Congress.

According to the Northern Shenandoah Valley Substance Abuse Coalition, they have seen 11 opioid overdoses resulting in four deaths since September 20th, making 33 deaths in that portion of my district so far this year.

Just recently, I met with a mother in Roanoke whose daughter is an opioid addict living on the streets. Her concern for her daughter was heartbreaking to hear.

Sadly, I know that every Member of Congress in this room has heard these stories of bright futures wasted away and lives taken too early.

That is why we must act to provide more tools to help addicts reclaim and rebuild their lives, stop drug traffickers, and make our communities safer.

We at the Judiciary Committee have been pleased to work with the committee on Energy and Commerce in this fight to combat this epidemic.

Since last year, the Judiciary Committee has passed seven legislative measures that address the multifaceted nature of the opioid epidemic.

Notably, the Judiciary and Energy and Commerce Committees worked collaboratively to see the Comprehensive Opioid Abuse Reduction Act—CARA—signed into law last year.

This bipartisan legislation combats the opioid epidemic by establishing a streamlined comprehensive opioid abuse grant program including vital training and resources for first responders and law enforcement, criminal investigations for the unlawful distribution of opioids, drug and other alternative treatment courts, and residential substance abuse treatment.

We have also targeted those who traffic in opioids. The Transnational Drug Trafficking Act, which is now law, improves law enforcement's ability to pursue international drug manufacturers, brokers, and distributors in source nations.

Federal prosecutors can now use the important tools in that bill to pursue foreign drug traffickers who are poisoning American citizens.

Additionally, in July of this year, the Judiciary Committee reported favorably the Stop the Importation and Trafficking of Synthetic Analogs Act. It is an unfortunate reality that synthetic drug use and the opioid epidemic are inextricably linked. Heroin is regularly laced with synthetic drugs such as fentanyl.

This bill ensures that our laws keep pace with the creation of new chemically altered drugs and provides law enforcement with the tools needed to keep these drugs off of our streets.

That legislation, I believe, is currently before the Energy and Commerce Committee. I hope you will take a very close look at it and if we can pass it out of the committee I am sure it will pass the House with a very strong vote.

Mr. Chairman and members of the committee, I appreciate the opportunity to testify. My dedication to curtailing the opioid crisis is unwavering and I look forward to our continued work together to that end.

Thank you.

[The prepared statement of Mr. Goodlatte follows:]

PREPARED STATEMENT OF HON. BOB GOODLATTE

Chairman Walden and Ranking Member Pallone, thank you for the opportunity to testify about the opioid crisis in America. This crisis affects Americans across all socioeconomic levels in all regions of the country—including in my home district in Virginia—and has rightfully gained the attention of Congress.

According to the Northern Shenandoah Valley Substance Abuse Coalition, they have seen 11 opioid overdoses resulting in four deaths since September 20th—making 33 deaths in that region so far this year. Just recently, I met with a mother in Roanoke whose daughter is an opioid addict living on the streets. Her concern for her daughter was heartbreaking to hear.

Sadly, I know that every Member of Congress in this room has heard these stories of bright futures wasted away and lives taken too early. That is why we must act

to provide more tools to help addicts reclaim and rebuild their lives, stop drug traffickers, and make our communities safer.

The Committee on Energy and Commerce, as well as the House Judiciary Committee, of which I currently serve as chair, has been active in the fight to combat this epidemic. Since last year, the Judiciary Committee has passed seven legislative measures that address the multifaceted nature of the opioid epidemic.

Notably, the Judiciary and Energy and Commerce Committees worked collaboratively to see the Comprehensive Opioid Abuse Reduction Act signed into law last year. This bipartisan legislation combats the opioid epidemic by establishing a streamlined, comprehensive opioid abuse grant program, including vital training and resources for first responders and law enforcement, criminal investigations for the unlawful distribution of opioids, drug and other alternative treatment courts, and residential substance abuse treatment.

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Mr. Chairman and members of the committee, I appreciate the opportunity to testify. My dedication to curtailing the opioid crisis is unwavering. I look forward to our continued work together to that end.

Mr. BURGESS. The Chair thanks the gentleman. Thanks for making time to be with us on our panel today. We sincerely appreciate you being here. We know we have got work to do, and we will work together on this.

Mr. GOODLATTE. Thanks for the opportunity.

Mr. BURGESS. Mr. Walberg, you are recognized for 3 minutes, please.

STATEMENT OF HON. TIM WALBERG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. WALBERG. Thank you, Mr. Chairman, and I am always delighted to go behind the chairman of the Judiciary Committee, especially since there are some of my bills in this committee.

But let me say, Chairman Burgess and Ranking Member Green, I want to thank you for holding today's hearing to receive input from members who represent different corners of our country and yet the very same problem.

Since the heroin and opioid crisis came to the forefront, I have heard so many devastating stories about families losing loved ones. I have toured recovery centers, talked with survivors who continue to battle addiction and ridden along with law enforcement to understand the challenges that they face in keeping our neighborhoods safe.

I have also met a number of amazing compassionate individuals—fellow citizens who have stepped up and are leading the fight in their communities.

A few weeks ago, I had the opportunity to meet with a constituent named George Barath from Monroe County. He established Ryan's Hope Foundation, a nonprofit organization named in honor of his son who died from a heroin overdose in 2012.

He was only 25. Ryan's Hope funds structured long-term residential treatment for addicts and so far they have helped nearly—helped nearly 40 addicts by sending them to rehab.

To help cover these costs, Mr. Barath has also teamed up with local first responders to organize a charity hockey game called Hockey Against Heroin.

In Lenawee County, my own home county, the Pathways Recovery Engagement Center just opened its doors last week. I got a chance to see the center in August when it was in the final stages of construction.

This recovery-based program in downtown Adrian is the result of a community partnership between local police and the county sheriff's office, Rotary Clubs, and the local hospital system and mental health authority.

Ryan's Hope and the Pathways Resource Center are just two shining examples of constituents in my district making a difference. We need more community-based initiatives like these to get resources to those in need.

But Congress also has more to do. One example is Jessie's Law, a bipartisan bill I have introduced with Congresswoman Debbie Dingell. It seeks to ensure that medical professionals are equipped to safely treat their patients and prevent overdose tragedies.

It is named after Jessie Grubb, who died last year of an opioid overdose. Jessie had battled a heroin addiction for nearly 7 years but had been clean for six months. She had made a new life for herself in Michigan and was training for a marathon when an infection related to a running injury required her to have surgery.

Jessie's parents told doctors that she was a recovering addict and shouldn't be prescribed opioids. Unfortunately, Jessie's discharging physician didn't know her addiction history and sent Jessie home with a prescription for 50 oxycodone pills. Jessie became a sad death by overdose statistic.

Jessie's law will ensure that physicians and nurses have access to a consenting patient's complete health information when making treatment decisions.

Such information is crucial to provide a patient-centered care, prevent relapses, and ultimately save lives. As we work together to address this crisis, it is my hope the stories and ideas shared today will inform our efforts and ensure we pursue meaningful solutions to remove obstacles to care and empower local communities to tackle the opioid crisis head on, and I thank you for listening to my story.

[The prepared statement of Mr. Walberg follows:]

PREPARED STATEMENT OF HON. TIM WALBERG

Chairman Burgess, Ranking Member Green, I want to thank you for holding today's hearing to receive input from Members who represent different corners of our country.

Since the heroin and opioid crisis came to the forefront, I have heard so many devastating stories about families losing loved ones. I've toured recovery centers, talked with survivors who continue to battle addiction, and ridden along with law enforcement to understand the challenges they face in keeping our neighborhoods safe. I've also met a number of individuals who have stepped up and are leading the fight in their communities.

A few weeks ago, I had the opportunity to meet with a constituent named George Barath from Monroe County. He established Ryan's Hope Foundation, a nonprofit

organization named in honor of his son who died from a heroin overdose in 2012. He was only 25. Ryan's Hope funds a structured, long-term residential treatment for addicts, and so far they have helped send nearly 40 addicts to rehab. To help cover these costs, Mr. Barath has also teamed up with local first responders to organize a charity hockey game called "Hockey Against Heroin."

In Lenawee County, the Pathways Recovery Engagement Center just opened its doors last week. I got a chance to see the center in August when it was in the final stages of construction. This recovery-based program in downtown Adrian is the result of a community partnership between local police and the county sheriff's office, rotary, and the local hospital system and mental health authority.

Ryan's Hope and the Pathways Recover Center are just two shining examples of constituents in my district making a difference. We need more community-based initiatives like these to get resources to those in need, but Congress also has more to do.

One example is a Jessie's Law, a bipartisan bill I introduced with Congresswoman Debbie Dingell. It seeks to ensure that medical professionals are equipped to safely treat their patients and prevent overdose tragedies.

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Jessie's Law will ensure that physicians and nurses have access to a consenting patient's complete health information when making treatment decisions. Such information is crucial to provide patient-centered care, prevent relapses and ultimately, save lives.

As we work together to address this crisis, it is my hope the stories and ideas shared today will inform our efforts and ensure we pursue meaningful solutions that remove obstacles to care and empower local communities to tackle the opioid crisis head on.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman, and I believe this concludes all the Energy and Commerce members seeking to give testimony. If any arrive, we will allow them to testify as they come in.

But I think our panel now will be Chairman Rogers, Mr. Marshall of Kansas, Mr. Turner, mayor of Dayton, Ohio.

Mrs. Bustos, if you wish to join us now, that would be good as well. And Chairman Rogers, thank you for being here and being part of this discussion this morning. You are recognized, sir.

STATEMENT OF HON. HAROLD ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. ROGERS. Well, thank you, Mr. Chairman, and colleagues. Thank you for hosting us on this very, very important topic.

Over the past 15 years, many of you have heard me advocate for a holistic approach to the calamity that we face, including enforcement, prevention, and treatment measures like those successfully implemented by Operation Unite in Kentucky.

We need to further encourage regional collaboration on this issue that ignores lines on a map, and I hope to work with the committee on this issue in the future.

Today, however, Mr. Chairman, I would like to focus on treatment. Despite the light we've shown on addiction, only 10 percent of those needing treatment for alcohol or drug-related addiction actually receive it—10 percent.

Underlying challenges in the treatment workforce further compound this lack of access. There are simply not enough incentives

for health professionals in training to specialize in addiction medicine.

Treatment professionals work in stressful environments, receive relatively low pay, and turn over at rates much higher than other health professionals.

NIH continually pioneers research on addiction science and new ways to treat this chronic disease. Yet, America has only half the number of practising addiction specialists needed to put their findings in practice.

This is a patient safety and public health calamity. Patients in need of addiction treatment often have access to specialized care in every corner of the country.

That is why I will soon be introducing legislation with my colleague, Katherine Clark, to create a student loan repayment program for qualified substance use disorder treatment professionals.

This program will not only encourage health professionals to pursue careers in addiction medicine but steer them towards areas most in need of their services.

Though it is not a silver bullet, this bill would be another substantial step in the right direction and I hope to work with each of you, Mr. Chairman and members, to this end and I thank you for allowing us here today.

I yield.

[The prepared statement of Mr. Rogers follows:]

PREPARED STATEMENT OF HON. HAROLD ROGERS

Thank you, Mr. Chairman. I appreciate you holding this hearing to discuss Congress' continued work on opioid misuse and abuse. Over the past 15 years, many of you have heard me advocate for a holistic approach to addiction, including enforcement, prevention, and treatment measures like those successfully implemented by Operation UNITE in Kentucky. We need to further encourage regional collaboration on this issue that ignores lines on a map. I hope to work with the committee on this issue in the future.

Today, however, I'd like to focus on treatment. Despite the light we've shone on addiction, only 10 percent of those needing treatment for alcohol- or drug-related addiction actually receive it. Underlying challenges in the treatment workforce further compound this lack of access.

There are simply not enough incentives for health professionals in training to specialize in addiction medicine. Treatment professionals work in stressful environments, receive relatively low pay, and turnover at rates much higher than other health professionals. NIH continually pioneers research on addiction science and new ways to treat this chronic disease, yet America has only half the number of practicing addiction specialists needed to put their findings in practice.

This is a patient safety and public health calamity. Patients in need of addiction treatment ought to have access to specialized care in every corner of this country. That is why I will soon be introducing legislation with my colleague Katherine Clark to create a student loan repayment program for qualified substance use disorder treatment professionals. This program will not only encourage health professionals to pursue careers in addiction medicine, but steer them towards areas most in need of their services.

Though it's not a silver bullet, this bill would be another substantial step in the right direction. I hope to work with each of you to this end and I thank the chairman for having me today.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Will the gentleman from Georgia, an Energy and Commerce member, wish to join us at the table and, Mr. Carter, if you are ready I will recognize you for 3 minutes.

STATEMENT OF HON. EARL L. "BUDDY" CARTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. CARTER. Thank you, Mr. Chairman and Ranking Member Green.

I want to start my testimony by thanking you for holding today's hearing for soliciting input from Members on how to continue to combat this growing epidemic.

As a pharmacist, I have always made it a priority to advise and assist my patients with the medications they are prescribed. As a community pharmacist, I develop close bonds with people who are often my friends and neighbors. That bond pushes pharmacists to always act proactively in helping their patients.

One of the largest concerns I have seen is the increased prescribing of opioids for pain relief. We need to look at other options and other outlets for the treatment of pain and find a good medium. I believe we can work with the FDA to prioritize nonopioid treatments for patients and create a channel for the approval of those therapies.

In addition, as it currently stands, prescribers are able to write up to three 30-day prescriptions or Schedule II drugs for patients. I believe it would be pertinent to reexamine that prescribing structure and look at the effectiveness of allowing fewer initial prescriptions and a limited number of refills rather than three months of prescriptions.

Similar to that notion, allowing pharmacists to have a greater say in limiting the number of pills filled in a prescription could help to address the transition to addiction.

For instance, limiting the fill for acute pain needs such as a dental procedure could help prevent an individual from getting hooked on opioids.

Under CARA, a pharmacist is only able to partially fill a prescription with the consent of the patient or prescriber or in the instance it doesn't have enough stock to fully fill a prescription.

A simple seven-day fill could cover their pain needs and keep more pills out of potential use or circulation. Prescription drug monitoring programs—PDMPs—are a great resource in combatting prescription drug abuse. But they can be strengthened to better curb this epidemic.

One way to do so is to better align the data including in those PDMPs so that States can collaborate to create a more comprehensive picture of people's drug use. Further linking State PDMPs and including data in work flows could allow for more accuracy in how States monitor and respond to potential abuses.

Drug take-back programs continue to expand across the country. Currently, at least 19 States have some form of drug take-back programs and 23 States have programs allowing pharmacists to accept unused and unwanted drugs.

One of the most common ways in which adolescents access prescription drugs is through the drug cabinets of their parents and grandparents.

Too often these unused pills can act as a gateway to further abuse by young adults. Expanding these programs through law enforcement pharmacies or paid-for mail programs can take some of these prescription drugs off the street.

The creation of middle grounds of therapies will provide for alternatives that are missing in today's market. By facilitating research and development, we can help drive the expensive and time-consuming efforts needed to make those treatments a reality.

Currently, there are few options left between Tylenol, Tramadol, and opioids, and that void is driving prescription decisions across the country.

So thank you, Mr. Chairman and committee, for the opportunity to provide testimony here today and I look forward to working with everyone to tackle this issue.

[The prepared statement of Mr. Carter follows:]

PREPARED STATEMENT OF HON. EARL L. "BUDDY" CARTER

Chairman Burgess and Ranking Member Green, I want to start my testimony by thanking you for holding today's hearing and for soliciting input from Members on how to continue to combat this growing epidemic.

As a pharmacist, I have always made it a priority to advise and assist my patients with the medications they are prescribed. As a community pharmacist, I developed close bonds with people who were often my friends and neighbors. That bond pushes pharmacists to always act proactively in helping their patients.

One of the largest concerns I have seen is the increased prescribing of opioids for pain relief. We need to look at other options and other outlets for the treatment of pain and find a good medium. I believe we can work with the FDA to prioritize nonopioid treatments for patients and create a channel for the approval of those therapies.

In addition, as it currently stands, prescribers are able to write up to three 30-day prescriptions for schedule two drugs for patients. I believe it would be pertinent to reexamine that prescribing structure and look at the effectiveness of allowing fewer initial prescriptions and a limited number of refills rather than 3 months of prescriptions.

Similar to that notion, allowing pharmacists to have a greater say in limiting the number of pills filled in a prescription could help to address the transition to addiction. For instance, limiting the fill for acute pain needs, such as a dental procedure, could help prevent an individual from getting hooked on opioids.

Under CARA, a pharmacist is only able to partially fill a prescription with the consent of the patient or prescriber or in the instance it doesn't have enough stock to fully fill a prescription. A simple, seven-day fill could cover their pain needs and keep more pills out of potential use or circulation.

Prescription drug monitoring programs (PDMPs) are a great resource in combating the prescription drug abuse, but they can be strengthened to better curb this epidemic. One way to do so is to better align the data included in those PDMPs so that States can collaborate to create a more comprehensive picture of people's drug use. Further linking State PDMPs and including data and work flows could allow for more accuracy in how States monitor and respond to potential abuses.

Drug take-back programs continue to expand across the country. Currently, at least 19 States have some form of drug take back programs and 23 States have programs allowing pharmacies to accept unused and unwanted drugs. One of the most common ways in which adolescents access prescription drugs is through the drug cabinets of their parents and grandparents. Too often, these unused pills can act as a gateway to further abuse by young adults. Expanding these programs through law enforcement, pharmacies, or a paid-for mail programs can take some of these prescriptions drugs off the street.

The creation of a middle ground of therapies will provide the alternatives that are missing in today's market. By facilitating research and development, we can help drive the expensive and time-consuming efforts needed to make those treatments a reality. Currently, there are few options left between Tylenol, Tramadol and opioids and that void is driving prescribing decisions across the country. We have an opportunity to support the efforts of NIH through public-private partnerships to address this and other issues.

Finally, as a lifelong pharmacist, I am never short of amazed at how my colleagues in our profession continue to evolve and excel in their roles advising patients. We now have an opportunity to capitalize on existing progress and to work with the administration, the FDA, and outside groups to right the ship on opioid

abuses. I thank the committee for the opportunity to provide testimony and I look forward to working with everyone to tackle this issue.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentlelady from Illinois, Mrs. Bustos, for 3 minutes, please.

**STATEMENT OF HON. CHERI BUSTOS, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF ILLINOIS**

Mrs. BUSTOS. All right. Thank you, Mr. Chairman, and also Ranking Member Green.

I would like to start out by telling you a story about a young man from my congressional district in Rockford, Illinois. His name is Chris Boseman. I had the good fortune of meeting his mother, who told me this story.

Chris passed away in the summer of 2014 when he was only 32 years old. He had injured his back and as a result of that his physician prescribed an opioid to relieve his pain. Soon after that, he became dependent upon those—that prescription opioid and found out that he could go to the street and find something very cheap called heroin—\$10.

So he continued the cycle of overdose, rehab, relapse, and he was on the right path. He enrolled in a college called Rock Valley College, where he was studying construction management.

But a year after being clean, he relapsed again and ended up passing away. And we know stories very similar to this are happening all over our country.

And I was so proud when we came together, Democrats and Republicans, and actually passed some meaningful legislation on—to help address this opioid crisis.

One of those bills that was included in that was to care for infants born with an opioid dependency due to their parents' addiction. In fact, we received the Government Accountability report that my bill called for very recently, and it reviews and makes recommendations to care for these infants.

But what it really ended up showing is that we have a very long way to go. The Department of Health and Human Services has a strategy for improving infant care, but they haven't yet put this into practice.

There is not even a protocol to screen and treat these newborn babies who are born addicted because of their parents' addiction. So it further reinforces that this is not the time to cut Medicaid.

Medicaid pays for four out of every five babies that are suffering from opioid withdrawal upon their birth. It has helped 1.6 million people with substance abuse disorders and access to treatment.

And I just really more than anything want to make the point that Medicaid has to be protected and not cut.

I want to stress one other point because of the congressional district that I represent and that is that the opioid crisis is actually worse in rural communities where the drug-related deaths are actually 45 percent higher.

Rural States have higher rates of overdose, especially prescription opioids like the kind that Chris had been prescribed for his back injury.

So, you know, we don't have the resources to fight back at the level that we need to. We don't have enough physicians in rural America.

We don't have enough hospitals that are—with up-to-date technology to help with this crisis. We don't even have the needed transportation to reach these treatment centers.

So that is why earlier this year I introduced bipartisan piece of legislation to help rural communities better leverage the U.S. Department of Agriculture programs to combat heroin and opioid use.

So we need to continue to look at solutions that work in rural areas like telemedicine, which will help us overcome the transportation and access issues that I mentioned earlier.

With that, Mr. Chairman, I yield back the rest of my time. Thank you.

[The prepared statement of Mrs. Bustos follows:]

PREPARED STATEMENT OF HON. CHERI BUSTOS

Thank you Chairman Walden and Ranking Member Pallone.

Let me tell you about a young man from Rockford, Illinois named Chris Boseman. Chris passed away in the summer of 2014. He was 32 years old.

He was a kind, tender-hearted son and brother. A back injury led to a painkiller prescription that he soon became dependent on.

And when he could no longer fill that prescription, he began buying pain medication on the street.

But as the costs added up, his dealer told him that heroin would give him the same effects for only \$10.

After a continuing cycle of overdose, rehab, and relapse, Chris was enrolled in Rock Valley College and studying construction management when, after a year of being clean, he relapsed and died.

This is happening every day, all across the country.

I was proud that Congress came together last summer to pass legislation that helps communities address the opioid crisis.

Which included my bill to improve care for infants born with an opioid dependency due to their parents' addiction.

In fact, we just received the GAO's report that my bill called for.

It reviews and makes recommendations to care for these infants. But really what it shows is that we have a long way to go.

HHS has a strategy for improving infant care.

But they haven't put it into practice yet.

There is not even a protocol to screen and treat these newborn babies who, through no fault of their own, are addicted.

Which further reinforces that this is not the time to cut Medicaid, which pays to treat over 80 percent—that's four out of every five—of our newborns suffering from opioid withdrawal.

And helped 1.6 million people with substance abuse disorders to access treatment.

It has dropped the uninsured rate for the mentally ill down to 5 percent in expansion States.

Medicaid must be protected, not cut.

And I want to stress another point: the opioid crisis is worse in rural communities, where drug-related deaths are 45 percent higher.

Rural States have higher rates of overdose, especially from prescription opioids like the kind Chris was given by his doctor.

And we just don't have the resources to fight back.

We don't have enough doctors.

We don't have hospitals with up-to-date technology and services.

And we don't have public transportation to reach the right treatment centers.

That is why earlier this year I introduced bipartisan legislation to help rural communities better leverage USDA programs to combat opioid and heroin use.

We need to continue to look at solutions that work in rural areas, like telemedicine, which will overcome transportation and access issues.

Thank you. I am happy to yield back.

Mr. BURGESS. Chair thanks the gentlelady. Gentlelady yields back.

Chair recognizes the gentleman from Dayton, Ohio, Mr. Turner, for 3 minutes, please.

**STATEMENT OF HON. MICHAEL R. TURNER, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. TURNER. Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee. I want to thank you for the opportunity to appear before you today on this important issue.

As the chairman said, I come from Dayton, Ohio. My counties in Ohio are Montgomery, Greene, and Layette, and despite our communities' efforts to battle the opioid epidemic for years, the epidemic continues to destroy my community and my constituents on a daily basis.

This year, current estimates suggest that 800 people could die in my primary county—Montgomery County—due to opioid overdose. Sadly, that would more than double the 371 drug overdose deaths from 2016, the highest number recorded to date. Imagine 800 families receiving notice that someone in their family has died as a result of opioid overdose.

Heartbreaking numbers like this have made Montgomery County, Ohio, ground zero in the fight against opioid abuse and addiction.

Recently, in working in conjunction with the county sheriff I have called for the appointment of a Dayton area drug czar to help us streamline and coordinate our region's response to this epidemic.

While I have worked on a local basis to help stem this tide, today I would like to highlight my bill, H.R. 982, the Reforming and Expanding Access to Treatment Act—the TREAT Act.

As the title suggests, the TREAT Act would increase access to substance abuse treatment by lifting two restrictions that hamstring full deployment of Federal resources.

Medicaid's Institutions for Mental Disease Exclusion States that facilities with more than 16 beds, like jails, are not eligible for reimbursement for substance abuse treatment services furnished to individuals who are incarcerated.

Composing the problem, a Substance Abuse and Mental Health Administration Policy dating to 1995 limits the use of grants from its Center for Substance Abuse Treatment—CSAT—to only community-based treatment facilities excluding those who are incarcerated.

My Treatment Act offers a common sense solution that would eliminate these barriers to treatment for individuals who are incarcerated by allowing Medicaid to reimburse for substance abuse treatment services furnished to individuals who are incarcerated. There is not reason why someone who is Medicaid eligible should lose their benefits the moment they become incarcerated.

Limiting the SAMHSA policy that prohibits the use of grant funding for providing substance abuse treatment to individuals who are incarcerated would also assist.

Since I first introduced the TREAT Act in November of 2015 and then reintroduced it in this Congress it has garnered a broad spec-

trum of support from law enforcement to medical providers to local jurisdictions.

The President's Commission on Combatting Drug Addiction and the Opioid Crisis Interim Report, which was just issued July 31st, 2017, strongly endorsed this concept that is in the TREAT Act.

The White House Commission called lifting Medicaid's IMD exclusions, quote, "the single fastest way to increase treatment availability across the Nation, noting that every Governor, numerous treatment providers, parents, and nonprofit advocacy group organizations have urged this course of action."

Chairman Burgess, Ranking Member Green, and members of the subcommittee, lives are at stake. This would be an important step to bring treatment to those individuals who are at a time we have an ability to intervene in their lives.

Thank you.

[The prepared statement of Mr. Turner follows:]

PREPARED STATEMENT OF HON. MICHAEL R. TURNER

Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to appear before you today.

I am Congressman Michael R. Turner, and I proudly represent Ohio's 10th Congressional District, which centers around the city of Dayton and includes Montgomery, Greene, and Fayette counties.

This morning, I will briefly explain how the opioid epidemic is ravaging the district I serve and propose possible solutions to what has become a national crisis of frightening proportions.

Despite battling against it for years, the heroin and opiate epidemic continues to destroy my community and my constituents on daily basis.

This year, current estimates suggest that 800 people could die in Montgomery County alone due to an opiate overdose. Sadly, that would more than double the 371 drug overdose deaths from 2016, the highest number recorded to date.

The Montgomery County morgue regularly surpasses capacity and has even been forced to use refrigerated trailers to house victims' bodies. The coroner has described what is occurring as a "mass-casualty event."

To make matters worse, deadly synthetic opioids like fentanyl, which can be 50 times stronger than heroin, and carfentanil, which can be 5,000 times stronger, have flooded the Miami Valley.

It is heartbreaking numbers and stories like these that have made Montgomery County, Ohio "the overdose capital of America"—meaning that, per capita, more of my Montgomery County constituents are dying as a result of drug overdoses than anywhere else in the United States.

Our struggle in southwestern Ohio mirrors that of countless other areas across the country—91 Americans die every day as the result of an opioid overdose.

These sobering statistics paint a picture of a country facing an exponentially growing epidemic of opioid abuse that is resulting in drastic increases in addiction rates, overdose deaths, and incarceration. The opiate crisis is tearing apart families, neighborhoods, cities, and indeed our society as a whole.

While I have spearheaded several initiatives—in conjunction with State and local partners—to stem the tide of the opioid epidemic, today I would like to highlight my bill H.R. 982, The Reforming and Expanding Access to Treatment (TREAT) Act.

As the title suggests, my TREAT Act would increase access to substance abuse treatment by lifting archaic restrictions that hamstring full deployment of Federal resources.

The concept behind my TREAT Act originated from a tour of my district's Greene County Jail and Green Leaf Alcohol & Drug Treatment Program in August 2015.

During the visit, I discovered that individuals who are incarcerated cannot receive substance abuse treatment through Medicaid, even if they are otherwise eligible.

This is due to Medicaid's Institutes for Mental Disease (IMD) exclusion, which states that facilities with more than 16 beds—like jails—are not eligible for reimbursement for substance abuse treatment services furnished to individuals who are incarcerated.

Compounding the problem, the Substance Abuse and Mental Health Administration (SAMHSA) currently prohibits the use of grants from its Center for Substance

Abuse Treatment (CSAT) for substance abuse treatment services provided to individuals who are incarcerated. Instead, this over 20-year-old policy limits use of such grants to only community-based treatment facilities.

These unnecessary restrictions act as obstacles, limiting our flexibility in how we employ the Federal resources that are so desperately needed to combat this growing epidemic and supply medical treatment to individuals suffering from substance abuse disorders and addiction.

My TREAT Act offers a common-sense solution that would eliminate these barriers to treatment for individuals who are incarcerated by:

- Allowing Medicaid to reimburse for substance abuse treatment services furnished to individuals who are incarcerated; and
- Lifting the SAMHSA policy that prohibits the use of grant funding for providing substance abuse treatment to individuals who are incarcerated.

Since I first introduced the TREAT Act in November 2015 and reintroduced it this Congress, it has garnered a broad spectrum of support from law enforcement to medical providers to local-level jurisdictions.

The President's Commission on Combating Drug Addiction and the Opioid Crisis' Interim Report, issued July 31, 2017, strongly endorsed the TREAT Act's core concept.

The White House Commission called lifting Medicaid's IMD exclusion the "single fastest way to increase treatment availability across the Nation," noting that "every Governor, numerous treatment providers, parents, and nonprofit advocacy organizations" have urged this course of action in an effort to combat the opioid epidemic.

Chairman Burgess, Ranking Member Green, and members of the subcommittee, my constituents' lives and indeed the well-being of my entire community are at stake here, as are many of yours. They are under assault from an opioid epidemic, the likes of which have never been seen.

My TREAT Act can help put an end to the opiate crisis-but it cannot wait any longer. I urge you to work with me to report the TREAT Act out of committee, and support its passage in the House of Representatives.

Thank you for the opportunity to speak with you today, and I look forward to addressing any questions or concerns you may have.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

Chair recognizes the gentleman from Kansas, Dr. Marshall, for 3 minutes.

STATEMENT OF HON. ROGER W. MARSHALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. MARSHALL. Thank you, Chairman, very, very much. Appreciate—thank you, Chairman, for the opportunity to come and talk and share some of my 30 years of experience as an OB/Gyn in rural Kansas.

As most of the members of the committee know, 92 people die in this country every day. Ninety-two people die in this country every day from opioid addiction.

What I wanted to do was describe a couple sentinel events. Why? Why did we end up in this situation? And as I—as I look back in these last 10 years, the number of pills that I would send home for a post-op patient doubled.

For the average C-section, the average hysterectomy, all of a sudden each week, to get the people to that post-op visit the number of pills they would need literally doubled.

So I went back to try to figure out why and how come, and the first thing I think of, the Patient Bill of Rights came about 1993 or so, and over the next 10 years, though it was a great document, patients suddenly began to expect that they should have no pain—no pain after surgery. They would come into the ER with a sprained ankle and expect to have no pain and the demand for narcotics went up and up.

Somewhere in the early 2000s, something was introduced called a pain scale and they called it the fifth vital sign. It is probably the worst thing I've ever seen introduced in my medical career where they suddenly described the amount of pain, which is very subjective, and beyond that it eventually became part of a measure of how good a medicine you were practising, even tied to your reimbursement.

So suddenly patients in the post-op PACU area were getting double and triple the medications, and then on the post-operative floor, rather than getting Percocets every 6 hours, they were getting them every 4 hours and the PCA pumps increased doses.

So what I am trying to say is we almost doubled the amount of narcotics people were getting in the hospital and then they wanted twice the amount to go home with as well.

So physicians were faced with this struggle of saying well, I don't think you need this much, but patients becoming more and more in control of how many—of their own health care.

So I think those are a couple of reasons why we ended up here and I think there needs to be some reeducation done. I would like to point towards Valley Hope at Norton, Kansas. They have treated over 300,000 patients over the past 50 years. They have kept incredible statistics. They have incredible treatment plans.

And what they taught me is about a month after release—a month after they started their Path to Recovery that they had a second physiological reaction and that is when they—these people OD and die. People need to recognize that for a month that they need to have very close treatment and probably for two months, then even a year.

So it's during that second episode when they—when before they had treatment they were taking a certain amount of heroin and a handful of pills and a pint of whiskey. When they retreated from that for a month and they went back to that same dose, they overdosed and stopped dying.

We need to understand what kills people is that—that if I gave anybody enough morphine you would stop breathing. So they are unable to metabolize it. We need to recognize that that is a very critical moment. Treatment plans cannot last a week.

They're going to last months and years probably. We need to make sure we are adequately funding outpatient treatment and that we are making sure that there is good follow-up at home and we need to reward facilities like Valley Hope who have great outcomes—great long-term outcomes.

Mr. Chairman, thank you so much for taking on this task and look forward to working with you, as always.

[The prepared statement of Mr. Marshall follows:]

PREPARED STATEMENT OF HON. ROGER W. MARSHALL

As a practicing physician for nearly 3 decades, and now a freshman Congressman, I have had a unique perspective from which to understand the causes, and to identify solutions for the opioid crisis we face.

Over the last decade, it has become clear that many actions taken by the medical community to better-address pain, such as pain-scales, and stronger pain treatments for chronic diseases or cancer, have helped fuel an opioid epidemic that is killing an unprecedented number of Americans.

While we began to improve the restrictions on prescribing these painkillers, tens of thousands of addicted people turned to street-level drugs as cheap, potent alternatives.

Today, I don't pretend to have all the answers or solutions to this complex situation, but there are some simple things already being done that have proven successful.

One part of the solution is quality community addiction treatment. For 50 years, Valley Hope in Norton, KS, has treated over 300,000 patients. They address substance-abuse as a chronic health care problem, just like you would treat hypertension or diabetes. They don't treat it as some sort of moral deficiency.

Valley Hope also recognizes that opioid addiction has a second withdrawal about a month after stopping the use of narcotics. It is that secondary withdrawal that patients are most likely to overdose. Patients go back to taking the amount of drugs they usually took to get high. Their bodies cannot metabolize like they used to, and the patient overdoses and stops breathing.

The key to avoiding these disasters is to maintain contact through weekly follow ups and outpatient checkups. The future treatment for opioid abuse will be found in rewarding good outpatient management, and institutions that pride themselves in low rates of readmission and relapse.

Solving this crisis begins in the doctor's office. Physicians, nurses and patients must all be willing to understand the potential for addiction when they prescribe, administer or take medications.

When we pair this understanding with capable community treatment, along with respect, compassion and empathy toward those suffering, we will have taken the first steps to overcome this challenge.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

The Chair recognizes the gentleman from Ohio, Chairman Stivers, for 3 minutes.

STATEMENT OF HON. STEVE STIVERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. STIVERS. Thank you very much, Mr. Chairman. I appreciate you holding this hearing. Appreciate Ranking Member Green and all of you looking at solutions that—for this opioid crisis that is plaguing all of the communities across this country.

Congressman Turner already alluded to it, but in Ohio opioid overdoses now exceed car accidents as the leading cause of death for most Ohioans.

And there have been a lot of great ideas presented here today and I really have appreciated learning from many of our colleagues.

I, for the last 5 years, have held opioid round tables—drug round tables in my district to talk about solutions and we have come up with some ideas from the field of folks that know what is driving this crisis.

And I will talk about some medical things in a second but the first thing I know we have to do is bring back hope and economic opportunity to people and I think what you are doing, Mr. Chairman, with regulatory reform and what we are doing with tax reform is going to help with that.

But there are a lot of other things we can do. First, you know, the idea that came out of our round table this year was on evidence-based treatment. If you've been to one treatment facility you have been to one treatment facility, because they all do things differently.

Too many of them do things that when you walk out that door, there is nothing tying you to the treatment anymore and that is

a problem, and they need to—I think we should have evidence-based treatment.

It should be based on the science of the day and how recovery works, and I think we need to build that into our reimbursement standards. I think that is so important.

Dr. Marshall already talked about the second issue I want to bring up, which is pain as a vital sign. Every other vital sign you can think of—you know, your temperature, your blood pressure, your pulse—can be measured by a machine. Pain can't be measured by a machine.

It is a subjective number and it should not be the fifth vital sign. It has led to our over prescribing culture in this country and we have to try to fix it.

I appreciate what CMS has done to remove the reimbursement based on the surveys of pain management. But I think we need to remove pain as a vital sign.

The third idea is encouraging alternatives. There is lots of ways to manage pain including acupuncture, chiropractic services, and other things that don't involve a pill and I think we need to change the culture on that.

The fourth idea is some prescription changes and I know that Buddy Carter, who is a pharmacist, talked about a couple of these. I sponsored the partial fill legislation that was rolled into CARA and became law. But I believe that pharmacists should be empowered to authorize partial fill of opioid prescriptions on their own.

And Buddy already said it, but 70 percent of the folks who misuse prescriptions get it at some point—bridge that addiction through their friends' and families' medicine cabinets and we have got to fix that.

The final issue that I don't hear talked about enough is tapering doses. When somebody is on an opioid for about 30 days, they have a physical addiction to it and if you talk to most pharmacists they will talk about a tapering does instead of going off cold turkey, and I think that is something we need to bring a culture around of having folks understand that because a lot of primary care physicians, Mr. Chairman, feel very uncomfortable with doing—issuing more prescriptions but a tapering does actually will reduce the physical addiction and actually will result in less people wanting to feed that addiction in other ways.

So those are just five ideas of some proposed solutions. Many of my colleagues also have great ideas. I really appreciate, Mr. Chairman and Ranking Member, you holding this hearing and we are committed to working with you to driving this scourge of drug addiction out of this country, and I really appreciate what you are doing.

I yield back.

[The prepared statement of Mr. Stivers follows:]

PREPARED STATEMENT OF HON. STEVE STIVERS

Thank you Chairman Burgess and Ranking Member Green for having this hearing today to discuss solutions for addressing the opioid crisis plaguing communities across America.

We have seen drug overdoses surpass traffic accidents as the leading cause of accidental death in the United States.

This issue affects everyone—no matter your race, income level, gender, or political party. We need to work together to curb this epidemic.

MY DISTRICT

Ohio has been devastated by this crisis. In 2016, 4,050 Ohioans died from an unintentional drug overdose. This was a 32.8 Percent increase from 2015 (3,050).

In my district alone, there were 112 overdose deaths in 2015, according to the Ohio High Intensity Drug Trafficking Area.

Because of how much this has affected my district, I have held roundtables for the past 5 years to bring together people from all sides of the issue to discuss how we can better work together to address this issue in Ohio.

EVIDENCE-BASED TREATMENT

In one of my recent roundtables, we discussed how we need to ensure that we support only the treatments that are proven to work and are evidence-based.

Based on these discussions, we have learned of a serious need to raise the evidenced based standards that are used in approving treatment programs that are largely funded by the Federal Government and administered at the local level.

The Ohio Department of Mental Health and Addiction Services estimates that almost 500,000 Ohioans receive publicly funded mental health services, which includes addiction treatment, every year.

Whether it be a discrepancy between accreditation standards, or inadequate reporting requirements, Congress should be ensuring that Federal funds going to Ohio, and to my district, are going towards treatments that are based on a foundation of evidence as to its efficacy.

Simultaneously, we need to promote data collection and research in order to better inform our evidence-based efforts over time, so that we do not discourage emergent therapies and can justify deploying innovative approaches that can meet this epidemic head on.

PAIN AS A VITAL SIGN

Another issue we discussed is removing pain as the fifth vital sign and finding ways to change the culture surrounding pain management and the overprescription of opioids.

Pain being considered a vital sign can, in some cases, lead to the overprescribing of opioids by focusing on pain management instead addressing and treating the underlying causes of pain.

This culture of overprescribing has also been found in patient-reported satisfaction scores. On these surveys, “pain management” is a section doctors and hospitals have been scored on.

Poor marks in satisfaction scores can lead to lower reimbursements for these doctors and hospitals, and this attempt to manage pain, while well intentioned, created a perverse incentive that led to some health care professionals to work towards a score, rather than the best overall health of the patient.

Recently, CMS has announced that they will no longer be directly tying these “pain management” questions to the Hospital Value-Based Purchasing Program, starting next year.

I am encouraged by CMS’s recent actions. By building upon these actions and working to remove the use of pain as a vital sign, we can remove the incentive to overprescribe opioids to patients, and rather focus on prescribing them when they are absolutely necessary. I implore the committee to learn from this example to ensure further policies are always focused on the long term health of the patient over short term benchmarks and quotas.

ENCOURAGING ALTERNATIVES

As we seek to change the culture of pain management, we also need to find ways to support and bolster alternative methods for treating and managing pain—outside of opioids.

This can include treatment options such as chiropractic services and acupuncture.

There is no doubt that we should ensure patients can receive the medicine they need, but overreliance as a quick and easy fix must be discouraged when there are other alternatives that could be used.

TAPERING OPIOID USE

Furthermore, as you know, last year, the passage of the Comprehensive Addiction and Recovery Act (CARA) was one of the highlights in the fight against opiate addiction.

Language from my legislation, the Reducing Unused Medications Act was included in the final passage of CARA. This bill allows for the partial fill of prescriptions at the request of patients or doctors, reducing the number of unused painkillers that can be abused or diverted.

With more than 70 percent of adults who misuse prescription opioids getting them from medicine cabinets of friends or relatives, we needed to reduce unused medications in homes.

Now, we need build on that legislation. One way to do that is to focus on supporting better education and protocols for physicians to taper down the dosages of prescribed opioids over the course of treatment.

This approach must be specific to each patient, and we should be finding ways to encourage better conversations about pain management between patients, their doctors, and their pharmacists.

I look forward to working with this committee to find better ways to better inform patients of resources and tools at their disposal—like partial fill opportunities—and giving physicians more freedom to address pain management at an individual level.

CLOSING

There is no single legislative fix for the opioid epidemic. We need to keep pushing to find ways to better prevent opioid abuse and treat those who are suffering from addiction.

Those are just a few of the proposed solutions I am advocating, and I hope I can continue working with everyone on this committee to craft legislation that delivers relief to Ohio's 15th District and all communities suffering from this epidemic.

Again, I want to thank the chairman and ranking member for having this important hearing. I look forward to working with everyone on solutions to stop the opioid epidemic in our country.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back, and I want to thank all of you for providing your testimony today.

This panel is excused, and our next panel will be Dr. Wenstrup from Ohio, Mr. Schneider from Illinois, Ms. Clark from Massachusetts, Mr. Jeffries from New York, and Mr. Jenkins from West Virginia.

And Representative Schneider, you are recognized for 3 minutes.

STATEMENT OF HON. BRADLEY SCOTT SCHNEIDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SCHNEIDER. Thank you. Thank you, Chairman Burgess, Ranking Member Green, for inviting me here today to discuss the epidemic of opioid addiction abuse and overdose that is ravaging our communities.

I represent the people of Illinois' 10th District including parts of Cook and Lake Counties, and the opioid crisis has hit our neighbourhoods extremely hard.

In Cook County, which includes the city of Chicago, opioid overdoses increased by 87.4 percent—I repeat that, 87.4 percent—between 2013 and 2016.

Over the same period, we witnessed a troubling increase in fentanyl, a synthetic opioid which is even more deadly than heroin and whose overdoses are often fatal.

In the face of these challenges, I would like to recognize the Lake County Opioid Initiative and Chicago area Opioid Task Force along

with other area organizations for their work to prevent opioid abuse, addiction, overdose, and health—and death, rather.

In this epidemic, our adversary is constantly shifting. So must ensure our doctors are up to date with the most recent best practices and research for preventing and treating this disease.

Earlier this year, I introduced a bill called the Preventing Opioid Abuse Through Continuing Education, or Opioid PACE Act. This bill would require providers who treat patients will prescription opioids for pain management to complete 12 hours of continuing education every 3 years.

This would be linked to renewal of the providers' Drug Enforcement Agency license. In an effort to cut down on over prescribing, the CME would focus on pain management treatment guidelines and best practices, early detection of opioid use disorder, and the treatment and management of patients with opioid use disorder.

I am proud that a modified version of this bill requiring continuing education of medical professionals at the Department of Defense was included as an amendment to the NDA authorization.

Our men and women in uniform are not immune from the damages of opioid addiction. In fact, the National Institute of Health reports rates of prescription opioid misuse are higher among service members than among civilians due to the use of these drugs to treat symptoms of PTSD and chronic pain.

As we seek new legislative solutions, I urge my colleagues to support these programs we have in place to fight back. In particular, the Affordable Care Act greatly increased our ability to counter opioid epidemic by expanding Medicaid and requiring individual market policies that they would cover services related to treating substance use disorders.

The States with the highest rates of drug overdose deaths are also the States that would suffer from a rollback of Medicaid expansion.

Simply put, repealing the ACA would add fuel to the fire of the opioid epidemic. I urge my colleagues to consider new solutions to address this crisis including the Opioid PACE Act and preserve the programs we have in place to address this epidemic.

And with that, I yield back.

[The prepared statement of Mr. Schneider follows:]

PREPARED STATEMENT OF HON. BRADLEY SCOTT SCHNEIDER

Thank you, Chairman Burgess and Ranking Member Green, for inviting me here today to discuss the epidemic of opioid addiction, abuse, and overdose that is ravaging our communities.

I represent the people of Illinois' 10th District including parts of Cook and Lake Counties, and the opioid crisis has hit our neighborhoods hard. In 2015, there were 42 heroin-related deaths in Lake County, a seven-percent increase over the previous year. In Cook County, which includes the City of Chicago, opioid overdoses increased by 87.4 percent between 2013 and 2016. Over the same period, we've witnessed a troubling increase in fentanyl—a synthetic opioid which is even more deadly than heroin and whose overdoses are often fatal.

In the face of these challenges, I'd like to recognize the Lake County Opioid Initiative and Chicago Area Opioid Task Force, along with other area organizations, for their work to prevent opioid abuse, addiction, overdose, and death.

In this epidemic, our adversary is constantly shifting, so we must ensure our doctors are up-to-date with the most recent best practices and research for preventing and treating this disease.

Earlier this year I introduced a bill called the Preventing Opioid Abuse Through Continuing Education or Opioid PACE Act, that would require providers who treat patients with prescription opioids for pain management to complete 12 hours of continuing medical education (CME) every 3 years, linked to the renewal of the provider's Drug Enforcement Agency (DEA) license.

In an effort to cut down on overprescribing, the CME would focus on pain management treatment guidelines and best practices, early detection of opioid use disorder, and the treatment and management of patients with opioid use disorder.

I'm proud that a modified version of this bill requiring continuing education medical professionals at the Department of Defense was included as an amendment in the National Defense Authorization Act. Our men and women in uniform are not immune from the damages of opioid addiction. In fact, the National Institute of Health reports rates of prescription opioid misuse are higher among service members than among civilians due to the use of these drugs to treat the symptoms of PTSD and chronic pain.

As we seek new legislative solutions, I urge my colleague to also support the programs we have in place to fight back.

In particular, the Affordable Care Act greatly increased our ability to counter the opioid epidemic by expanding Medicaid and requiring individual market policies cover services related to treating substance use disorders.

The States with the highest rates of drug overdose deaths are also the States that would suffer from a rollback of the Medicaid expansion. Simply put, repealing the ACA would add fuel to the fire of the opioid epidemic.

I urge my colleagues to consider new solutions to address this crisis—including the Opioid PACE Act—and preserve the programs we have in place to counter the epidemic.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Chair recognizes Representative Jeffries from New York for 3 minutes, please.

STATEMENT OF HON. HAKEEM S. JEFFRIES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. JEFFRIES. Thank you, Chairman Burgess and Ranking Member Green, for holding this hearing as well as for your leadership on this very important issue. Appreciate the opportunity to testify today on the Synthetic Drug Awareness Act of 2017—H.R. 449.

The opioid crisis has ravaged families across the country without regard to zip code, income, race, religion, or gender. Like a malignant tumor, the opioid crisis is eating away at young people in urban American, rural America, as well as suburban America.

One reason the opioid abuse has become so prevalent and so deadly is the emergence of the synthetic drug called fentanyl, a substance that can be 50 to 100 times stronger than morphine.

In order to address the multifaceted public health crisis we confront, it's important to consider both the cause and effect. H.R. 449 addresses a critical and sometimes overlooked threat—the use of synthetic drugs by teenagers.

It requires the surgeon general to prepare a comprehensive report on the public health effects of synthetic drug abuse by 12-to-18-year-olds in America.

With the information the study will provide, Congress can work to prevent substance abuse by younger Americans through an enhanced and enlightened lens. Nationwide, the drug overdose death rate has more than doubled during the past decade among younger Americans.

Many experts believe this troubling phenomenon results from the rise and availability of potent and dangerous substances like illicit fentanyl and other synthetic drugs.

Teenage fentanyl use is a vicious cycle. Adolescents have a still developing prefrontal cortex which can facilitate drug-seeking behavior. The drug then alters the development of this area of the young brain, making that behavior permanent.

In fact, more than 90 percent of adults who develop a substance abuse disorder begin using prior to the age of 18. In New York City, overdoses now kill more people each year than murder, suicides, and car crashes combined. This phenomenon we have seen repeated over and over again all across America.

This bill has significant support amongst Republicans and Democrats and has been incorporated into the legislative agenda for the bipartisan Heroin Task Force. It also has support from a number of health and patient advocacy groups including the American Academy of Pediatrics, American Association of Nurse Practitioners, as well as the National Association of Police Organizations.

Thank you again for this opportunity to testify and I respectfully respect committee consideration at your earliest convenience.

[The prepared statement of Mr. Jeffries follows:]

PREPARED STATEMENT OF HON. HAKEEM S. JEFFRIES

Let me first thank the leadership of the Energy and Commerce Committee, Chairman Walden and Ranking Member Pallone, and of the Subcommittee on Health, Chairman Burgess and Ranking Member Green, as well as the distinguished Members of the Energy and Commerce Committee for holding this hearing. I appreciate the opportunity to testify today on the "Synthetic Drug Awareness Act of 2017"-H.R. 449.

The opioid crisis has ravaged families across the country without regard to zip code, income, race religion or gender. Like a malignant tumor, the opioid crisis is eating away at young people in urban, rural and suburban America. One reason opioid abuse has become so prevalent, and so deadly, is the emergence of the synthetic drug called fentanyl-a substance that can be 50 to 100 times stronger than morphine.

In order to address the multifaceted public health crisis, we must consider both the cause and effect. H.R. 449 addresses a critical and sometimes overlooked threat, the use of synthetic drugs by teenagers. It requires the Surgeon General to prepare a comprehensive report on the public health effects of synthetic drug use by 12-to-18-year-olds in America. With the information this study will provide, Congress can work to prevent substance abuse by younger Americans through an enhanced and enlightened lens.

Nationwide, the drug overdose death rate has more than doubled during the past decade among younger Americans.¹ Many experts believe this troubling phenomenon results from the rise and availability of potent and dangerous substances like illicit fentanyl and other synthetic drugs.

Teenage fentanyl use is a vicious cycle: adolescents have a still-developing prefrontal cortex, which can facilitate drug-seeking behavior. The drug then alters the development of this area of the brain, making that behavior permanent. In fact, more than 90 percent of adults who develop a substance abuse disorder begin using before they are 18 years old.

In New York City, overdoses kill more people each year than murders, suicides and car crashes combined. Between 2015 and 2016, city officials saw a huge jump in overdose-related deaths, with more than eight in ten involving an opioid, a trend driven by fentanyl.³

This bill has significant support among Republicans and Democrats and has been incorporated into the legislative agenda for the Bipartisan Heroin Task Force. Furthermore, a number of health and patient advocacy groups are supportive of this bill, including the American Academy of Pediatrics, American Association of Nurse Practitioners, American Academy of Child & Adolescent Psychiatry, American Psychological Association, College on Problems of Drug Dependence, Community Anti-

Drug Coalitions of America, Friends of the National Institute on Drug Abuse, Healthy Teen Network, Mental Health America, National Association of County and City Health Officials and National Association of Police Organizations.

Thank you again for the opportunity to testify today, and I respectfully request committee consideration of the "Synthetic Drug Awareness Act" at the earliest possible time.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Chair recognizes the gentleman from West Virginia, Mr. Jenkins, for 3 minutes, please.

**STATEMENT OF HON. EVAN H. JENKINS, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF WEST VIRGINIA**

Mr. JENKINS. Thank you so much, Chairman Burgess, Ranking Member Green, and members of the subcommittee for giving me the opportunity to discuss this most challenging public health and safety issue of our time.

My home State of West Virginia is ground zero for the opioid epidemic. West Virginia has the Nation's highest overdose rate and the highest rate of newborns exposed to opioids and other drugs known as neonatal abstinence syndrome, or NAS.

From this tragic epidemic, however, has come an exceptional response from communities across my State coming together to find solutions. One shining example is Lilly's Place, a unique facility that specializes in treating newborns suffering from NAS.

I was proud to work with two NICU nurses and a passionate community leader to start Lilly's Place after they saw, we saw, the dramatic rise in newborns with NAS. Lilly's Place has been operating for 3 years and has cared for more than 190 precious newborns.

Lilly's Place has brought national attention to West Virginia solutions. Just yesterday, the First Lady, Melania Trump, visited Lilly's Place in my hometown of Huntington to talk with the caregivers about helping the most vulnerable in our society. Lilly's Place provides a great environment with are given by doctors and nurses in a nurturing setting conducive to recovery.

Mothers and families are included in the healing process. Lilly's Place and others advocating for this model of care had struggles dealing with CMS, making it harder to replicate this model.

That led to my introduction of the Nurturing and Supporting Healthy Babies Act. Last year through this committee's work my legislation was incorporated in CARA, which, of course, became law and was passed. Thank you for your work.

My legislation requiring GAO to closely look at the different care models for NAS and Medicaid coverage and the GAO report was just released last week.

It found that nonhospital settings like Lilly's Place are a proven model of care to treat NAS newborns. It identified this model of care as a proven effective treatment approach and can actually reduce the cost of care.

Here is my ask. I would encourage this committee to advance two measures critical to the care of these precious newborns. First, I have sponsored the CRIB Act pending before this committee with Congressman Mike Turner which makes sure these models of care

are included in nonhospital treatment facilities are recognized by Medicaid to remove the barriers.

Second, based on the GAO report, I ask you, working with me—this committee—to memorialize in legislation the recommendations in this report and have these become law so these precious newborns can receive the very best possible care.

Thank you, Mr. Chairman, for your interest in this issue, and I yield back.

[The prepared statement of Mr. Jenkins follows:]

PREPARED STATEMENT OF HON. EVAN H. JENKINS

Thank you, Chairman Burgess, Ranking Member Green, and members of the subcommittee, for giving me the opportunity to discuss the most challenging public health crisis of our time. States and communities across this country have been dealing with the ravages of opioid and drug addiction. This is not a rural or urban problem, it is a crisis that has hit cities and small towns alike.

West Virginia has been ground zero for the opioid epidemic. The statistics speak for themselves. West Virginia has the highest overdose death rate, we have the highest rate of newborns exposed to opioids and other drugs known as Neonatal Abstinence Syndrome or NAS, and the lowest workforce participation rate.

But from this tragic epidemic has come an exceptional response from communities across my home State. Communities have come together to find solutions and they are working to get their communities healthy again.

One of the most shining examples is Lily's Place, a unique stand-alone facility that specializes in treating newborns suffering from NAS in a clinically appropriate setting. I was proud to have worked with two NICU nurses to start Lily's Place after they had seen a dramatic rise in newborns with NAS at the local hospital.

Lily's Place has brought national attention to West Virginia solutions, being featured in a number of news stories. Just yesterday, First Lady, Melania Trump, visited Lily's Place in West Virginia to talk with caregivers helping the most vulnerable in our society, newborns suffering from NAS.

Lily's Place provides a perfect environment for newborns suffering from NAS, with a low lit, low stimulus environment with doctors and nurses providing care. Lily's Place has become a model for its ability to treat newborns, and Lily's Place includes the mothers and families in the healing process.

Last year, with the tireless work of the Energy and Commerce Committee, Congress passed and the President signed the Comprehensive Addiction and Recovery Act or CARA. I was honored to have my legislation, the Nurturing and Supporting Healthy Babies Act included in the package of bills. This legislation required the GAO to take a close look at the different care models for NAS and how NAS is covered by Medicaid. I thank the members of this committee for working with me to further our understanding of how best to take care of newborns with NAS.

The GAO report released last week, had important information and a number of key findings in it. Part of what we have learned from the GAO report is that non-hospital settings are sometimes a better alternative to the NICU for the care that NAS newborns need. The report identified and took a close look at different care models and how the best practices at nonhospital settings can actually reduce costs of care.

I have sponsored legislation, the CRIB Act, with Congressman Mike Turner which makes sure that these nonhospital settings are recognized by Medicaid to remove this barrier to care for NAS newborns. This legislation would clear the confusion at CMS on how to certify these facilities and as to what a nonhospital NAS treatment center is.

The GAO report also highlighted that the Department of Health and Human Services has a number of recommendations they developed but HHS does not have a clear strategy or timeline for implementing these recommendations. I am working on legislation to make sure HHS develops a clear timeline and begins implementing a number of these recommendations. This legislation will give the needed push to HHS so we can help the newborns that are most impacted by the opioid epidemic start their lives happy and healthy.

We have a unique opportunity to continue the strong bipartisan work on addressing the opioid epidemic and these two pieces of legislation can continue this effort. I look forward to working with the committee to bring these two pieces of legislation to the House floor and send them to the President's desk.

Caring for the most vulnerable impacted by the opioid crisis is a truly noble cause and one that we can all come together to support.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Dr. Wenstrup, you are recognized for 3 minutes, please.

**STATEMENT OF HON. BRAD R. WENSTRUP, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Mr. WENSTRUP. Well, thank you, Chairman Burgess and Ranking Member Green, for hosting this today, and I mean that sincerely. We are hearing a lot of good ideas and it gives us a lot of food for thought.

But the opioid crisis is affecting each and every one of our districts across the country. That is very obvious, and I appreciate the chance to come and speak today and share with you some stories from Ohio's 2nd District.

My office recently sent a survey to the constituents of our district and we asked them to share their stories and experiences with the opioid epidemic, and the results are heartbreaking, as you might imagine.

We received hundreds of responses—up to seven pages of responses, and I just want to share a couple of those with you.

One said, “My brother, unfortunately, became addicted as a teenager. He is very lucky, because at 33 years old he’s still here but he is still fighting every day to stay sober. These drugs have no place in our country. They are ruining our youth, our future.”

Another one—a woman said, “I have four boys and three of them are struggling with this addiction. The cost of going to a methadone clinic is very difficult. The cost of treatment facilities is too expensive. I am going broke trying to get my children sober.”

Clearly, this epidemic is devastating for southern Ohio as it is across the country. In one county alone, the overdose death rate was 37.5 per 100,000 residents and in another county 318 residents died of an intentional drug overdose in just—in 2016.

This spring, the Columbus Dispatch reported at least 4,149 Ohioans died from an unintentional drug overdose in 2016 and one local newspaper called the overdoses the new normal in that county.

I appreciate what Dr. Marshall had to say earlier. As a doctor, I can agree with him on many of the factors that have driven so many people into addiction, and I would really like for us to talk sometime about prevention, which I think is the long-term vision for our country.

I can tell you as a doctor I had someone come up to me just last year and say, “My friend wanted me to thank you if I met you,” and I said, “Why is that?” He said, “Because she was addicted to prescription pain meds, and when she came to you, you gave her alternatives, and you didn’t give her any.”

We search for answers. We are all searching for answers. One of the sheriffs in my district, he’s working hard on the solution and he’s using prevention because he said, I can’t incarcerate our way out of this.

But he did show me what one patient received on Medicaid in a year—what one patient in one year received from Medicaid as far

as narcotics, and I promise you it was more than I prescribed in my entire surgical practice in a year.

And then he showed me what Medicaid paid for it. And so while I understand that Medicaid is providing help and care for a lot of people, it may be driving the problem as well, because as some are getting treatment, many are getting fed and the problem is being exacerbated and we need to look at that and there needs to be better oversight of how we are handling this.

This sheriff directs an essay contest, asking local students to write an essay about the dangers of opioids and how they hope to become the generation to stop the epidemic.

As I said before, he said he can't incarcerate his way out of this. We can't always treat our way out of this. But I hope that we take some time in this process for a long-term vision of how we can prevent people from ever getting in this situation to begin with.

And with that, I yield back, and I thank you for your time and attention today.

[The prepared statement of Mr. Wenstrup follows:]

PREPARED STATEMENT OF HON. BRAD R. WENSTRUP

Thank you, Health Subcommittee Chairman Burgess and Health Subcommittee Ranking Member Green, for hosting this Member Day today. The opioid crisis is affecting each and every one of our districts across the country, so I appreciate the opportunity to come and speak to you today, along with my colleagues, and share with you some stories from Ohio's 2nd District.

My office recently sent a survey to the constituents of Ohio's 2nd District, asking them to share their stories and experiences with the opioid epidemic. The results are heartbreaking. We received hundreds of responses—all telling the same stories. I wanted to just read aloud a few of them for you.

One woman wrote, "My brother unfortunately became addicted as a teenager. He is a very lucky one at 33 years old he is still fighting every day to stay sober. These drugs have no place in our country. They are ruining our youth, our future."

Another said, "My daughter is currently in rehab for heroin addiction; she's destroyed several relationships with various members of our family, I am raising her 18-month-old son and she's been in and out of jail for several years and she's only 27. She's overdosed at least once that I know about and has been physically and emotionally abused by a boyfriend. I am terrified that she won't live to see 30 and that her son will never know the sweet and caring person she was/is when not high."

Another constituent shared, "I have 4 boys and 3 of them are struggling with this addiction. the cost of going to a methadone clinic is very difficult. the cost of treatment facilities is too expensive. I am going broke trying to get my children sober."

Clearly, this epidemic is devastating for Southern Ohio, as it is across the country. In one county in Ohio alone, the overdose death rate was 37.5 per 100,000 residents. In another county, 318 residents died of an unintentional drug overdose in 2016. This spring, the Columbus Dispatch reported that at least 4,149 Ohioans died from unintentional drug overdoses in 2016. One local newspaper called the overdoses the "new normal" in that county.

As we search for solutions to this crisis, I hope you'll keep this in mind: Adams County Sheriff Kimmy Rogers, in my district, is working hard on a key part of this solution: prevention. He runs an after-school program at a local church that teaches young kids about the dangers of drugs and opioids. He also runs an essay contest, asking local students to write an essay about the dangers of opioids and how they hope to become the generation to stop the epidemic. When I asked Sheriff Rogers about these programs, he said we can't incarcerate our way out of this problem. We can't always treat our way out of this. But I hope we take some time in this process for a long-term vision of how we can prevent people from ever getting in this situation to begin with.

With that, I yield back, and I thank you for your time and attention today.

Mr. GREEN [presiding]. Thank you.

The Chair, in absence, is recognizing Congresswoman Clark.

STATEMENT OF HON. KATHERINE M. CLARK, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Ms. CLARK. Thank you, Ranking Member Green, and thank you to you and to Chairman Burgess for holding this Member Day today.

We are all here because we lose 91 Americans a day to the opioid epidemic and every one of those 91 deaths affects not only the victim but also their loved ones, their workplace, and their community.

Now is the time for us to come together and find solutions to end this national health emergency. And with that in mind, I would like to speak in favor of four common sense proposals that I am leading, each with a great Republican partner, aimed at addressing a different aspect of the opioid epidemic.

The first is the Youth Act, which I introduced with my colleague from Indiana, Dr. Bucshon. The opioid epidemic has had a tragic impact on our young people. From harmful changes in brain and social development to long gaps in education and job training, the effects can be profound.

The Youth Act would expand access to evidence-based medication-assisted treatment for adolescents and young adults, giving them the best possible chance at recovery.

The second proposal is the Prescriber Support Act, which I introduced with my colleague, Congressman Evan Jenkins. Tragically, opioid addiction often begins in the doctor's office where patients are often prescribed more medication than they need or without being informed about the risks of addiction.

The Prescriber Support Act would establish State-based resources for prescribers to consult when making decisions about prescribing opioids.

Third, I recently the Every Prescription Conveyed Securely Act with my colleague from Oklahoma, Congressman Mullin. This proposal would ensure that all prescriptions for controlled substances filled through Medicare Part D would be transmitted electronically.

Electronic transmission would help doctors and pharmacists spot patients attempting to doctor shop and it would make more—make it more difficult to forge a prescription, all the while saving taxpayer dollars.

Finally, I will soon be introducing a bill with my colleague from Kentucky, Congressman Hal Rogers, that will create a student loan forgiveness program for professionals who enter and stay in the substance use treatment field.

In my district, I have heard time and time again from families and providers that there simply aren't enough treatment specialists available to help the growing number of Americans struggling with substance use disorder.

Our bill will help build this critical work force. There is no single solution to the opioid crisis. However, these four bipartisan solutions can help put us on a path to beating this epidemic.

I thank the chairman and the ranking member for giving us this opportunity to have this conversation, and I look forward to working together.

I yield back.

[The prepared statement of Ms. Clark follows:]

PREPARED STATEMENT OF HON. KATHERINE M. CLARK

Thank you, Mr. Chairman.

I'd first like to thank you, Chairman Burgess and Ranking Member Green, for holding this Member Day today.

The opioid epidemic claims the lives of 91 Americans a day.

Every one of those 91 deaths affects not only the victim who has lost their life, but also their loved ones, their workplace, and their community.

Now is the time for us to come together and find solutions to end this national health emergency.

With that in mind, I would like to speak in favor of four common-sense proposals that I am leading, each with a great Republican partner and aimed at addressing a different aspect of the opioid epidemic.

The first is the YOUTH Act, which I introduced with my colleague from Indiana, Dr. Buchson.

The opioid epidemic has had a tragic impact on our young people.

From harmful changes in brain and social development, to long gaps in education and job training—the effects can be profound.

The YOUTH Act would expand access to evidence-based medication assisted treatment for adolescents and young adults, giving them the best possible chance at recovery.

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Our bill will help build this critical workforce.

There is no single solution to the opioid crisis. However, these four bipartisan solutions can help put us on a path to beating this epidemic.

I thank the chairman and the ranking member for giving us the opportunity to have this conversation, and I look forward to working together.

Mr. BURGESS [presiding]. Chair thanks the gentlelady. Gentlelady yields back.

The gentlelady from Connecticut, Ms. Esty, is recognized for 3 minutes, please.

STATEMENT OF HON. ELIZABETH H. ESTY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Ms. ESTY. Thank you, Mr. Chairman—Chairman Burgess and Ranking Member Green. Thank you so much for holding this important hearing on the growing opioid epidemic.

Everywhere I go in Connecticut, I meet people whose families have lost loved ones to drug addiction—moms and dads, sons and daughters, brothers and sisters. It is an epidemic that affects families and communities across the country regardless of age, race, gender, socioeconomic status.

During one of my visits recently to Staywell Oasis—it's an addiction treatment center in Waterbury—I met a young woman who has been struggling on the streets with addiction.

She has a new child and she is so grateful to be in a program that is allowing her to stay clean and helping her keep her child.

I met a 45-year-old man in the Farrell Treatment Center in New Britain who for 20 years has been battling his addiction and is finally coming to terms with it and able to hold a steady job.

These are real people, real families, and real lives that are affected by this crisis, and the stakes are high. If these vital treatment centers are forced to close their doors or if we limit access to them, people will die.

In my home town of Cheshire, a neighbor whose daughter was a classmate of one of my children contacted the office. They had lost track of their daughter.

She had been on the streets, addicted to drugs. We were able to help them find her. She wouldn't accept the treatment, and a week later she was dead.

That's what it's like now in America. The situation is so dire in Connecticut that our chief medical examiner lost its accreditation. They cannot keep up with the autopsies.

We are expecting more than a thousand deaths this year. That is the third-highest rate in the country. They literally cannot keep up with the autopsies. We need to do something and this Congress needs to act.

I am pleased at our good bipartisan work last year. My bill of the Prevent Drug Addiction Act of 2016 was included as part of the conference committee in our good bipartisan work to ensure that we are addressing the issues of prevention with many of my colleagues have addressed here today—both provider education on how to prescribe as well as for parents, coaches, and others who need to be aware of the risks of prescription drugs.

But there is important—there is important work at stake and I do want to say something about the Affordable Care Act. We need to protect the funding, which is providing vital access for people across America, and we are real risk now as we consider that funding and whether the Medicaid access will be cut off, which is funding so many of the important programs in my State.

So again, I want to thank this committee for the good work and encourage all of our members to come together and help address this vital need—this growing epidemic that is affecting all Americans.

Thank you, and I yield back.

[The prepared statement of Ms. Esty follows:]

PREPARED STATEMENT OF HON. ELIZABETH H. ESTY

Mr. Chair, thank you for holding this hearing on the growing opioid epidemic. This epidemic is literally filling the morgues across our country.

Everywhere I go in Connecticut, I meet people whose families have lost loved ones to drug addiction—moms and dads, sons and daughters, brothers and sisters.

It's an epidemic that affects families and communities across the country—regardless of age, sex, race, or socio-economic status.

During one of my recent visits to Staywell Oasis, an addiction treatment center in Waterbury, I met a young woman who has a new baby and is so grateful for the help that the program is providing for her.

She emphasized to me how important Staywell is for her—that it is keeping her clean and off the streets so that she can keep her baby.

Or there's the 45-year-old man that I met at Farrell Treatment Center in New Britain who is getting his 20-year battle with opioids under control for the first time.

These are real people, real families, and real lives that are affected by the opioid crisis.

And the stakes are high.

If these vital treatment centers are forced to close their doors, or if we limit access to them, people will die.

In my hometown of Cheshire, one of my neighbors came to my office pleading for help—they could not find their daughter.

Their daughter had been battling substance addiction for years.

The family did ultimately find their daughter, but it was too late.

She died weeks later without the care and treatment she so desperately needed.

This is how dire the situation is: In our State, the Office of the Chief Medical Examiner actually lost its accreditation because it simply could not keep up with the body count, due to the sharp rise of drug overdose deaths in Connecticut.

Connecticut's Chief Medical Examiner projected that Connecticut will hit a devastating benchmark this year: More than 1,000 people will die from opioid overdoses in our State alone before the end of the year.

The medical examiner's office simply cannot keep up with the demand for autopsies on the rising number of people who are dying from drug overdoses.

Congress needs to act, and it needs to act now, to save lives.

Instead of finding ways to hire more medical examiners to keep up with the rocketing death toll, Congress needs to work together to come up with commonsense solutions to end this devastating epidemic.

Last year, I was proud to help write a landmark, bipartisan bill to improve resources for cities and towns to address this crisis and to create new consumer and provider education campaigns to encourage prevention.

The funding in this bill was not everything our communities need—but it was an important step forward.

The State Targeted Response to the Opioid Crisis Grant program, created by the 21st Century Cures Act, provided \$1 billion over the next 2 years to States to address the opioid epidemic.

These grants help support programs for people struggling with addiction at places like the Farrell Treatment Center in New Britain, the Staywell Oasis Addiction Treatment Center in Waterbury, or the McCall Center for Behavioral Health in Torrington, provide life-lines to people struggling with addiction.

At the same time, we must ensure that the millions of Americans with substance use disorders who currently get treatment through Medicaid expansion are able to continue to get the care they need.

The recent, misguided efforts to repeal the Affordable Care Act and defund Medicaid expansion would have cut over \$800 billion from the Medicaid program, removing access to treatment for low-income people with mental and substance use disorders.

I am heartened that you have invited me here today to talk about how this devastating epidemic is affecting my district, and I am committed to continuing to partner with my colleagues in Congress to prevent more lives from being taken by the opioid epidemic and to help those suffering from addiction to recover and move forward.

Thank you.

Mr. BURGESS. Chair thanks the gentlelady. The gentlelady yields back.

The Chair recognizes the gentlelady from Utah, Mrs. Love, for 3 minutes, please.

**STATEMENT OF HON. MIA B. LOVE, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF UTAH**

Mrs. LOVE. Thank you, Mr. Chairman, for such—talking about such an issue, and I would like to thank the Ranking Member Green also for giving us the opportunity to speak about the opioid epidemic and crisis.

Nationwide, the rate of deaths has exploded to over—over the last 10 years to now more than 60,000 deaths every year. In Utah, the Department of Health says that more people are dying from opioid and heroin overdose than ever before.

Six people die from opioid overdose per year. Alarming increases from 2013 to 2015. Utah is seventh-highest for those deaths per capita in the United States.

Here is what hits me the hardest is the innocent children that are being affected by the opioid epidemic. In too many cases, parents are no longer parents. Their children are parenting themselves and the parents are now slaves to their addiction.

This is actually happening in Elk Ridge, Utah, a place where—which is just a few minutes away from my home. There is a boy who is in 3rd grade who talks about his life with his mom, who is addicted, and his stepfather, who is addicted.

He talks about waking up by himself and getting himself ready for school and also getting his brother ready for school and his newborn sister. He makes breakfast for them and prepares a bottle for his newborn baby, who is his sister.

He talks about the fact that many times he misses the bus when he's going to school because he is taking care of his brother and sister and there is no one to take him to school.

His brother cries, asking for his mom and dad, and he, as a 3-year-old has to try to explain to his brother why Mom and Dad aren't around.

That's not the end of his story. His newborn sister is actually addicted to opioids because his mother took the drugs while she was pregnant, and while in the hospital, for fear of getting caught, she actually took opioids and would rub it on the gums of her baby so that the baby wouldn't show signs of withdrawal.

This is what is happening in America. This story is not unique to Utah. It is happening everywhere. The parents are now in jail. They were arrested for trying to return stolen merchandise at the local Wal-Mart and neglect of their children.

But I have to say that the children's lives aren't better now without mom and dad. Their nightmare is just beginning. So I feel very strongly about this. At a time where there is so much partisan politics, this is an issue where so many of us are standing together.

I believe that American democracy is at its best when two people are in a room and talk about what they are for, and here we are, in a room talking about what we are for.

I am so proud that we are actually coming together, but coming together is not enough. We actually have to apply some of these solutions that we are talking about when it comes to the crisis, and I think the opportunity to—I am thankful for the opportunity to work on this.

Thank you, and I yield back.

[The prepared statement of Mrs. Love follows:]

PREPARED STATEMENT OF HON. MIA B. LOVE

I appreciate the opportunity to speak on this epidemic of the Opioid Crisis, and I appreciate the efforts of everyone here. To fight this public health crisis, we must work together. I pledge to do whatever I can to assist in that effort, because Utah is being hit especially hard by opioid abuse and death.

I am humbled by the raw fact and statistics regarding this in my State:

- The Utah Department of Health says that 24 individuals die from prescription opioid overdoses every month in Utah. A growing number of people are dying from heroin overdoses.

- The rate of these deaths has exploded over the last 10 years. I would say it's out of control. The National Institute on Drug Abuse reports that there are more than 60,000 deaths per year in our country from prescription and heroin use. Utah is in the top five for those types of death per capita.

I don't like to see anyone suffer and die from the miserable cycle of drug dependency and abuse.

And here's what hits me the hardest: Innocent children are being affected by this epidemic.

In too many cases, parents are no longer parents, they're drug addicts. Their children are doing the parenting themselves, and for their brothers and sisters.

I recently learned of a case in Elk Ridge, Utah, which is just minutes from my home.

There, a boy in the 3rd grade told the story of life with his mom and stepdad: Waking up by himself, making breakfast and dinner for his 2-year-old brother and newborn sister. About missing the bus, with no one to take him to school. Of his brother crying because his mom and dad weren't there.

Mom and Dad were on heroin: That's why they weren't there.

And that's not the end of the story.

That boy's sister—the newborn baby—was born addicted to opioids, because her mother was using while she was pregnant. After she was born, to hide the baby's withdrawal symptoms from the hospital staff, the parents rubbed crushed opioids on the child's gums.

The parents are now in jail-arrested trying to return stolen merchandise for money at the local Wal-Mart. And for child abuse and neglect.

Those kids are just an example of the toll this epidemic is taking.

But there are those in my State that are taking steps to deal with it. Utah's Intermountain Healthcare has set a goal to reduce opioid prescribing by 40 per cent in its 22 hospitals and 180 clinics by the end of next year.

I applaud this effort, but it's obviously just one piece of a larger puzzle.

We need to put those pieces together for our children, for ourselves, and for the future of the United States of America.

Mr. BURGESS. Chair thanks the gentlelady. Gentlelady yields back.

Let me take the New Jersey delegation in seniority, and, Mr. Pascrell, I will go to you first for 3 minutes.

STATEMENT OF HON. BILL PASCRELL, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PASCRELL. Thank you, Chairman Burgess, Ranking Member Green.

I don't have to tell you or anyone here that opiate abuse and misuse is one of our country's fastest growing problems. It is also one of the most vexing problems we face and there are no simple solutions.

Prescription drugs serve a valid medical purpose. But many of them carry high risk of addiction and abuse. Many of my colleagues have good ideas about steps we can take to address opiate abuse and misuse. So I commend you for giving us the opportunity to share them.

Today, I would like to share some information about a program that was developed and is in use at my hometown hospital, St. Joseph's Regional Medical Center in Paterson, New Jersey.

As the busiest emergency department in the State of New Jersey, St. Joe's commitment to reducing abuse can serve, I believe, as a model for emergency departments across the State and across the country. We need to recognize that emergency departments are in a unique position with respect to prescription drug abuse.

On one hand, a component of many of their patients' treatment involves acute pain that legitimately needs to be addressed. But emergency departments, because of the short-term nature of the care they provide, are also more susceptible to doctor shopping than many other health settings.

To prevent addiction, where it often starts with a valid prescription in the emergency room, St. Joe's initiated a first-of-its-kind Alternatives to Opioids, or ALTO—ALTO program, the Alternatives to Opiates.

This new approach utilizes protocols primarily targeting five common conditions. The alternative therapies offered through St. Joe's ALTO program include targeted nonopiate medications, trigger point injections, nitrous oxide, ultrasound-guided nerve blocks to tailor patient pain management needs, and avoid opiates whenever possible.

In the first year of operations, this program decreased emergency department opiate prescriptions by more than 50 percent. The goal is not to eliminate opiates altogether because these drugs remain an important part of pain management.

However, the ALTO program reserves their use for severe pain, end-of-life pain, surgical conditions. That's it. As a result, only about 25 percent of the acute pain patients treated with nonopiate protocols since the program's launch, eventually needed opiates.

I believe that the initial successes of this program make it very important that we—to have a broader implementation and study. I leave this to your discretion.

That is why Senator Booker and I plan to introduce legislation to establish a national demonstration program to test pain management protocols that limit the use of opiates in hospital-based emergency departments.

It is my hope that strategies that provide alternatives to opiates can become a larger part of the discussion on how to combat this—the opiate epidemic and that this committee will review and consider my legislation upon its introduction.

And with that, Mr. Chairman, Mr. Ranking Member, I yield back to you.

[The prepared statement of Mr. Pascrell follows:]

PREPARED STATEMENT OF HON. BILL PASCRELL, JR.

Chairman Burgess, Ranking Member Green, thank you for holding this hearing today. I don't have to tell you or anyone here that opioid abuse and misuse is one of our country's fastest-growing problems. It is also one of the most vexing problems we face; and there are no simple answers. Prescription drugs serve a valid medical purpose, but many of them carry a high risk of addiction and abuse. Many of my colleagues have good ideas about steps we can take to address opioid abuse and misuse, so I commend you for giving us the opportunity to share them.

Today, I would like to share some information about a program that was developed and is in-use at my hometown hospital St. Joseph's Regional Medical Center in Paterson, New Jersey. As the busiest emergency department in the State of New Jersey, St. Joe's commitment to reducing abuse can serve as a model for emergency departments across the State and across the country.

We need to recognize that emergency departments are in a unique position with respect to prescription drug abuse. On one hand, a component of many of their patients' treatment involves acute pain that legitimately needs to be addressed. But emergency departments—because of the short-term nature of the care they provide—are also more susceptible to doctor shopping than many other health care settings.

To prevent addiction where it often starts—with a valid prescription in the emergency room—St. Joe's initiated a first-of-its kind Alternatives to Opioids (ALTO) program. This new approach utilizes protocols primarily targeting five common conditions. The alternative therapies offered through the St. Joe's ALTO program include targeted nonopioid medications, trigger point injections, nitrous oxide, and ultrasound guided nerve blocks to tailor patient pain management needs and avoid opioids whenever possible.

In the first year of operations, the ALTO program decreased Emergency Department opioid prescriptions by more than 50 percent. The goal is not to eliminate opioids altogether, because these drugs remain an important part of pain management. However, the ALTO program reserves their use for severe pain, end of life pain, and surgical conditions. As a result, only about 25 percent of the acute pain patients treated with nonopioid protocols since the program's launch eventually needed opioids.

I believe that the initial successes of this program make it worthy of broader implementation and study. That is why Senator Booker and I plan to introduce legislation to establish a national demonstration program to test pain management protocols that limit the use of opioids in hospital-based emergency departments.

It is my hope that strategies that provide alternatives to opioids can become a larger part of the discussion on how to combat the opioid epidemic; and that this committee will review and consider my legislation upon its introduction.

Thank you.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

Mr. MacArthur, you are recognized for 3 minutes, please.

STATEMENT OF HON. THOMAS MACARTHUR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. MACARTHUR. Well, I thank the Chairman Burgess and Ranking Member Green for hosting this opportunity today for those of us not on this committee to share our thoughts.

We have all seen the numbers. Last year, over 60,000 deaths from overdose, opioids involved in the vast majority of those.

In Ocean County, New Jersey, my home county, we are losing somebody every 43 hours. A couple of weeks ago, my county was designated a high-intensity drug trafficking area—desperately needed, but also disturbing sign of where we are.

It may be unusual for a member to sit here and promote other people's bills, even bills written by the other party. But as the Republican cochairman of the bipartisan Heroin Task Force, representing over 90 members of both parties, that is exactly what I am here to do today.

As your committee considers legislative next steps to pursue, I want to recommend the bipartisan Heroin Task Force's legislative agenda for your consideration.

We are committed to being rigorously bipartisan. We did not include any bills in our agenda unless it had bipartisan cosponsors and both the Republican and the Democratic cochair agreed to it.

Five of the bills that were recommended fall within your jurisdiction. Representative Tim Walberg's Jessie's Law will ensure that doctors have access to a consenting patient's prior history of addiction so they can make informed decisions.

Representative David Joyce's Stop OD Act will increase first responders' access to Narcan and synthetic opioid testing. Representative Hakeem Jeffries' Synthetic Drug Awareness Act requires that we investigate how the synthetic opioid crisis is affecting young people specifically.

Representative Evan Jenkins' CRIB Act will ensure treatment for babies with neonatal abstinence syndrome, and Representative Brian Fitzpatrick's Road to Recovery Act addresses the IMD exclusion, which is one of the primary barriers preventing access to substance abuse treatment.

We are proud of our members' work. I would also note that many of our agenda ideas coincide with the White House's Opioid Commission's recommendations and I also note the good work being done by the Republican Main Street on this same issue.

On behalf of my Democratic cochair, Representative Annie Kuster, our vice chairs, Donald Norcross and Brian Fitzpatrick, and our 90-plus members, I urge you to consider these bills.

We will continue to expand and update our legislative agenda as we tackle this critical issue facing our country.

Thank you, and I yield back.

[The prepared statement of Mr. MacArthur follows:]

PREPARED STATEMENT OF HON. THOMAS MACARTHUR

Mr. Chairman, Ranking Member:

Thank you for the opportunity to testify. We have all seen the numbers—drug overdose deaths have increased from 52,000 in 2015 to an estimated 64,000 last year, with opioids involved in the majority of those deaths. In Ocean County, New Jersey—my home county—someone dies of an overdose, on average, once every 43 hours. So thank you for the committee's work on this incredibly important subject.

It may be unusual for a Member to sit here and promote other people's bills, even bills written by the other party, but as the Republican cochairman of the Bipartisan Heroin Task Force, representing over 90 members of both parties, that is exactly what I'm here to do.

As the committee considers legislative next steps to pursue, I want to recommend the Bipartisan Heroin Task Force's legislative agenda for your consideration. We are committed to being rigorously bipartisan—we did not include a bill on this agenda unless it had bipartisan cosponsors and unless the bipartisan chairs all agreed to it. Five of these bills fall under your jurisdiction:

- Rep. Tim Walberg's Jessie's Law, which would help ensure doctors have access to a consenting patient's prior history of addiction in order to make fully informed treatment decisions.
- Rep. David Joyce's STOP OD Act, which would expand efforts to prevent addiction, promote treatment and recovery, and increase first responders' access to Naloxone and synthetic opioid testing.
- Rep. Hakeem Jeffries' Synthetic Drug Awareness Act, which requires that we investigate how the synthetic opioid crisis is affecting young people specifically.
- Rep. Evan Jenkin's CRIB Act, which would help increase access to treatment for babies with neonatal abstinence syndrome (NAS) due to exposure to opioids during pregnancy.
- And Rep. Brian Fitzpatrick's Road to Recovery Act, which would address the IMD exclusion, which we all recognize as one of primary barriers preventing access to substance abuse treatment.

We're proud of our members' work, and I would also note that many our agenda's ideas coincide with the White House Opioid's Commission's recommendations. I also note the good work being done by Republican Main Street on this issue—many of the bills they recommend are also on our agenda.

On behalf of my Democratic cochair, Rep. Annie Kuster, our Vice Chairs Donald Norcross and Brian Fitzpatrick, and our 90-plus members, I urge you to consider these bills. We'll continue to expand and update our legislative agenda as we tackle additional critical topics like PDMPs and prescriber education, and we stand ready to work with committee staff however we can to promote good legislation that addresses all aspects of this devastating epidemic.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

Chair recognizes the gentleman from Arizona, Mr. O'Halleran, for 3 minutes, please.

**STATEMENT OF HON. TOM O'HALLERAN, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF ARIZONA**

Mr. O'HALLERAN. Chairman Burgess, Ranking Member Green, and members of the committee, thank you for allowing me to come before you today to testify on an issue that has had a devastating impact on my district.

I want to, first of all, echo the sentiments of Representative MacArthur. I am also on the task force.

At least two Arizonans die every day from opioid overdoses. Last year, deaths due to opioids rose 16 percent from the year before.

As a former law enforcement officer, some of what I see today is familiar from my time serving communities—the harrowing stories of addiction, the pain family members face including child abuse, domestic abuse, and the loss of a loved one, and also the relationship to organized crime.

But I must tell you that what we are seeing today, the devastation that opioids have wrought on our communities is far more impactful than the drugs I fought to keep off the streets when I was a cop.

Over the summer, I held a round table in my district on opioids. I heard from families, first responders, local law enforcement, and health care providers.

I am here today to bring their voices to you as we commit to tackling this issue in a bipartisan and comprehensive way.

As you work to develop policies to combat this epidemic, I implore you to consider the impacts to rural communities and to tribal communities, which face unique obstacles and barriers to treatment, care, and recovery resources.

According to the CDC, American Indian and Alaska natives have the highest death rates from opioids than any other community. American Indians and Alaska natives have long faced disparities when it comes to resources for mental health care and substance abuse.

That's why funding created by the 21st Century Cures Act, in addition to expanded Medicaid coverage in Arizona, have been crucial in helping families get the care they need.

As many of your know, access to crucial healthcare services in rural communities and across Indian country can be scarce and often requires families to travel long distances.

Providers in rural America have benefited from expanded Medicaid coverage and are now seeing lower rates of uninsured patients than before.

In fact, in States that expanded Medicaid, the share of uninsured substance use or mental health disorder hospitalizations fell from 20 percent in 2013 to 5 percent in 2015.

The increase in coverage has allowed rural providers to operate on the thinnest of margins, to help keep their lights on and their doors open. If Congress repeals that coverage, rural providers will close their doors and patients who need the help will face fewer choices.

We need to give States, local law enforcement, and tribes more resources and more flexibility to test what works. But we must approach this problem comprehensively and with a robust commitment to those we represent.

I urge your committee to thoughtfully consider these issues and how they affect communities across rural and tribal communities. Those voices must be heard when it comes to this crisis.

And I thank you, and I yield.

[The prepared statement of Mr. O'Halleran follows:]

PREPARED STATEMENT OF HON. TOM O'HALLERAN

Chairman Walden, Ranking Member Pallone, and members of the committee:

Thank you for allowing me to come before you today to testify on an issue that has had a devastating impact in my district.

At least two Arizonans die every day from opioid overdoses. Last year, deaths due to opioids rose 16 percent from the year before.

As a former law enforcement officer, some of what I see today is familiar from my time serving communities: the harrowing stories of addiction, the pain family members face, and the relationship to organized crime.

But I must tell you that what we're seeing today—the devastation that opioids have wrought on our communities—is far scarier than the drugs I fought to keep off the streets when I was a cop.

Over the summer, I held a roundtable in my district on opioids. I heard from families, first responders, local law enforcement, and health care providers. I'm here today to bring their voices to you as we commit to tackling this issue in a bipartisan and comprehensive way.

As you work to develop policies to combat this epidemic, I implore you to consider the impacts to rural communities and to tribal communities, which face unique obstacles and barriers to treatment, care, and recovery resources.

According to the CDC, American Indian and Alaska Natives have the highest death rates from opioids than any other community.

American Indian and Alaska Natives have long faced disparities when it comes to resources for mental health care and substance abuse.

That's why funding created by the 21st Century Cures Act, in addition to expanded Medicaid coverage in Arizona have been crucial in helping families get the care they need.

As many of you know, access to critical health care services in rural communities and across Indian Country can be scarce, and often requires families to travel long distances.

Providers in rural America have benefitted from expanded Medicaid coverage, and are now seeing lower rates of uninsured patients than before. In fact, in States that expanded Medicaid, the share of uninsured substance use or mental health disorder hospitalizations fell from 20 percent in 2013 to about 5 percent in 2015.

The increase in coverage has allowed rural providers, who operate on the thinnest of margins, to help keep their lights on and their doors open. In communities across my district, these providers are the backbone of care.

If Congress repeals that coverage, rural providers will close their doors and patients who need help now will face fewer choices. We need to work with each other to build on the progress we've made, not go backwards.

We need to give States, local law enforcement, and tribes more resources and more flexibility to test what works. But we must approach this problem comprehensively, and with a robust commitment to those we represent. For too long, care and resources have been delivered in silos, and those looking for help have had to navi-

gate a patchwork of programs, many of which were never created to address the scope of the problems we're seeing today.

I urge your committee to thoughtfully consider these issues and how they affect communities across rural and tribal communities, whose voices must be heard when it comes to this crisis.

Thank you.

Mr. BURGESS. Gentleman yields back. The Chair thanks the gentleman.

If you wish to be excused, you may do so. But we are all anxious to hear what the gentleman from Maine has to share with us.

So, Mr. Poliquin, you are recognized for 3 minutes.

**STATEMENT OF HON. BRUCE POLIQUIN, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MAINE**

Mr. POLIQUIN. Thank you, Mr. Chairman, very much and thank you, Ranking Member, for the opportunity to be in front of you today.

In our great State of Maine, Mr. Chairman, we have on average one person dies every day from a drug overdose. There was a recent study that said that six out of 10 families in our great State—six out of 10, Mr. Chairman—are impacted directly or indirectly by this epidemic, including, I might add, my own family.

Rural Maine has been hard hit. Rural America has been hard hit with this epidemic and that is why I joined the bipartisan task force to combat the heroin epidemic and that led in part to a very comprehensive bill that we all passed in a bipartisan way last year, the Comprehensive Addiction Recovery Act, that sent about a billion dollars back to our States so they had better resources and more flexibility to address this scourge on our kids and our family members directly at the—on the ground in our—in our respective districts.

Now, the motto, Mr. Chairman, of the great State of Maine is “Dirigo.” It means, in Latin, “I lead.” And there are a bunch of things we have been doing in Maine to help fight this epidemic that I think the rest of the country can learn as we learn from others.

We have put in place a prescription monitoring program that is very tough and very effective. In particular, it sets very strict limits on what opioid—opiates are prescribed.

It mandates the use of this system by prescribers and if you are prescribing opioids in the State of Maine, you must check this program—this database—on a regular basis to make sure those that are being prescribed should be, in fact, those that are receiving the painkillers.

If folks are coming from out of State or they're paying with cash, it also triggers a review of the program to make sure that these drugs are falling in the hands of the right people.

Now, I also serve, Mr. Chairman, I might add, on the House Veterans Affairs Committee, and along with Mr. Dunn, Ms. Tenney, Jodey Arrington from Texas, and Mr. Tonko, we have introduced a bill that asks the Veterans Administration facilities in the State of Maine, and hopefully around the country, to use their local State prescription monitoring programs or to interface with those be-

cause they're more comprehensive. In many cases, they are tougher.

I would also encourage you, Mr. Chairman and Mr. Ranking Member, as you are going down this path to make sure we do everything humanly possible to hold those that are manufacturing synthetic opioids like fentanyl, hold them accountable. These drugs are horrible, they are not expensive to manufacture, and they are anywhere from 50 to 100 times more potent than heroin and methadone.

So with that, sir, I appreciate the opportunity to participate here. I know that my associates on either side of me have a lot to say. But we've done a lot in Maine, and we are very proud of it. But we've got a lot more work to do.

Thank you, sir.

[The prepared statement of Mr. Poliquin follows:]

PREPARED STATEMENT OF HON. BRUCE POLIQUIN

Good afternoon, Chairman Burgess, Ranking Member Green and members of the subcommittee. I appreciate the opportunity to discuss an issue that touches so many Maine families, including my own. An increasing number of Mainers are severely affected by drug abuse and addiction. In 2015 alone, 269 Mainers died of an opioid overdose. It is clear that we must work to solve this serious problem impacting Maine and the rest of our Nation.

I am a founding member of the Bipartisan Task Force to Combat the Heroin Epidemic. Since 2015, we have been a force for action, addressing the epidemic by learning from professionals in communities impacted by addiction. We have welcomed panelists, who have been able to provide valuable, real-life insight to help us work toward common-sense solutions. The Task Force helped bring awareness to the Nation's need to address drug prevention and treatment, as well as to ensure that law enforcement officers have the tools necessary to fight this epidemic. I'm pleased that Congress responded to this crisis by passing the Comprehensive Addiction and Recovery Act.

This legislation was a crucial step towards recovery for our families, friends, and communities, but was just one of many steps on the long road ahead. I am here today to discuss the importance of advancements in tools for prevention, enhanced reforms for bad actors, and our role in fostering interagency communication.

In order to help ensure that patients are not abusing prescriptions, Maine has set strict limits on opioid prescriptions. In addition to mandating the use of the prescription monitoring program, Maine requires prescribers to check the program when first prescribing, and every 90 days thereafter, requires dispensers to check the respective State's program when dispensing to an out-of-State resident and for a prescription written by an out-of-State provider. The dispenser also needs to check the program if an individual is paying with cash or if the person has not had a prescription for an opioid medication in the previous 12 months.

These additional requirements create significant barriers to those attempting to abuse the system. Looking forward, it is crucial that we work toward the sharing of data between States to further deter system abuse and decrease the number of patients who will develop an addiction. As a member of the House Veterans Affairs Committee, I, along with Rep. Dunn, Rep. Tenney, Rep. Arrington and Rep. Tonko, have introduced the Veterans Opioid Abuse Prevention Act to ensure that providers from the Department of Veterans Affairs also use the program when prescribing controlled substances.

There will always be bad actors, but it is our responsibility to remain steadfast in our work to close any loopholes for abuse. As the Energy and Commerce Committee continues to examine synthetic opioids, it is crucial that law enforcement receive the resources they need to hold accountable those who illegally manufacture fentanyl. The death rate for synthetic opioids other than methadone has significantly increased in Maine. The Task Force has discussed how local law enforcement can collaborate with the Federal and State governments as well as public health agencies to combat the use of synthetic opioids. Furthermore, we have discussed how the investigative arm of the Department of Homeland Security works with Federal, State, and local law enforcement to investigate criminal organizations that are

participating in the trafficking of synthetic drugs. I hope to continue these discussions as we review and modify best practices.

As we continue to work towards addressing today's crisis and future threats, I would like to thank you for your time and attention to these critical issues.

Mr. BURGESS. Chair thanks the gentleman.

Would the gentleman entertain one question on your prescription drug monitoring program?

Mr. POLIQUIN. Yes, sir.

Mr. BURGESS. Do you provide feedback to the prescribing doctor: This is the list of patients we have for you that you have prescribed? Is this a two-way street?

Mr. POLIQUIN. It is, but the system is quite accurate, Mr. Chairman, such that the prescriber can see that data online.

Mr. BURGESS. Very well.

Representative Rouzer, you are recognized for 3 minutes, please.

STATEMENT OF HON. DAVID ROUZER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. ROUZER. Thank you, Mr. Chairman, and the other members of this distinguished committee for your work to bring awareness to this opioid epidemic as well as your work to bring forward solutions to help address it.

I am particularly grateful for your willingness to allow members who do not serve on this committee the opportunity to share how our districts have been impacted by this scourge.

Opioid addiction has become a growing problem throughout North Carolina and particularly in the southeastern part of the State, home of the 7th Congressional District, which I have the privilege to represent.

It is a growing and significant challenge for our communities, parents, law enforcement, local health departments, treatment facilities, and schools, to name just a few.

This epidemic is so rampant, in fact, it would not be a stretch to say that if a family doesn't have a relative suffering from this addiction, they know a friend or a family who does.

Perhaps most alarming to me are the reports out of my district about Narcan parties. That's right, Narcan parties. These are parties where teens and others go intending to get as high as possible with the expectation that they will be brought back to life by an injection of Narcan if needed.

I also hear from members of the law enforcement community that they are administering Narcan to the very same individuals on a regular, even weekly, basis.

Now, if this isn't a sobering fact of how this addiction is destroying lives, I don't know what is.

In 2015, there were more than 1,100 opioid-related deaths across the State of North Carolina. The three counties most impacted by the opioid epidemic in the 7th Congressional District are Brunswick, New Hanover, and Pender counties.

In 2015, there were 24 deaths in Brunswick County, 45 deaths in New Hanover, and 14 deaths in Pender County. Now, I've met with and heard from parents who have lost a child to an overdose, law enforcement officers who are struggling daily to prevent this epidemic from further penetrating into our communities, and indi-

viduals working at treatment facilities who do not have enough resources or beds to keep up with the demand.

As with every complex problem, there is no silver bullet answer to this epidemic, unfortunately. However, it's my belief that Congress can play a significant role by facilitating collaboration among the very best and brightest to bring solutions forward that will enable the country to turn the tables on this scourge.

In the 7th Congressional District, we are fortunate to have many bright and committed individuals who have been working diligently on this issue for some time, many of whom serve on my Law Enforcement and Health Care Advisory Committees.

And each of them, Mr. Chairman, stand ready to assist this committee and Congress as we work to address this problem in a comprehensive and effective way.

Thank you again, Mr. Chairman, for the opportunity to testify today. I yield back.

[The prepared statement of Mr. Rouzer follows:]

PREPARED STATEMENT OF HON. DAVID ROUZER

Thank you, Mr. Chairman, and the other members of this distinguished committee for your work to bring awareness to the opioid epidemic as well as your work to bring forward solutions to help address it. I am particularly grateful for your willingness to allow members who do not serve on this committee the opportunity to share how our districts have been impacted by this scourge.

Opioid addiction has become a growing problem throughout North Carolina, and particularly in the southeastern part of the State, home of the 7th Congressional District, which I have the privilege to represent. It is a growing and significant challenge for our communities, parents, law enforcement, local health departments, treatment facilities, and schools to name just a few. This epidemic is so rampant, in fact, it would not be a stretch to say that if a family doesn't have a relative suffering from this addiction, they know a friend or family who does.

Perhaps most alarming are the reports out of my district about Narcan parties. That's right—Narcan parties. These are parties where teens and others go intending to get as high as possible with the expectation that they will be brought back to life by an injection of Narcan, if needed. I also hear from members of the law enforcement community about how they administer Narcan to the same individuals on a regular and repeated basis. If this isn't a sobering fact of how this addiction is destroying lives, I don't know what is.

In 2015, there were more than 1,100 opioid related deaths across the State of North Carolina.

The three counties most impacted by the opioid epidemic in the 7th District are Brunswick, New Hanover, and Pender counties. In 2015, there were 24 deaths in Brunswick County, 45 deaths in New Hanover County and 14 deaths in Pender County.

I've met with and heard from parents who have lost a child to an overdose, law enforcement officers who are struggling daily to prevent this epidemic from further penetrating into our communities, and individuals working at treatment facilities who do not have enough resources and beds to keep up with the demand.

There is no silver-bullet answer to this epidemic, unfortunately. However, Congress can play a significant role by facilitating collaboration among the very best and brightest to bring solutions forward that will enable the country to turn the tables on this growing epidemic.

In the 7th Congressional District, we are fortunate to have many bright and committed individuals who have been working diligently on this issue—many of whom serve on my law enforcement and health care advisory committees. Each of them stands ready to assist this committee and Congress as we work to address this problem in a comprehensive and effective way.

Thank you again, Mr. Chairman, for allowing us this opportunity to testify today.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

Chair recognizes the gentleman from Iowa, Mr. Young, for 3 minutes, please.

STATEMENT OF HON. DAVID YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. YOUNG. Thank you, Mr. Chairman and Ranking Member. I would like to thank the committee for holding this hearing and I just really want to tell a story.

I want to highlight the actions the community of Bridgewater, Iowa has undertaken in the last year to take back their town. Bridgewater, a small town of about 200 people in Adair County in southwest Iowa, is facing a problem with opioids and a range of other drugs.

As drug use in the area slowly started to rise in the community, which relies on the county sheriff's office to keep them safe, the residents were unable but not unwilling to stop the influx of drugs into their town.

Residents of Bridgewater started to see cars coming into their town with out-of-State license plates and from counties across the State as the cars came, so did the crime.

Residents and law enforcement noticed an uptick of crimes, theft, and vandalism, which traced back to drug users and dealers coming to town. Empty houses turned into drug houses powered by gas and generators, which led to more than four houses burning to the ground.

Last spring, the residents were fed up as they saw the town they were raised up in slipping away. They decided to take action. Concerned residents met in the basement of a church to find a way to save their town. This is when they decided to take back Bridgewater.

Residents formed a nonprofit group to fight the drug crisis together. As word spread, media outlets across the State came to the small town to shine a light on one of the many communities suffering in this 3rd District.

I visited Bridgewater in April to meet with the residents in that same church basement as they began their mission to make sure that their town was safe again. I studied their faces, listened intently, and their mission is my mission.

They started to hold forums with drug counsellors, law enforcement, State and local legislators and other individuals offering help. As residents started to clean up their town, they were met with hostility and retaliation from drug dealers and users.

Leaders of the take back Bridgewater movement were run off the road, swerved at by those who wanted to protect the status quo. A number of other incidents occurred but the residents pressed on. The citizens of Bridgewater will not surrender.

As neighboring communities saw what the residents of Bridgewater were doing, they wanted to do something in their communities. Leaders from towns across southwest Iowa often discussed strategies together to protect their neighbors. That is what Iowa is all about—neighbors helping neighbors, communities helping communities.

Just last night, residents of Bridgewater gathered in the basement of that very same church to kick off a fundraiser for their

nonprofit. They will be going throughout southwest Iowa to sell Christmas trees to adorn the doors of homes throughout the region.

Residents will use these funds to take back the community. Bridgewater will not turn a blind eye to opioids and drugs in their community. And, of course, we mustn't forget the human tragedy of addiction and desperation. This epidemic is enslaving and killing our sons and daughters, our mothers and fathers.

As the Federal Government addresses this issue, it is my hope we use Bridgewater as an example that local communities can have the largest impact if we partner with them and helping them to have those tools they need to be successful.

A one-size-fits-all program will not save as many lives as a solution tailored to one community which has the buy-in of its residents.

Take back Bridgewater is not just a slogan. It is an action plan, it is reality, and it is happening, and it is not just happening in Bridgewater. It is happening all around the country.

Thank you for holding this hearing.

[The prepared statement of Mr. Young follows:]

PREPARED STATEMENT OF HON. DAVID YOUNG

Mr. Chairman, I would like to thank the committee for holding this hearing.

I want to highlight the actions the community of Bridgewater, Iowa has undertaken in the last year to take back their town.

Bridgewater, a small town of around 200 in the heart of Adair County in southwest Iowa, is facing a problem with opioids and a range of other drugs.

As drug use in the area slowly started to rise in the community, which relies on the county sheriff's office to keep them safe, the residents were unable, but not unwilling, to stop the influx of drugs into their town.

Residents of Bridgewater started to see cars coming into town with out of State license plates, and from counties across the State.

As the cars came, so did the crime.

Residents and law enforcement noticed an uptick of crimes—theft and vandalism—which traced back to drug users and dealers coming to town.

Empty houses turned into drug houses powered by gas and generators, which led to more than four houses burning to the ground.

Last spring, residents were fed up as they saw the town they were raised in slipping away. They decided to take action.

Concerned residents met in the basement of a church to find a way to save their town. This is when they decided to take back Bridgewater.

Residents formed a nonprofit to fight the drug crisis together. As word spread, media outlets across the State came to this small town to shine a light on one of many communities suffering in the 3rd District.

I visited Bridgewater in April to meet with residents in that church basement as they began their mission to make their town safe again. I studied their faces. I listened intently. And their mission is my mission.

They started to hold forums with drug counselors, law enforcement, State and local legislators, and other individuals offering help.

As residents started to clean up their town they were met with hostility and retaliation from drug dealers and users.

Leaders of the Take Back Bridgewater movement were run off the road, swerved at by those who wanted to protect the status quo. A number of other incidents occurred, but the residents pressed on. The citizens of Bridgewater will not surrender.

As neighboring communities saw what the residents of Bridgewater were doing, they wanted to do the something in their communities. Leaders from towns across southwest Iowa often discuss strategies together to protect their neighbors.

That is what Iowa is all about: neighbors helping neighbors, communities helping communities.

Just last night, residents of Bridgewater gathered in the basement of that very same church to kick off a fundraiser for their nonprofit. They will be going throughout southwest Iowa to sell Christmas wreaths to adorn the doors of homes throughout the region.

Residents will use the funds to take back their community. Bridgewater will not turn a blind eye to opioids and drugs in their community. And of course we must not forget this this human tragedy of addiction and desperation. This epidemic is enslaving and killing our sons and daughters; mothers and fathers.

As the Federal Government addresses this issue, it is my hope we use Bridgewater as an example local communities can have the largest impact if we partner with them and helping with the tools they need to be successful. A one-size-fits-all program will not save as many lives as a solution tailored to each community which has the buy-in of its residents.

Take Back Bridgewater is not just a slogan. It's an action plan. It's a reality. And it's happening. And it's not just happening in Bridgewater, it's happening all around the country.

Thank you again for the opportunity to join you today.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

The gentleman from Oregon, Mr. Blumenauer, recognized for 3 minutes.

STATEMENT OF HON. EARL BLUMENAUER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate the focus on the opioid crisis that grips every community to some degree and affects every State, especially critical for our veterans who are twice as likely to die from accidental overdoses.

As we are slowly acknowledging the depths of the opioid crisis, which is good, we seldom acknowledge one of the simplest most effective solutions—medical marijuana. Cannabis. Now available in 28 States, largely driven by the voters, not the politicians, most recently in Florida, where their voters approved it by over 70 percent.

I have distributed some information here entitled, “The Physician Guide to Cannabis-Assisted Opioid Reduction” On the back are the citations for each of the points that are on this chart referencing cannabis reducing opioid overdose mortality, how cannabis reduces opioid consumption, how cannabis can prevent dose escalation and the development of opioid tolerance. Cannabis alone or in combination with opioids could be a viable first line analgesic.

Mr. Chairman, we don't talk much about this, although on the floor of the House repeatedly over the last 3 years Congress has been moving in this direction and voted last Congress to have the Veterans Administration be able to work with veterans in States where medical marijuana is legal.

But I focus on just one simple item, not the facts, which I hope this committee would look at. But there is one piece of legislation that I have introduced with Dr. Andy Harris, somebody who doesn't agree with me about the efficacy of medical marijuana but he strongly agrees with me that there is no longer any reason for the Federal Government to interfere with research to be able to prove it.

The Federal Government as a stranglehold on this research. We have bipartisan legislation, 3391, which would break that stranglehold and be able to have robust research to resolve these questions so there would no longer be any doubt.

This is the cheapest, most effective way to be able to stop the crisis. Where people have access to medical marijuana, there are fewer overdoses and people opt for it dealing with chronic pain.

I would appreciate the subcommittee looking at this issue as your time permits. Thank you, Mr. Chairman, Ranking Member.
[The prepared statement of Mr. Blumenauer follows:]

PREPARED STATEMENT OF HON. EARL BLUMENAUER

As this hearing today highlights, opioids have wreaked havoc on our country, killing people and devastating families. I am here today to offer an alternative treatment for pain, PTSD, and a number of other health problems—medical cannabis.

Despite the fact that more than 95 percent of Americans live in States that have legalized some form of medical cannabis, Federal policy is blocking biomedical research of marijuana.

This is outrageous!

We owe it to patients and their families to allow for the research physicians need to understand marijuana's benefits and risks and determine proper use and dosage. The Federal Government should get out of the way to allow for this long overdue research.

Unfortunately, States cannot address this research gap on their own. Congress must act to allow for the research of marijuana—which I stipulate would be a safer, less addictive alternative than opioids for some health problems.

And, it's not just me who thinks this. I have veterans banging down my door seeking alternatives to opioids. Many veterans are in an untenable situation—Untreated chronic pain can increase the risk of suicide, but poorly managed opioid regimens can also be fatal. The fact that veterans are TWICE as likely to die from accidental opioid overdoses than their civilian counterparts to get Congress off the dime.

Dr. Andy Harris—a well-known marijuana prohibitionist—and I—the Member of Congress from Portlandia—have teamed up to introduce the Medical Marijuana Research Act. This bill would create a pathway for qualified researchers to conduct research using marijuana. Senators Hatch and Schatz have a similar bill on the Senate side.

I ask that this committee hold a hearing on the bill as patients desperately need a safer, less addictive alternative to opioids.

Mr. BURGESS. The Chair thanks the gentleman. Gentleman yields back.

Chair recognizes the gentlelady from Georgia, Mrs. Handel, for 3 minutes, please.

**STATEMENT OF HON. KAREN C. HANDEL, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF GEORGIA**

Mrs. HANDEL. Thank you, Mr. Chairman, and thank you as well for holding this hearing.

The opioid crisis has hit the suburban Atlanta counties of Fulton, Cobb, and DeKalb as hard as, frankly, anywhere in the country, from prescription painkillers to synthetic drugs to heroin.

In 2016, 72.3 percent of all drug-related fatalities in Cobb County were caused by opioids and that was an increase from 16.8 percent just the year before.

In 2015, the Cobb County narcotics team seized more than—more heroin than in the previous 20 years combined. Meanwhile, in Fulton County, the medical examiner's office recorded a total of 77 heroin deaths in 2014. That is compared to just four such deaths in 2010.

Behind these statistics, though, are hurting devastated families—families that are being torn apart by addiction, facing financial ruin in their desperate effort to try anything to make things right, or worse, losing a loved one to a drug overdose or suicide.

The opioid crisis, as we've heard, is indeed a complex one. It is an incredibly sensitive issue, particularly for communities that have long felt immune to fatal substance abuse problems.

Still, communities, through churches, law enforcement, non-profits, with the support of local, State, and Federal government are coming together to take action.

This year in the city of Alpharetta, they created a new program designed to reduce painkiller abuse across the county. With the help of the Rotary Club in Alpharetta, the city purchased special boxes that were—are used to collect unused and unwanted prescription medication and locating those at police headquarters and fire stations throughout the county.

While the boxes cost about a thousand dollars each, they are designed and constructed specifically to prevent anyone from stealing the drugs inside. This is—may seem a small measure, but it is making an impact by providing a safe secure disposal point.

In the city of Johns Creek, the Hub Community Resource Center is acting as a lifeline for those seeking drug abuse and mental illness attention.

Ultimately, the incarceration of addicts, though, should not be seen as some kind of victory or solution. Instead, we have to continue to look for the root causes.

As the district attorney in Cobb County said, we are not going to be able to arrest our way out of this epidemic. The road to recovery must be lined with treatment options.

So further, nonopioid and nonpharmacological treatments for therapies do exist. Atlanta's Emory University recognized Pain Awareness Month in September by educating our community about these alternatives.

We also need to do a better job of data sharing important information that exists at the local, State, and Federal level. I stand ready to help you in any way.

Thank you, Mr. Chairman, for this opportunity.

[The prepared statement of Mrs. Handel follows:]

PREPARED STATEMENT OF HON. KAREN C. HANDEL

The opioid crisis has hit the suburban Atlanta counties of Fulton, Cobb & Dekalb as hard as anywhere in the country.

In 2016, 72.3 percent of all drug-related fatalities in Cobb County were caused by opioids, up from 64.8 percent just 1 year before. And in 2015, the Cobb County Narcotics team seized more heroin than in the previous 20 years—combined.

Meanwhile, in neighboring Fulton County, the Medical Examiner's Office recorded a total of 77 heroin deaths in 2014, compared to just four in 2010.

Behind these statistics are hurting families—families that are being torn apart by addiction, facing financial ruin in their effort to try anything to make things right, or worse, losing a loved one to overdose or suicide.

Our community's—our Nation's—opioid crisis is a complex issue, and it's not going to be solved with any single proposal. Admitting there is a problem is the first step, however.

This is an uncomfortable, sensitive issue, particularly in communities that have long felt immune to fatal substance abuse problems. Still, communities—through churches, law enforcement, non profits—are coming together to take action.

This year, the North Fulton city of Alpharetta created a new program designed to reduce painkiller abuse across the county. With the help of Alpharetta's Rotary Club, the city purchased boxes that will collect unused and unwanted prescription medications at its police headquarters and fire stations.

The boxes cost about \$1,000 each and are designed and constructed to prevent anyone from stealing the drugs inside.

It may seem a small measure, but it is making an impact by providing a safe, secure disposal point.

In the city of Johns Creek, the Hub Community Resource Center acts as a lifeline for those seeking drug abuse and mental illness attention. Centers like these help

people suffering from addiction and prevent others from succumbing to the same fate in the future.

Ultimately, the incarceration of addicts should not be seen as some kind of victory or solution. Instead, we must look at the root causes, most effective potential solutions, and—most importantly—we must work towards finding ways for those affected by opioid addiction to recover to lead healthy, productive lives.

As Cobb County District Attorney Vic Reynolds said, “We cannot arrest our way out of this epidemic. The road to recovery must be lined with treatment options.”

Further, nonopioid and nonpharmacological treatments or therapies for pain do exist. Studies show that these alternative therapies can be just as beneficial or better than prescription pain medications, but without the side effects of overuse and abuse.

Atlanta’s Emory University recognized Pain Awareness Month in September by educating the community about pain relief alternatives to prescription medications.

As the opioid epidemic spreads, we need data and alternatives to medications now more than ever.

Finally, I want to specifically commend two legislators in my home State of Georgia—State Senator Renee Untermann and State Representative Sharon Cooper—each of whom have been leading the efforts on opioid addiction prevention from the State capitol. Senator Unterman is the chairman of the Committee on Health and Human Services and sponsor of SB81, legislation focused on Naloxone availability and electronic reporting of controlled substances in Georgia.

We can do better than this crisis we’re facing across the country, and creative options like those we’re seeing throughout the 6th District of Georgia are all part of the national effort. Our local, State and Federal law enforcement, healthcare groups, drug enforcement agencies and elected leaders must continue to work together. The lives of tens of thousands of Americans are literally depending on it.

Mr. BURGESS. The Chair thanks the gentlelady. Gentlelady yields back.

Recognize Representative Crist from Florida, 3 minutes, please.

STATEMENT OF HON. CHARLIE CRIST, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. CRIST. I would like to thank Chairman Burgess and Ranking Member Green for providing us this opportunity for Members to share how the opioid crisis is affecting their constituents, including my neighbors in Pinellas County, Florida.

The statistics for opioid deaths and disorders are shocking. Our society’s use of opioids has truly become an epidemic. Last year, 11.8 million Americans age 12 or older misused opioids, including nearly 900,000 children age 12 to 17.

Over 50 percent of the people with both substance abuse and a mental health disorder do not receive treatment for either issue. Tragically, my home State of Florida was the prescription drug abuse capital of the United States in the last decade.

They were known as pills mills and prescribed massive amounts of otherwise legal narcotics which were then distributed into our neighborhoods, schools, communities, and throughout the country.

When I was Governor, we went after pill mills and put them out of business. While Florida may have won the battle against these pill mills, our country is losing the war on opioid abuse and its addiction.

We are ignoring mental health, under funding addiction treatment, sidestepping what the science tells us is the best way to fight the addiction, and now the scope of the crisis has broadened beyond prescription drugs into heroin and even fentanyl.

My home of Pinellas County was no exception. Last year, we saw a string of deaths from Xanax mixed with fentanyl. In 2015, her-

oin, fentanyl, and oxycodone were responsible for over 3,800 deaths in Florida alone.

It is a tragedy, it is an epidemic, and the need for action is immediate. I saw the devastation firsthand recently when I visited the nonprofit Operation PAR in my district just a few months ago.

I heard directly from those in recovery being helped by their innovative, more holistic approach.

If we are going to combat this problem, we can't concentrate on law enforcement alone. Florida should serve as an example to the rest of the country that only going after suppliers is insufficient.

Let us be clear. The people who misuse opioids aren't the worst of the worst. They are our neighbors, our friends, parents, and children who are desperately in need of help.

They often suffer in silence and isolation because of the stigma and shame surrounding drug abuse. Unfortunately, America learned this lesson the hard way, treating the crack epidemic as simply a law enforcement exercise.

We can't combat our opioid crisis without investing in new treatment options, long-term mental health, and substance abuse recovery resources, and the men and women on the ground working in nonprofits and Government, collaborating with first responders and law enforcement to help those in need in all of our communities.

This includes funding for the substance abuse mental health service and the National Institutes of Health, which provides the research and innovative treatments not often permitted using traditional funding.

This funding provides grants including in Pinellas County for innovative local solutions for treating mental health and substance abuse disorders, like what is happening at Operation PAR and Bent Not Broken organization.

This includes funding overdose reversal. We will lose this fight without Naloxone. Americans will die unnecessarily, and because Florida did not expand Medicaid, the funding for these organizations is even more vital and something I hope your committee continues to prioritize in this ongoing battle.

Thank you again for this opportunity to share how my home in Pinellas County is combatting this epidemic.

Thank you, Mr. Chairman, and committee.

[The prepared statement of Mr. Crist follows:]

PREPARED STATEMENT OF HON. CHARLIE CRIST

I'd like to thank Chairman Burgess and Ranking Member Green for providing us this opportunity for Members to share how the opioid crisis is affecting their constituents, including my neighbors in Pinellas County, Florida.

The statistics for opioid deaths and disorders are shocking. Our society's use of opioids has truly become an epidemic. Last year, 11.8 million Americans aged 12 or older misused opioids, including nearly 900,000 children aged 12-17. Over 50 percent of the people with both substance abuse and a mental health disorder do not receive treatment for either issue.

Tragically, my home State of Florida was the prescription drug abuse capital of the United States in the last decade. They were known as "pill mills" and prescribed massive amounts of otherwise legal narcotics, which were then distributed into our neighborhoods, schools, communities, and throughout the country. When I was Governor, we went after "pill mills" and put them out of business.

While Florida may have won the battle against these "pill mills", our country is losing the war on opioid abuse and its addiction. We're ignoring mental health, underfunding addiction treatment, side-stepping what the science tells us is the best

way to fight addiction. And now the scope of the crisis has broadened beyond prescription drugs—into heroin and even fentanyl. My home of Pinellas County was no exception. Last year, we saw a string of deaths from Xanax mixed with fentanyl. In 2015, heroin, fentanyl, and oxycodone were responsible for over 3,800 deaths in Florida alone. It is a tragedy. It is an epidemic. And the need for action is immediate. I saw the devastation firsthand recently when I visited the nonprofit “Operation PAR” in my district just a few months ago. I heard directly from those in recovery, being helped by their innovative, more holistic approach.

If we are going to combat this problem, we can’t concentrate on law enforcement alone. Florida should serve as an example to the rest of the country that only going after suppliers is insufficient. Let’s be clear: the people who misuse opioids aren’t the worst of the worst; they are our neighbors, our friends, parents, and children who are desperately in need of help. They often suffer in silence and isolation because of the stigma and shame surrounding drug abuse. Unfortunately, America learned this lesson the hard way treating the crack epidemic as simply a law enforcement exercise.

We can’t combat our opioid crisis without investing in new treatment options, long-term mental health and substance abuse recovery resources, and the men and women on the ground working in nonprofits and Government, collaborating with first responders and law enforcement, to help those in need in all of our communities. This includes funding for the Substance Abuse and Mental Health Service (SAMHSA) and the National Institutes of Health, which provides the research and innovative treatments not often permitted using traditional funding. This funding provides grants, including in Pinellas County, for innovative, local solutions for treating mental health and substance abuse disorders, like what’s happening at “Operation PAR” and “Bent Not Broken” organization. This includes funding overdose reversal. We will lose this fight without naloxone. Americans will die unnecessarily. And because Florida did not expand Medicaid, funding for these organizations is even more vital, and something I hope your committee continues to prioritize in this ongoing battle.

Thank you again for this opportunity to share how my home of Pinellas County is combating the opioid crisis. Thank you, Mr. Chairman and committee.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman.

The Chair recognizes Mr. Faso for 3 minutes, please.

**STATEMENT OF HON. JOHN J. FASO, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK**

Mr. FASO. Thank you, Chairman Burgess, Ranking Member Green, and members of the committee for holding this important hearing and hosting all of us today.

I appreciate and understand many of the testimonies we have heard from our colleagues. It is important to note that we represent districts that are often extremely different from each other—Democrat, Republican, rural, and urban. It is rare when an issue can unite not only a conference but an entire Congress.

At the risk of speaking for my colleagues, I would like to express that we all stand together against the opioid epidemic. Now, in my district, in the 19th District in upstate New York, I can tell you a couple of stories.

Greene County emergency responders recently reported to me they came upon a scene where they had two individuals who had overdosed. One individual required eight doses of Naloxone in order to be revived. Another required six.

This is not an uncommon phenomena. County sheriffs had reported to me going back to the same household, the same apartments on the same evening to administer Narcan to revive people who have overdosed.

Other county sheriffs have told me that every single drug dealer they arrest has public benefit and food stamp cards in their posses-

sion. It is ironic that we, the public, are often sustaining economically those that prey upon our citizens.

In my district in the Board of Supervisors in Columbia County recently passed an opioid epidemic response plan. This plan is an enormous step forward to combatting the opioid crisis in our region.

Ulster County has also substantially increased local funding to fight the crisis. Twin County Recovery Services in Columbia and Greene Counties is also serving those with addiction through clinical, residential, and educational programs.

And I think the bottom line, Mr. Chairman, my colleagues, we have got to have educational programs that help us staunch the demand for these substances and not just try to staunch the supply.

Congress must continue to help our local communities by ensuring they have the support and the 21st Century Cures and CARA, supporting SAMHSA legislation, and passing legislation such as the STOP Act to support our local law enforcement officers by making it more difficult for the U.S. Postal Service to ship fentanyl and carfentanyl through the mail.

I recommend more research into how opioids affect the brain and learn more into how to defeat this chemical dependency.

Our work is far from finished. We must stay engaged with each other, stay engaged with our communities and stay engaged with victims and families to truly effectuate and facilitate an authentic reversal of this dangerous and upward trend of opioid addiction in our communities.

I thank the committee for their service and for allowing us to bring this testimony forth today.

[The prepared statement of Mr. Faso follows:]

PREPARED STATEMENT OF HON. JOHN J. FASO

Thank you, Chairman Burgess, Ranking Member Green, and members of the committee for holding this important hearing and hosting me today.

I appreciate and understand many of the testimonies we have heard from our colleagues. It is important to note that we represent districts that are extremely different from each other; Democrat, Republican, rural, and urban. It is rare when an issue can unite not only a conference, but an entire Congress. At the risk of speaking for my colleagues, I would like to express that we stand together against the opioid epidemic.

My particular district in upstate New York is fairly rural, Mr. Chairman.

When we think of rural America, it evokes images of small towns, diners on the corners, two lane roads framed by family farms, and a community where neighbors look out for each other, and work hard for what they have.

While all of these sentiments ring especially true in my district, so does the opioid crisis.

Our local communities and counties across upstate are stepping up to the plate and finding ways to address this problem in a manner that meets their needs. With help from the State and Federal governments, our local governments and groups facilitate outreach programs, education programs, informational resources, trainings and working groups.

In my district, the Board of Supervisors of Columbia County recently passed an Opioid Epidemic Response Plan. This plan is an enormous step forward in combating the opioid crisis in our region. Twin County Recovery Services is also another institution in my district serving those with addiction through clinical, residential, and educational programs. These initiatives enable local entities to most effectively help those with addiction, educate first responders, prevent future tragedies, and deploy Federal and State funding in our communities.

I come before the committee today to implore my colleagues to work with me to empower local governments, that are closest to the crisis, to improve education and prevention programs and fight addiction on the front lines.

Congress must continue to help our local communities by ensuring they have our support through means such as adequately implementing and funding CARA and 21st Century Cures, supporting SAMHSA (sam-sa) and passing legislation such as the STOP Act to support our local law enforcement officers by making it more difficult to ship fentanyl and carfentanil.

I appreciate committee-led initiatives to work in a bipartisan-nature in passing ground-breaking addiction treatment legislation, holding numerous hearings to explore further Congressional action, and remaining open and inclusive during this process.

Our work is far from finished. We must stay engaged with each other, stay engaged with our communities, and stay engaged with the victims to truly, and effectively facilitate an authentic reversal of this dangerous upward trend of opioid addiction.

I stand ready to help the committee in this fight. Thank you.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

Chair recognizes Mr. Katko for 3 minutes, please.

**STATEMENT OF HON. JOHN KATKO, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF NEW YORK**

Mr. KATKO. Thank you, Mr. Chairman and Ranking Member Green. I appreciate you giving me the opportunity to testify today about this most important topic and giving me the opportunity to not only discuss what has been being discussed but a possible partial solution to the problem from a law enforcement standpoint.

And that is a bill that I introduced, H.R. 2851, the Stop the Importation Trafficking of Synthetic Analogs Act of 2017, which I will refer to as SITSA.

I am driven in my testimony today and my support for this bill by two things. One is my 20 years as a Federal organized-crime prosecutor, prosecuting every manner of drug known to man, and knowing that, based on that experience, I have never seen anything that remotely resembles the tragic consequences of the current synthetic drug problem and the heroin issue in this country, and they are intertwined.

And I can talk chapter and verse about what is going on in my community but I just want to introduce you to a few people that we have lost since I have been in Congress.

John and Tina Socci lost their daughter, who was murdered in front of her 18-month-old child by her boyfriend, who was addicted to opioids. Two years later, still grieving the loss of their daughter, they lost their son to a heroin overdose. Their son was a drug counselor.

Joe Campanella lost his son—I am sorry—Joe Campanella lost a son and his son was a drug counselor at the time, and John Socci and Tina Socci lost their son as well. Kevin Jones lost his step-daughter.

Theresa Wilson lost her son after he ingested synthetic marijuana that was purchased over the counter at a local head shop and he had convulsions and drowned.

Deanna Axe—all these stories are tragic but this one is perhaps the worst—Deanna was a high school athlete, a great individual. She got involved with heroin after abusing opiates and she became

pregnant. She went cold turkey and quit. She was five months pregnant and she had not had any relapses whatsoever.

A drug dealer who I can only describe as one of the most reprehensible creatures on earth, cajoled her into trying one more time because a new mixture had come in. She tried it that one time and she died, and she lost her five-month-old child as well—unborn child.

That is the face of this tragedy. That is the face of what is going on here and that is what I am trying to address with respect to the SITSA Act.

Toxic synthetic drugs are designed to mimic street drugs like marijuana and what this drug is trying to do is recodify the problem. The problem I encountered when I was a prosecutor doing synthetic drugs prosecutions is that the statutes don't keep up.

The drug that killed Theresa Wilson's son took 4 1A½ years after they identified the chemical compound before it was listed in a drug analog statute.

This bill that I have that has already passed the Judiciary and is simply waiting to get out of E and C before it can be voted on on the floor and I think will pass overwhelmingly turbo charges that process to reduce it to about 30 days, and it also, in a nutshell, will give individuals in Congress who may disagree with the classification of one of these drugs 180 days after it is classified to have it removed through a congressional act.

So I was going to talk much longer about it. I realize my time is up. But I can tell you from looking through the prism of a prosecutor there is three ways that you need to address this.

Number one is law enforcement, number two is prevention, and number three is treatment. As my colleague, Mr. Faso, noted, we have done a lot with the CARA Act and other things to address prevention and treatment.

This SITSA Act is something that law enforcement needs and, quite frankly, it is a game changer and I hope that E and C will consider it in a swift manner so it can get to floor for a vote and get into law and give another—put it in the arsenal for law enforcement to be able to attack this problem in a meaningful manner.

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

[The prepared statement of Mr. Katko follows:]

PREPARED STATEMENT OF HON. JOHN KATKO

Thank you, Chairman Burgess, Ranking Member Green, and members of the Subcommittee on Health, for allowing me to speak today about the synthetic drug epidemic and my bill, H.R. 2851, the Stop the Importation and Trafficking of Synthetic Analogues (SITSA) Act of 2017.

Synthetic drug abuse has crippled communities across this Nation, leading to countless tragedies in places like my district. This year, Syracuse area hospitals saw a record number of overdoses due to synthetic drug abuse. In May, over 15 individuals had overdosed on synthetic drugs and were taken to the ER in the span of 24 hours. Unfortunately, stories like this have become the new normal. First responders and emergency room physicians across the Nation have seen incredible increases in calls due to synthetic overdoses, which is why they wholeheartedly support my legislation.

Toxic, synthetic drugs are designed to mimic street drugs like marijuana, LSD, cocaine, ecstasy and other hard drugs. They can be more potent than the real thing and oftentimes are more deadly. Unfortunately, when law enforcement encounters and begins to combat a specific synthetic drug compound, manufacturers of these

substances are able to slightly alter the chemical structure of the drug. This puts law enforcement at a serious disadvantage, leaving them constantly one step behind. As a former U.S. attorney, but more importantly, as a father, getting these drugs off the streets and out of the hands of our loved ones remains a top priority for me.

Right before I introduced the bill, I met with a constituent in my district, Teresa Woolson, whose son was tragically killed by a synthetic drug identified as XLR-11. Unfortunately for Teresa, the drug that killed her son managed to remain legal and on the streets for 4 years after his death, until it was finally added to the controlled substances list. This is unacceptable and these families deserve to see justice.

The potency and danger of synthetic drugs do not only threaten users, we are now seeing local law enforcement and first responders put in harm's way simply by coming in contact with these often lethal substances. Numerous cases across the country have resulted in emergency personnel becoming gravely ill and even dying while responding synthetic overdoses. The threats synthetic drugs pose to our communities and law enforcement must be stopped. H.R. 2851 takes a big step towards eradicating these harmful substances and protecting our communities.

The SITSA Act will give local, State, and Federal law enforcement the necessary tools to target synthetic substances and the criminals who traffic them. Specifically, this legislation will create a new schedule to the Controlled Substances Act and establish a mechanism by which synthetic analogues can be temporarily or permanently added to that schedule in as little as 30 days after the chemical composition is determined by the Attorney General. The new schedule, Schedule A, will also add 13 synthetic fentanyl that have been identified by the DEA as an immediate threat to public health and safety. These synthetics have been confirmed as the cause of death in at least 162 cases in the United States. Finally, the bill maintains firm penalties for foreign manufacturing and importation and provides a multistep sentencing process which includes application of existing Federal guidelines. The goal of this legislation is to not only prevent drug abuse, but to facilitate proper research so that we may better understand these chemical compounds.

The stories of synthetic drug abuse are in no way limited to my area of the country; this is a nationwide epidemic. I respectfully ask this subcommittee to consider the SITSA Act because every moment we fail to act; another person is effected by synthetic drugs.

This summer, the Judiciary Committee unanimously passed this bipartisan legislation. We have worked with Members on both sides of the aisle as well as stakeholders across the law enforcement and health communities. I welcome your comments and amendments so that we can make this bill a powerful tool in eradicating these harmful substances.

Again, I thank you for allowing me to testify this morning and urge this subcommittee to take action on H.R. 2851.

Mr. BURGESS. Gentleman yields back. Chair thanks the gentleman.

The Chair recognizes the gentleman from Massachusetts, Mr. Keating, for 3 minutes, please.

STATEMENT OF HON. WILLIAM R. KEATING, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. KEATING. Thank you, Mr. Chairman.

Let me just go off my notes and try and speak from the heart. Before I was a Member of Congress, I was a DA for 12 years. Started a task force. Now, it's over a decade and a half on—at the time, heroin task force, but it was the result of my work as a DA.

We would go to unattended deaths. We would find out that the person there had no criminal record. They started their addiction with prescription drugs, went to heroin—it was just cheaper, more available, believe it or not—and then they died.

I consoled parents who lost the child. I worked with grandparents who were raising their children. In my own family, I lost a cousin to an overdose right after he was coming out of detox, the

most dangerous time. On a brighter note, I have another family member a decade and a half in recovery.

So I've seen this first hand. I've dealt with it in my district now. Since we are sharing that, one of my communities I share with Representative Kennedy.

At Fall River, Mass., they are on pace for over a thousand—just this one city over a thousand overdoses this year and over a hundred deaths. It is the effect of fentanyl and carfentanyl in our area.

In my district, I have four of the five leading counties in terms of opioid deaths.

I want to thank this committee, though, for the work they have done with the CARA Act, with 21st Century Cures. You are working—I think that work is at risk if we backtrack on the availability of treatment through the ACA or another source because, as you know, 34 percent of the people before then did not have the guarantee of that treatment, which is important.

Eighteen percent didn't have the coverage for mental health treatment that is necessary as well. In the Medicaid expansion—those States that did it—there is now 11 million low-income Americans covered by this.

I also want to thank you on efforts that we've worked on a bipartisan basis. I worked on efforts with the STOP Act, which was part of this committee. I hope that it moves forward.

Some of that is being done administratively where we look at making our drugs that are there tamper resistant—abuse resistant. Cosponsoring a Saves Act also, which allows a coprescription of Naloxone that is there—it solves the problem for the medical community and work with the veterans in terms of making sure they are educated.

I just heard my colleague talk about the fact that we deal with this in three ways. The interdiction is limited. I just had a private meeting, since I am on Homeland Security, in my office with the leaders in terms of Customs and Border Patrol and what is going on.

It is limited because so much of it's increased through the mail, through Fed Ex, through UPS. Very hard to deal with in that respect, although we should do what we can to do it.

Prevention is important, obviously, in terms of medical-assisted treatment and dealing with the middle school population.

Let me just conclude with this, because I was up last night thinking what I was going to say to you today. About 7 years ago when I got here, four Members of Congress, myself included, sat down with the FDA and people just to air out some real concerns. Only myself and Representative Hal Rogers are still here from that group.

At the end of listening to us, all these experts came and they said, Congressman, you don't understand—you don't understand about medicine. You don't understand about medical treatment. We are there to deal with some pain and, you know, that is part of our reason.

And I said—and I slammed the table and I said, you don't understand about pain—the pain of losing a son or a daughter, a grandchild. The pain of families—the pain of what it does to your income and work when this happens. That kind of pain doesn't go away.

And we haven't progressed enough from that, frankly. It is great for this committee. It is great, I think, for myself to take whatever expert advice we can.

But on this issue, people are depending on us. We've got to create the urgency and deal with it ourselves. We can't rely on other people to do it. In many cases, we are the court of last resort.

We can do this. We can work together and we can make sure it can be done. But let's do it ourselves and let us take that leadership, and I want to thank you for the leadership you've shown in this, and I plan to work with you any way I can.

Thank you.

[The prepared statement of Mr. Keating follows:]

PREPARED STATEMENT OF HON. WILLIAM R. KEATING

Chairman Burgess, Ranking Member Green, and other distinguished members of the committee, thank you for the opportunity to testify about this critical issue.

Dating back to my time as District Attorney, I have witnessed the devastation of the opioid crisis for nearly two decades. Countless families in my area have felt the effects, including my own. I have been called to sites of unattended deaths resulting from overdose. I have consoled parents who have lost a child to an overdose. I have worked with grandparents who are raising their grandchildren because of addiction. And all of this was before I got to Congress 7 years ago, when the number of opioid-related deaths was 45 percent lower than it is today. Today, we even have entire facilities dedicated to babies born addicted to opioids. As the members of this committee know, we cannot continue only to talk about this at arm's length. This goes beyond just numbers or statistics. People are feeling real pain. And we are losing an entire generation.

The district I represent in Congress includes four of the top five counties in Massachusetts by opioid death rate. Further, Fall River, Massachusetts, a city I represent along with Congressman Kennedy, is projected to see at least 1,000 opioid overdoses and over 100 deaths in 2017 alone. This is a horrible scourge for my constituents, and as evinced by the need for this hearing, a tragic epidemic nationwide.

To begin, I thank this committee for their work guiding the House through enactment of two important laws, laws which laid meaningful groundwork for progress in battling the opioid crisis. The strategy outlined in the Comprehensive Addiction and Recovery Act (CARA) and the \$1 billion in funding included in the 21st Century Cures Act have been significant steps in the right direction. More people have access to treatment, more health professionals understand early signs of addiction, and the number of opioid prescriptions has declined. However, some of the health legislation we have seen this year places this progress at risk.

Prior to the Affordable Care Act (ACA), an estimated 34 percent of insurance plans did not cover treatment for opioid use and other substance use disorders, and 18 percent did not provide coverage for any mental health conditions. The ACA required insurance policies to include this coverage. Similarly, the law's Medicaid expansion provided access to treatment for substance use disorders to 11 million low-income Americans. In fact, at an estimated \$60 billion in coverage for behavioral health services each year, Medicaid is the largest source of funding for mental healthcare in the country—including services related to substance use disorders. Efforts to repeal the Affordable Care Act and cut funding for Medicaid place this coverage at grave risk. Accordingly, I am committed to defending the Affordable Care Act and preserving access to addiction treatment for all Americans.

Aside from these concerns, I am encouraged that we do find consensus elsewhere. For example, we agree the solution to this crisis requires a multipronged approach. Last Congress, I introduced three bipartisan pieces of legislation aimed at combating the opioid crisis from three different fronts. The first, the Stop Tampering of Prescription Pills Act, calls on the Food and Drug Administration to facilitate the creation of tamper-resistant formulations for commonly misused pain medication. The second, the Coprescribing Saves Lives Act, encourages physicians to coprescribe naloxone alongside opioid prescriptions and make naloxone more widely available in Federal health settings. The legislation also authorizes a grants program to fund State-level efforts to encourage the establishment of coprescribing guidelines, assist in the purchase of naloxone, fund training for health professionals and patients, and support patient copays. Last, the Safe Prescribing for Veterans Act outlines a common-sense plan to decrease opioid overuse among veterans by establishing a pain

management continuing education requirement for opioid prescribers affiliated with the Department of Veterans Affairs. I look forward to working with my colleagues as I reintroduce these initiatives this Congress.

We in this House are constantly learning about innovative approaches to pain management, improved methods of treating addiction, and novel ideas for opioid disorder prevention and education. There are even technologies that function as alternatives to pain medications, such as spinal cord stimulators implanted as long-term solutions to chronic pain. I appear before this committee ready to work on new approaches to caring for those who need help and ensuring our families, our neighbors, and all Americans have the resources they need as they seek a path down the road to recovery.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

The Chair recognizes the gentleman from Minnesota, Mr. Paulsen, for 3 minutes, please.

STATEMENT OF HON. ERIK PAULSEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PAULSEN. Thank you, Mr. Chairman, and also for this opportunity to speak about the opioid addiction in Minnesota.

Minnesota is like the rest of the country. It is struggling with the crisis. It is tearing families apart through addiction and death and the numbers are only getting worse.

Minnesota saw a 12 percent rise in opioid deaths from in 2016 over 2015. The crisis affects Minnesotans of all backgrounds in rural communities, big cities, and in our suburbs.

Just a year and a half ago in my hometown of Chanhassen, we saw the passing of music legend Prince due to an opioid overdose. In Minnesota, there are 50 opioid prescriptions written for every 100 patients that visit our doctors.

Clearly, we need to change the culture and our delivery of care to stop the flow of opioids when there are proven alternative types of treatments that may not require those prescriptions.

When someone requires surgery for back pain, they can choose between minimally invasive surgery or the standard surgery that requires a long post-surgery stay in the hospital and powerful painkillers.

One way to reduce the dependency on opioids is to use procedures that are minimally invasive and do not require long hospital stays and opioids to dull the pain from other invasive procedures.

An example is minimally invasive sacroiliac, or IS, infusion, which has been shown to reduce the need for dangerous pain killers.

Unfortunately, some private insurers don't cover this procedure, forcing people to choose the standard surgery that requires addictive opioids for pain management.

Instead of simply prescribing a drug for the pain, providers should also look to other therapies and insurers so they can proactively cover these therapies so that people are given more choices to manage their pain.

We must hold providers and patients accountable and encourage insurers to cover more types of procedures. The opioid crisis also affects businesses including our local pharmacies.

According to the DEA, in 2014 there were 16 armed robberies involving stolen opioids at Minnesota pharmacies. Last year, that number doubled. People get hurt and die during these crimes.

Dangerous drugs are put on the street. Businesses have to close their doors because of safety concerns and communities lose vital resources and neighbors because of addiction and the crime that goes with it.

Earlier this year, I spoke to a mom from Maple Grove, Minnesota, whose son bought carfentanyl online, consumed it, and died.

We need to increase funding for safety resources, for addicts and trained law enforcement officers to spot and stop opioid-related crime.

Our communities depend on access to health care and we need to do more to reduce the crime and death associated with opioid addiction if we are going to help get people—and get the care that they need.

I want to thank you, Mr. Chairman. I look forward to working with you and the rest of the members on your committee for bipartisan solutions to the problems associated with opioid addiction.

[The prepared statement of the Mr. Paulsen follows:]

PREPARED STATEMENT OF HON. ERIK PAULSEN

Thank you, Chairman Walden and Ranking Member Pallone, for this opportunity to speak about the opioid addiction crisis in Minnesota.

Minnesota is like the rest of the United States in and unfortunately, it is suffering with addiction to and death from opioids.

It's a crisis tearing families apart through addiction and death and the numbers are only getting worse. Minnesota saw a 12 percent rise in 2016 over 2015—with 376 opioid related deaths. The crisis affects Minnesotans of all backgrounds in rural communities, big cities, and suburbs. In April 2016, in my hometown of Chanhassen, we saw the passing of music legend Prince due to an opioid overdose.

In Minnesota, there are 50 opioid prescriptions written for every 100 patients that visit our doctors. Clearly we need to change the culture in our delivery of care to stop the flow of opioids when there are proven alternative types of treatments that may not require those prescriptions.

When someone requires surgery for back pain, they can choose between minimally invasive surgery or the standard surgery that requires a long post-surgery stay in the hospital and powerful pain killers. One way to reduce the dependency on opioids is to use procedures that are minimally invasive and so do not require long hospital stays and opioids to dull the pain from other invasive procedures. An example is minimally invasive sak-roh-il-ee-ak joint, or SI fusion, which has been shown to reduce the need for dangerous pain killers.

Unfortunately, some private insurers don't cover this procedure, forcing people to choose the standard surgery that requires addictive opioids for pain management. Instead of simply prescribing a drug for the pain, providers should look to other therapies and insurers should proactively cover those therapies so that people are given more choices to manage their pain. We must hold providers and patients accountable, and encourage insurers to cover more types of procedures.

The opioid crisis also affects businesses, many times our local pharmacies. According to the DEA, in 2014 there were 16 armed robberies involving stolen opioids at Minnesota pharmacies. Last year, that number doubled. People get hurt and die during these crimes, dangerous drugs are put on the street, businesses have to close their doors because of safety concerns and communities lose vital resources and neighbors because of addiction and the crime that goes with it.

Earlier this year, I spoke to a mother Maple Grove, MN whose son bought carfentanyl online, consumed it, and died. We must increase funding for safety resources for addicts and train law enforcement officers to spot, and stop opioid-related crime. Our communities depend on access to health care, but we must do something to reduce the crime and death associated with opioid addiction if we are going to help people get and keep the care they need.

I thank you again, Mr. Chairman and Ranking Member Pallone, for allowing me this opportunity, and I look forward to working with to come up with more bipartisan solutions to the problems associated with opioid addiction.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

Chair recognizes the gentlelady from Delaware, Ms. Rochester, for 3 minutes, please.

STATEMENT OF HON. LISA BLUNT ROCHESTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF DELAWARE

Ms. BLUNT ROCHESTER. Thank you, Mr. Chairman. Thank you, Mr. Chairman.

I want to start off by saying as a former Deputy Secretary of Health and Social Services in Delaware, former Secretary of Labor, and community member and family member, substance abuse has touched my life and so many others, everything from our economy to our prison system to our families, from crack to heroin to all forms of opioids.

And in many ways, Delaware reflects our Nation. Geography—we are urban and rural. We mirror the country in terms of demographics and, unfortunately, like the rest of the Nation we are facing a growing opiate crisis.

Just yesterday, our death toll from this horrible disease rose to 171 Delawareans for the year. That might not seem like a lot to some, but to put that into perspective, that many deaths in a State the size of Delaware made us number 13 per capita in the country last year for opioid overdose deaths, according to the Kaiser Family Foundation.

This public health crisis is prevalent in districts across the country, and Congress has the opportunity to impact it in a meaningful way and take action.

This is why it's so important to tackle this issue on a bipartisan basis. The opioid addiction has taken a strong hold across the Nation and we must work together to combat the flow of drugs throughout our country.

This is a problem for all States but particularly on the East Coast, where compact States means that none of us can act alone. Drug trafficking doesn't stop at Delaware's borders with Maryland or Pennsylvania or New Jersey, and neither does this public health crisis.

Delaware and our neighbors have made great progress through collaborative programs like HIDTA and prescription drug monitoring programs. But that should just be the beginning. We aren't doing enough.

But it is also important to remember that there are people in Delaware and in all of our communities making a difference. Every day on the ground for people, for families, and in neighbourhoods they are combatting this crisis on the ground.

I want to thank all those people who are fighting, whether they are in public health, whether they are doctors, first responders, the faith community, community groups, families—all those who are doing their part to make sure that we tackle this issue.

We in Congress need to join them. I hope that we in Congress will also continue to work together and address this epidemic by providing resources for prevention, support for recovery, and access to care.

Thank you so much. I yield back my time.

[The prepared statement of Ms. Blunt Rochester follows:]

PREPARED STATEMENT OF HON. LISA BLUNT ROCHESTER

In many ways, Delaware reflects our Nation. Geography—we're urban and rural, demographics, and unfortunately we are facing a growing opioid crisis.

Just yesterday, Delaware's death toll from this horrible disease rose to 171 for the year. This public health crisis is prevalent in districts across the country and Congress has the opportunity to impact it in a meaningful way and take action. This is why it's so important to tackle this on a bipartisan basis.

The opioid epidemic has taken a strong hold across the Nation, and we must work together to combat the flow of drugs throughout our country. This is a problem for all States, but particularly on the East Coast, where compact States mean that none of us can act alone. Drug trafficking doesn't stop at Delaware's borders with Maryland, or Pennsylvania, or New Jersey—and neither does this public health crisis. Delaware and our neighbors have made great progress through collaborative programs like HIDTA and prescription drug monitoring programs, but that should be just the beginning. We aren't doing enough.

But there are people in Delaware, and in all of our communities, making a difference. Every day, on the ground, for people and families and neighborhoods they are combating this crisis on the ground. Thank you to the people who are fighting—the doctors, public safety officers, community groups, all of those doing what they can to help those around them. We need to join them.

I hope that we, in Congress, will all continue to work together to address this epidemic by providing resources for prevention, support for recovery, and access to care.

Mr. BURGESS. Chair thanks the gentlelady. Gentlelady yields back.

We are going to have a series of votes, and it is my hope that we will adjourn when votes occur. I am going to ask the Members who are here, and I appreciate you staying with us for so long.

Let us continue to yield 3 minutes, but let's try to do it in 2 so everyone gets a chance to testify before the vote. So all the Members who remain, if you will join us at the table.

And Ms. Chu, you are recognized for 3 minutes.

STATEMENT OF HON. JUDY CHU, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF CALIFORNIA

Ms. CHU. Mr. Chair, I want to start by thanking you for allowing Members to testify on this issue.

Today, I would like to draw the subcommittee's attention to the significant needs of those who have sought help for addiction, completed treatment and are just beginning to live in recovery.

These individuals often choose to live in sober living facilities after completing treatment in order to ease into the routines of daily life.

However, there are far too many sober homes that are commonly unequipped to handle patients at risk of overdose or do not employ staff with specialty training for individuals in recovery.

Worst of all, some of these facilities do not encourage recovery at all but exploit vulnerable people recently released from treatment in order to collect insurance payments.

This could mean life or death for people like Tyler from my district of Pasadena, California, who died from an overdose after his sober home didn't recognize the symptoms of his overdose and didn't have Naloxone, the medication that can reverse an overdose. Tyler was only 23 years old.

Unfortunately, this is not an isolated issue. I have heard from advocates in Arizona, Pennsylvania, Missouri, Ohio, and countless others who are concerned for their friends and neighbors living in unregulated sober living facilities.

I would like to submit for the record a New York Times article from 2015 and a May 2017 report from the Department of Justice outlining abuse and fraud at sober homes in New York and Florida.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. CHU. These reports describe sober living facilities that lacked access to Naloxone, ordered unnecessary tests on residents to exhaust their insurance benefits, and required residents to relapse and reenter treatment so resident directors could claim some of the Medicaid benefits.

Licensing for recovery residences or sober living facilities vary substantially from State to State, and there are facilities in every State operating without licenses at all.

Further, oversight of these facilities is minimal so patients and families with loved ones in recovery struggle to distinguish good actors from bad ones.

For some individuals, they may not discover their facility is negligent until it is too late. That is why this week I plan to introduce the Ensuring Quality Sober Living Act. My legislation would require the Substance Abuse and Mental Health Services Administration to develop a set of best practices for residential recovery facilities so patients, families, and States can distinguish quality sober living facilities from sites that are fraudulent or unequipped to offer appropriate assistance.

The bill would require SAMHSA to disseminate these best practices to each State and authorize the agency to provide technical assistance and support.

My bill would require States to help SAMHSA set up criteria to distinguish quality sober living facilities. These best practices to allow the guidelines for common sense measures like requiring that all fees and charges be explained to residents before entering a binding agreement and that Naloxone is available and accessible and that staff and residents are trained to use it in emergencies.

Thank you very much.

[The prepared statement of Ms. Chu follows:]

PREPARED STATEMENT OF HON. JUDY CHU

Chairman Burgess and Ranking Member Green, I want to start by thanking you for allowing Members to testify on this issue, which has impacted all of our districts.

Today, I would like to draw the subcommittee's attention to the significant needs of those who have sought help for addiction, completed treatment, and are just beginning to live in recovery. These individuals often choose to live in sober living facilities after completing treatment in order to ease into the routines of daily life. However, "sober homes" are commonly unequipped to handle patients at risk of overdose, or do not employ staff with specialty training for individuals in recovery. Worst of all, some of these facilities do not encourage recovery at all, but exploit

vulnerable recently released from treatment in order to collect insurance payments. This can mean life or death for people like Tyler, from my district of Pasadena, California, who died from an overdose after his sober home didn't recognize the symptoms of his overdose, or have Naloxone, the medication that can reverse an overdose, on hand. Tyler was only 23 years old.

Unfortunately, this is not an isolated issue. I have heard from advocates in Arizona, Pennsylvania, Missouri, Ohio, and countless others who are concerned for their friends and neighbors living in unregulated sober living facilities. I would like to submit for the record a New York Times article from 2015 and a May 2017 report from the Department of Justice outlining abuse and fraud at sober homes in New York and Florida. These reports describe sober living facilities that lacked access to Naloxone, ordered unnecessary tests on residents to exhaust their insurance benefits, and required residents to relapse and re-enter treatment so resident directors could claim some of the Medicaid benefits.

Licensing for recovery residences, or sober living facilities, varies substantially from State to State, and there are facilities in every State operating without licenses at all. Further, oversight of these facilities is minimal, so patients and families with loved ones in recovery struggle to distinguish good actors from bad ones. For some of these individuals, they may not discover that their facility is negligent until it is too late.

That is why this week, I plan to introduce the Ensuring Quality Sober Living Act. My legislation would authorize the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a set of best practices for residential recovery facilities so patients, families, and States can distinguish quality sober living facilities from sites that are fraudulent or unequipped to offer appropriate assistance to their residents. The bill would require SAMHSA to disseminate these best practices to each State, and authorize the agency to provide technical assistance and support to States that wish to adopt or implement these best practices.

My bill would allow States, who are struggling to address the opioid crisis, to work with SAMHSA to help set up criteria to designate quality sober living facilities. These best practices will follow the guidelines that have been published by the National Association of Recovery Residences, which provide benchmarks for various levels of quality facilities. These benchmarks include common-sense measures like requiring that all fees and charges be explained to residents before entering a binding agreement, that paid work performed at the facility be completely voluntary and not impede the recovery process, and that Naloxone is available and accessible, and that staff and residents are trained to use it in emergencies.

Thank you again for taking the time to hear from your colleagues on ways to address this growing crisis. I ask that as you continue to consider legislation on the opioid epidemic, you include ways to address the needs of those newly in recovery.

Mr. BURGESS. Gentlelady's time has expired.

The Chair recognizes the gentlelady from Indiana, Mrs. Walorski, for 3 minutes, please.

STATEMENT OF HON. JACKIE WALORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mrs. WALORSKI. Thank you, Mr. Chairman.

Indiana is no different than any other State that we've heard from sitting here. Pain is the number-one reason why Americans seek health care, the number-one cause of disability that costs the U.S. economy more than \$600 billion in direct health care costs and lost productivity.

The veteran population is particularly impacted by the chronic pain crisis with more than 50 percent of the VA patient responding and reporting to chronic pain.

We can reduce demand by more effectively treating chronic pain and providing better access to FDA-approved Nonopioid pharmaceuticals, advanced medical devices, and integrated alternative therapies.

As we develop policy, we should, number one, recognize the importance of a multi disciplinary approach. Chronic pain is pervasive and is largely unaddressed by the public health care system.

Promote—and number two, promote cutting-edge pain research to encourage effective opioid alternatives. High quality evidence is urgently needed to help clinicians and patients make informed decisions about how to manage chronic pain safely and understand the causes and mechanisms of chronic pain.

Advanced best practices and pain management within Medicare. In 2016, one in three Medicare Part D beneficiaries received a prescription opioid. The GAO should conduct a study of the coverage options offered within Medicare for evidence-based pain management as an alternative to opioid prescriptions.

Also, there should be a review of the graduate medical education programs' training and education of providers on pain management and opioid prescriptions.

I hope these ideas will be helpful in future planning discussions to reduce the abuse of opioids in our communities.

Thank you, Mr. Chairman. I yield back my time.

[The prepared statement of Mrs. Walorski follows:]

PREPARED STATEMENT OF HON. JACKIE WALORSKI

Thank you, Chairman Burgess and Ranking Member Green, for holding this hearing on the opioid crisis.

America is facing two interrelated public health epidemics: chronic pain and opioid addiction, misuse, and abuse. A long-term solution to the opioid epidemic will not be achieved without addressing the challenge of appropriately treating chronic pain. According to the Institute of Medicine (IOM), 100 million Americans suffer from chronic pain. Pain is the number one reason why Americans seek health care, the number one cause of disability, and costs the US economy more than \$600 billion in direct healthcare costs and lost productivity. The veteran population is particularly impacted by the chronic pain crisis with more than 50 percent of VA patients reporting chronic pain.

Thousands of lives are lost to both opioid-related overdose and chronic pain-related suicide. Reducing the supply of or access to opioids will not, by itself, solve this crisis. Currently, 80 percent of heroin users started with prescription opioids. We must reduce demand for them by more effectively treating chronic pain, and providing better access to FDA-approved nonopioid pharmaceuticals, advanced medical devices, and integrated alternative therapies.

As we look to develop policy, we should:

1. Recognize the importance of a multidisciplinary approach to pain management as a key component of overcoming the opioid crisis. Chronic pain is pervasive and largely unaddressed public health crisis. Solving it is a crucial part of solving the larger opioid epidemic.

2. Promote cutting edge pain research to encourage effective opioid alternatives. High-quality evidence is urgently needed to help clinicians and patients make informed decisions about how to manage chronic pain safely and understand the causes and mechanisms of chronic pain.

3. Advance best practices in pain management in Medicare. Currently 1 in 3 Medicare beneficiaries are prescribed an opioid. The GAO should conduct a study of the coverage options for evidence-based pain management. In addition, there should be a study conducted on the Graduate Medical Education program on the training and education that providers receive regarding pain management.

I hope these ideas will be helpful in future policy discussions to reduce the abuse of opioids in our communities. Thank you for the time, and I yield back.

Mr. BURGESS. The Chair thanks the gentlelady.

Mr. Donovan, you are recognized for 3 minutes.

STATEMENT OF HON. DANIEL M. DONOVAN, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. DONOVAN. Thank you, Mr. Chairman.

Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify before you today to share my thoughts on the opioid crisis.

This year alone, there have been more than 100 reported overdose deaths in my district. That number would be much higher if it weren't for the 574 Naloxone saves reported by our local hospitals and the New York City Police Department.

Before I came to Congress, I served as district attorney of Richmond County, which comprises of Staten Island, New York. Based on that experience, my time in Congress, and input from local experts like the Staten Island Partnership for Community Wellness, I support a three-tiered approach for this problem that addresses education, treatment, and enforcement.

Targeted education campaigns can teach the next generation of potential users about the dangers of substance abuse including particularly sinister compounds like fentanyl.

Treatment is, of course, crucial. We have learned that recovery is a cycle and relapses will happen. Our policies should reflect that reality. Our society now understands that addiction is a medical illness and not a criminal act.

Let us help the addicted, not punish them. To that end, consistently appropriating grants for local treatment programs is the most effective way to help end the cycle of addiction from the Federal level.

Lastly, we cannot ignore the importance of enforcement, particularly against traffickers. My Comprehensive Fentanyl Control Act would ban pill presses that traffickers use to create their deadly fentanyl-laced cocktails. It would also update sentencing guidelines to reflect the fact that a few grains of—few grains of rice worth of fentanyl can kill an individual.

I firmly believe that the experts on the ground are best equipped to tailor their approaches to meet their communities' needs. It is our job as legislators to provide them with the resources necessary to accomplish their mission.

Legislation like the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act, which I championed to constituents back in my district, are exactly the right approach.

Thank you again for the opportunity to share my thoughts. I look forward to working with the subcommittee and to continuing to address this national crisis.

Thank you, sir.

[The prepared statement of Mr. Donovan follows:]

PREPARED STATEMENT OF HON. DANIEL M. DONOVAN, JR.

Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify before you today to share my thoughts on the opioid crisis.

This year alone, there have been more than 100 reported overdose deaths in my district. That number would be much higher if it weren't for the 574 Naloxone saves reported by our local hospitals and the NYPD.

Before I came to Congress, I served as District of Attorney of Richmond County, which comprises Staten Island, NY. Based on that experience, my time in Congress, and input from local experts like the Staten Island Partnership for Community Wellness, I support a three-tiered approach that addresses education, treatment, and enforcement.

Targeted education campaigns can teach the next generation of potential users about the dangers of substance abuse, including particularly sinister compounds like fentanyl.

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I firmly believe that experts on the ground are best equipped to tailor their approaches to meet their community's needs. It's our job as legislators to provide them with the resources necessary to accomplish their mission. Legislation like the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act—which I championed to constituents back in my district—are exactly the right approach.

Thank you again for the opportunity to share my thoughts. I look forward to working with the subcommittee to continue addressing this national crisis.

Mr. BURGESS. Chair thanks the gentleman.

Representative Hartzler, you are recognized for 3 minutes.

STATEMENT OF HON. VICKY HARTZLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mrs. HARTZLER. Thank you, Mr. Chairman.

Mr. BURGESS. But only use two.

Mrs. HARTZLER. And thank you for this opportunity.

In Missouri, the scourge of drug abuse is a growing problem and it will take all of us to help solve it. I have heard of too many stories of families torn apart and livelihoods in tatters.

To this end, I ask the committee to explore ways to make it easier for faith-based organizations to offer addiction treatment programs. I have seen firsthand the power of faith-based recovery programs in treating addiction.

In my own district, I have visited multiple Christian organizations that have high rates of success in treating addiction.

By centering on a community of faith, these organizations provide support structures that stay with recovering addicts their entire lives. In some cases, they also provide services that aren't available in other addiction recovery programs in the area.

For instance, one religious organization in my district provides housing for both mothers and their children while the mothers seek treatment for their addiction. No doubt their recovery is greatly facilitated by the additional support of their children.

I firmly believe faith-based recovery programs are part of a holistic approach to treat both the body and spirit. They provide emotional and spiritual support for individuals and their families during the darkest times and I ask the committee to seriously consider making available and expanding any and all funding opportunities to faith-based organizations providing addiction, treatment, and programs.

In addition, on a second topic, the IMD exclusion caps the number of beds mental health facilities receiving Medicaid can have at 16. Multiple health care groups have come into my office saying this blocks critical access to treatment for people who need inpatient treatment for addiction including some of society's most vulnerable—veterans, pregnant addicted women, women with dependent children, and youth.

I encourage the committee to explore ways to provide some relief to this outdated rule. Thank you very much. I yield back.

[The prepared statement of Mrs. Hartzler follows:]

PREPARED STATEMENT OF HON. VICKY HARTZLER

Chairman Burgess, Ranking Member Green, and members of the Subcommittee on Health, I thank you for the opportunity to talk today about the opioid crisis that's facing our Nation, and I appreciate the committee continuing to look for solutions to this ongoing epidemic.

In Missouri, the scourge of drug abuse is a growing problem, and it will take all of us to help solve it. I have heard too many stories of families torn apart and livelihoods in tatters. Over one-twelfth of U.S. and Missouri adults report substance use disorders, and this rate is even higher among young adults. As we continue to address this problem, we must consider all avenues available. To that end, I ask the committee to explore ways to make it easier for faith-based organizations to offer addiction treatment programs.

I have seen first-hand the power of faith based recovery programs in treating addiction. In my own district, I have visited multiple Christian organizations that have high rates of success in treating addiction. By centering on a community of faith, these organizations provide support structures that stay with recovering addicts their entire lives. In some cases, they also provide services that aren't available in other addiction recovery programs in the area. For instance, one religious organization in my district provides housing for both mothers and their children while the mothers seek treatment for their addiction. No doubt, their recovery is greatly facilitated by the additional support for their children.

I firmly believe faith based recovery programs are part of a holistic approach that treat both the body and spirit. They provide emotional and spiritual support for individuals and their families during their darkest times. These religious organizations provide a foundation for recovery that medication assisted treatment alone cannot. It's the love and power of God and the life purpose He gives that ultimately provides a sustainable path to recovery for many individuals. I ask the committee to seriously consider making available and expanding any and all funding opportunities to faith based organizations providing addiction treatment programs.

REPEAL THE IMD EXCLUSION

The IMD exclusion caps the number of beds mental health facilities receiving Medicaid can have at 16. Multiple health care groups have come into my office saying this blocks critical access to treatment for people who need inpatient treatment for addiction, including some of society's most vulnerable: veterans, pregnant addicted women, women with dependent children, and youths. I encourage the committee to explore ways to provide some relief to this outdated rule.

Mr. BURGESS. Chair thanks the gentlelady. Gentleman from Pennsylvania is recognized for 3 minutes, but only use 2, please.

STATEMENT OF HON. BRIAN K. FITZPATRICK, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. FITZPATRICK. Thank you, Mr. Chairman.

As this committee is aware, drug overdoses involving prescription opioids and heroin have nearly quadrupled since 1999 and are now the leading cause of accidental death in this Nation.

Substance abuses costs our country over \$600 billion annually. In my home State of Pennsylvania, drug-related deaths and opioid addiction rates were amongst the highest in the Nation.

Within one year, Pennsylvania's opioid-related deaths rose 20 percent while my district's increased by 50 percent.

Mr. Chairman, this epidemic is costing us both resources and precious lives, like my constituent, Carlos Castellanos. Carlos, in Falls Township, always loved sharing his talents and love of music by playing the guitar and drums at school for a local church group.

However, like so many around the Nation, Carlos got involved with drugs during his time at school and even spent some time in jail. But with the strength and support of his family he began receiving treatment and his life improved. He helped others by volunteering at a recovery home and he brought people suffering in similar situations to treatment programs.

Last December, Carlos walked his mother, Pamela, down the aisle for her wedding. He was getting ready to get back to school. He had a steady job and a girlfriend.

It would seem that many of Carlos' battles with addiction were heading in the right direction, a needed point of hope in the war that has caused so much devastation.

Then, Mr. Chairman, on December 23rd, just days before Christmas, two police detectives showed up at Pamela's door to tell her the devastating news that no mother can ever prepare for.

Carlos overdosed on a drug laced with fentanyl and was unable to be saved.

Mr. Chairman, Carlos' life and his death cast a bright light on the fact that addiction is nothing short of a chronic disease and I would also like to bring to this attention what my colleague did—the so-called Institute for Mental Disease, or IMD, exclusion is a longstanding policy that prohibits the Federal Medicaid matching funds to States for services rendered to Medicaid enrollees who suffer from substance use disorder for mental health treatment.

Some States, like my State of Pennsylvania, have used the in lieu of services provision allowing for inpatient treatment but with limitations on population size, facility size and length of stay.

These limitations disproportionately affect those using Medicaid, blocking access to treatment for people who need inpatient treatment for addiction including some of society's most vulnerable.

I urge my colleagues to adopt the Road to Recovery Act, a bill I introduced which addresses real-world concerns expressed by local lawmakers, community leaders, and health care professionals.

Mr. Chairman, I yield back.

[The prepared statement of Mr. Fitzpatrick follows:]

PREPARED STATEMENT OF HON. BRIAN K. FITZPATRICK

I would like to start off by thanking Chairman Burgess, Ranking Member Green, and members of the Subcommittee on Health for holding this hearing.

Mr. Chairman, drug overdoses involving prescription opioids and heroin have nearly quadrupled since 1999 and are now the leading cause of accidental death. Substance abuse costs our country over \$600 billion annually. In my home State of Pennsylvania, drug-related deaths and opioid addiction rates were among the highest in the country. Within 1 year, Pennsylvania's opioid-related deaths rose 20 percent while my district's increased by 50 percent.

This epidemic is costing us both resources and precious lives.

Carlos Castellanos of Falls Township, Bucks County always loved sharing his talents and love of music by playing the guitar and drums at school and for local church groups.

However, like so many around the Nation, Carlos got involved with drugs during his time in school and even spent some time in jail. But, with the strength and support of his family, he began receiving treatment and his life improved. He helped others by volunteering at a recovery house and he brought people suffering in similar situations to treatment programs.

In early December, Carlos walked his mother, Pamela, down the aisle for her wedding. He was getting ready to go back to school, he had a steady job, and a girlfriend. It would seem to many that Carlos' battle with addiction was heading in the right direction—a needed point of hope in a war that's caused so much devastation.

Then, on December 23rd, just days before Christmas, two police detectives showed up at Pamela's door to tell her the devastating news that no mother can prepare for: Carlos had overdosed on a drug laced with fentanyl and was unable to be saved.

Mr. Chairman, Carlos' life—and his death—cast a bright light on the fact that addiction is nothing short of a chronic disease.

I share this story with Members of this chamber because we must realize that we have treat the whole person, not just the addiction. We must focus on the underlying issues driving people to seek opioids, while increasing the accessibility and affordability for prevention, education, treatment, and recovery of this disease. The so-called Institutions for Mental Diseases—or IMD—exclusion is a long-standing policy that prohibits the Federal Medicaid matching funds to States for services rendered to Medicaid enrollees who suffer from substance use disorder and mental health treatment.

Some States—including my home State of Pennsylvania—have used an “in lieu of services” provision allowing for inpatient treatment, but with limitations on patient population, facility size, and length of stay. These limitations disproportionately affect those under Medicaid—blocking access to treatment for people who need inpatient treatment for addiction including some of society's most vulnerable.

That is why I introduced bipartisan legislation that eliminates the IMD exclusion for substance use disorder and help States expand access to inpatient addiction services for Medicaid enrollees in a fiscally responsible manner while not intruding on their flexibility to implement care.

The Road to Recovery Act addresses real-world concerns expressed by local lawmakers, community leaders and healthcare professionals in my district who endeavor to tackle this epidemic each day.

I urge my colleagues to learn more about this issue and support this bipartisan bill, but also to recommit ourselves to addressing the addiction crisis and fighting for those who suffer.

I yield back.

Mr. BURGESS. Chair thanks the gentleman.

Chair recognizes the gentleman from Pennsylvania for 3 minutes.

**STATEMENT OF HON. RYAN A. COSTELLO, A REPRESENTATIVE
IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. COSTELLO. Thank you, Mr. Chairman.

In speaking with constituents about the opioid epidemic, I have learned firsthand the impact this epidemic is having on our communities in Pennsylvania. It is affecting families and individuals of all ages, races, and socioeconomic backgrounds.

Throughout my congressional district and throughout this Nation there are parents, teachers, athletes, doctors, teenagers, and seniors struggling with addiction, a disease that has no boundaries when it comes to who it affects.

These families and these individuals are why we must continue our work to pass legislation like the Comprehensive Addiction Recovery Act and the 21st Century Cures Act, two bills I supported that are both now law.

These bipartisan bills are helping our communities through increasing access to treatment and expanding prevention, education, and intervention efforts.

In the communities I represent, a recurring sentiment I have heard was, you would not believe how much treatment costs. The cost of treatment and recovery is, indeed, crippling for so many families, even for individuals who have insurance—\$35,000 for a 30-day at a treatment center, \$10,000 for a 10-day detox, hundreds of dollars spent on flights to recovery programs across the country.

Families are being forced to refinance their homes, parents are taking on second jobs, and retirees are reentering the workforce to help pay for treatment for a family member struggling with addiction.

Those seeking help should not be faced with insurmountable costs. To help individuals provide assistance—financial assistance to family members struggling with addiction, I have added my name as a cosponsor to H.R. 1575, the Addiction Recovery through Family Health Accounts Act.

Under current law, individuals can only use funds in their health savings account, flexible spending account, or health reimbursement arrangement to pay for addiction treatment for their spouse or dependents.

This bill will give individuals the option to use funds from these accounts to help family members receiving drug treatment, be it a niece, grandfather, cousin, in-law, et cetera. This legislation is a step in the right direction in alleviating the financial burden of substance abuse treatment.

I am proud of the work the committee has done to help those facing this epidemic and I am committed to continuing this work.

I yield back. Thank you, Mr. Chairman.

[The prepared statement of Mr. Costello follows:]

PREPARED STATEMENT OF HON. RYAN A. COSTELLO

In speaking with constituents about the opioid epidemic, I have learned firsthand the impact this epidemic is having on our communities in Pennsylvania—it is affecting families and individuals of all ages, races, and socioeconomic backgrounds.

Throughout my Congressional district and throughout this Nation, there are parents, teachers, athletes, doctors, teenagers, and seniors struggling with addiction—a disease that truly knows no boundaries when it comes to who it affects.

These families, these individuals are why we must continue our work to pass legislation like the Comprehensive Addiction and Recovery Act, and the 21st Century Cures Act—two pieces of legislation I supported that are both now law. These bipartisan bills are helping our communities through increasing access to treatment, and expanding prevention, education, and intervention efforts.

In the communities I represent, a recurring sentiment I've heard was, "you wouldn't believe how much money we've spent."

The cost of treatment and recovery is crippling, even for individuals who have insurance \$35,000 for a 30-day stay at a treatment center. \$10,000 for a 10-day detox. Hundreds of dollars spent on flights to recovery programs across the country.

Families are being forced to refinance their homes, parents are taking on second jobs, and retirees are re-entering the workforce to help pay for treatment for a family member struggling with addiction.

Those seeking help should not be faced with these insurmountable costs.

To help individuals provide financial assistance to family members struggling with addiction, I have added my name as a cosponsor of H.R. 1575, the Addiction Recovery through Family Health Accounts Act.

Under current law, individuals can only use funds in their Health Savings Account, Flexible Spending Account, or Health Reimbursement Arrangement to pay for addiction treatment for their spouse or dependents.

This bill would give individuals the option to use funds from these accounts to help family members receive drug treatment—a niece, a grandfather, a cousin, a grandchild's spouse, in-laws, etc.

This legislation is a step in the right direction in alleviating the financial burden of substance abuse treatment.

I am proud of the work we have done in this committee to help those facing this epidemic, and I am committed to continuing this critical work.

Mr. BURGESS. Chair thanks the gentleman. Gentleman yields back.

The Chair recognizes the final gentleman from Pennsylvania for 3 minutes, but only use 2.

**STATEMENT OF HON. KEITH J. ROTHFUS, A REPRESENTATIVE
IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. ROTHFUS. Thank you, Mr. Chairman, for holding this important hearing today for Members across the country to come and testify about this epidemic.

I think it is interesting that you have had three Pennsylvanians right in a row that represents the geography of Pennsylvania—eastern, middle, and western. Certain, communities in western Pennsylvania are among the hardest hit in our national opioid epidemic.

There has been a staggering amount of overdose deaths specifically in my district. In 2016, Allegheny County had 648 individuals lose their lives from heroin or opioid-related overdoses. Last year, that number was 4,342 in Pennsylvania alone.

According to a recent article in the Pittsburgh Post Gazette in 2016, the number of overdose deaths in Pennsylvania was four times the number of deaths caused by car accidents.

In other recent reports, three people in my district were revived by Narcan after each overdosed at a convenience store. Thankfully, the first responders were able to save their lives.

While it is encouraging to see that both Congress and the administration have taken action to address this issue, we still have a long way to go. From my perspective, we should be taking a three-pronged approach to combatting the epidemic.

We must implement measures to prevent addiction. We must treat addiction once it has taken hold over someone. Finally, we must vigorously enforce the laws on the books to stop drug traffickers from spreading their poison into our communities.

To help combat this, I led an effort to include language in the landmark Comprehensive Opioid Reduction Act that will help ensure our veterans who are at significant risk to have access to the specialized program they need—program that they need to prevent or overcome opioid addiction. This is one positive step in the right direction.

Another area where Congress should focus, one of which is of specific interest to me, is to increase and strengthen our partnership with Mexico, especially through the State Department's Merida Initiative.

Our neighbor to the south has suffered a horrific level of murder at the hands of drug cartels. By increasing our cooperation with Mexico, we can help them defeat the cartels that caused so much pain both there and here in the U.S.

Often overlooked is the fact that many of the narcotics that Mexican cartels traffic end up in the hands of Americans. Furthermore, increasing security at ports of entry through increased use of technology, cameras, and manpower is absolutely necessary to interdicting drugs.

Pending legislation like Chairman McCaul's Border Security for America Act will do just that. Another bipartisan bill that I hope will end the crisis was introduced with Congressman Collin Peterson, H.R. 3526. I look forward to that moving forward.

Again, I sincerely thank you for the opportunity to testify before the committee this morning on an issue that greatly affects the constituents in my district.

[The prepared statement of Mr. Rothfus follows:]

PREPARED STATEMENT OF HON. KEITH J. ROTHFUS

Thank you Mr. Chairman for holding this important hearing today for members from across the country to testify about this epidemic.

I think it is interesting that you've had three Pennsylvanians right in a row. It represents the geography of Pennsylvania; Eastern, Middle and Western.

Certainly communities in Western Pennsylvania are among those hit hardest in the National opioid epidemic. There has been a staggering amount of overdose deaths, specifically in my district. In 2016, Allegheny County had 648 individuals lose their lives from heroin or opioid-related overdoses. Last year, that number was 4,342 in Pennsylvania alone.

According to a recent article in the Pittsburgh Post-Gazette, in 2016, the number of overdose deaths in Pennsylvania was four-times the number of deaths caused by car accidents. In other recent reports, three people in my district were revived by Narcan after each overdosed at a convenience store. Thankfully, the first responders were able to save their lives.

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Another area where Congress should focus, one of which is of specific interest to me, is to increase and strengthen our partnership with Mexico, especially through the State Department's Merida Initiative. Our neighbor to the south has suffered a horrific level of murder at the hands of drug cartels. By increasing our cooperation with Mexico we can help them defeat the cartels that cause so much pain both there and here in the US. Often overlooked, is the fact that many of the narcotics that Mexican cartels traffic end up in the hands of Americans.

Furthermore, increasing security at ports of entry through increased use of technology, cameras, and man-power is absolutely necessary to interdicting drugs. Pending legislation, like Chairman McCaul's Border Security for America Act, will do just that.

Another bipartisan bill that I hope can help end the crisis is one that I introduced with Congressman Collin Peterson, H.R. 3526 (the Border Protection Fund Act). I look forward to that moving forward.

Again, I sincerely thank you for the opportunity to testify before the committee this morning on an issue that greatly affects my constituents and our country.

Mr. BURGESS. Chair thanks the gentleman. The gentleman yields back.

All Members having had a chance to speak, with votes on the floor, the committee stands adjourned.

[Whereupon, at 1:33 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. WM. LACY CLAY

Good morning Mr. Chairman, Mr. Ranking Member, and honorable Members of this vital committee.

I thank you for this special opportunity to come before you.

I am here because, in 2016, 650 people in the St. Louis metropolitan area died from an opioid overdose.

I am here because that number of needless, tragic deaths has quadrupled since 2007.

I am here because the number of annual opioid overdose deaths in the community that I represent is now more than three times the number of homicides.

I am here because this Congress must summon our national courage to finally confront the menace of opioid addiction and opioid overdoses as an urgent public health emergency.

First, incarcerating people does very little to get at the underlying causes of this epidemic.

We absolutely should not condone criminals who are peddling heroin, fentanyl, carfentanil and other deadly drug combinations.

But just putting someone behind bars who has an addiction doesn't solve that person's problem. In fact, it is a huge waste of scarce taxpayer dollars that would be much better spent on treatment.

Indeed, people who go to jail and are then released—if they are not given treatment—are at high risk of re-using and are also at a very high risk of a life-threatening overdose.

I strongly believe in the value of life-saving and life-renewing services offered by community-based nonprofits that provide treatment for substance abuse disorders.

We know that evidence-based treatment is effective and that when people are in treatment, they use drugs less and they overdose less.

Treatment comes in many forms, but in the United States, we rely heavily on nonprofit community-based treatment providers as the safety net for treatment for low-income people and others who are disenfranchised, such as people who are homeless; many of whom are veterans.

Many of these providers rely on the Substance Abuse Prevention and Treatment Block Grant to survive, and I would wholeheartedly urge that we continue to robustly fund this essential program.

I do want to highlight the antiquated policy, over 50 years old, known as the Medicaid Institution of Mental Diseases Exclusion, better known as the IMD Exclusion, which bars Medicaid from paying for residential treatment at a facility of more than 16 beds.

According to the New York Times in a July 10, 2014 article on the negative impact of the IMD Exclusion, in some States this policy means that 9 out of 10 treatment beds are in programs too large to receive Medicaid reimbursement.

That is a huge barrier to recovery for our most needy, most vulnerable, poorest Americans—and it yields a two-tiered health care system, where only people on Medicaid lose access to a kind of treatment that may be clinically indicated and medically necessary.

Fortunately, there is growing support for ending this outdated policy.

For example, the National Governors Association has called for the elimination of the IMD Exclusion for SUD to help States expand access to addiction treatment.

And in July 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis Interim Report recommended that all 50 States be granted waiver approvals to eliminate barriers resulting from the IMD exclusion.

Perhaps most importantly in terms of legislative action, two key bills have been introduced in the 115th Congress that deserve your favorable consideration.

One is H.R. 2938, sponsored by Rep. Brian Fitzpatrick of Pennsylvania, the Road to Recovery Act, which would eliminate the IMD Exclusion for community-based residential treatment.

This is not a full repeal of the IMD Exclusion which also affects treatment for mental health, but rather is finely targeted to repeal the ban for the SUD treatment that is so sorely needed today amid the opioid epidemic.

Another bill is H.R. 2687, the Medicaid CARE Act, sponsored by Congressman Bill Foster of Illinois, which would turn the current exclusion into a cap on Medicaid reimbursement, under which programs could be reimbursed for residential SUD treatment for up to 40 beds in a program for up to 60 days.

These are just two ways that Congress can end one of the most formidable barriers to treatment, and immediately help increase capacity and beds in every State.

Opioid addiction and the thousands of American lives it takes each year does not respect political parties, regional differences, racial or ethnic backgrounds or even

age. it is an equal opportunity killer that we need to confront together as the People's House.

Thank you for allowing me to share this time with you today, and I look forward to working closely with you in a bipartisan way to save our fellow Americans.

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Thank you, Chairman Burgess and Ranking Member Green, for holding this listening session and giving Members of the House the opportunity to speak about the tragic impacts of the opioid crisis in their districts. This crisis claims 142 lives each day and has killed more people than our deadliest wars. Over 2 million people have a prescription opioid addiction, 591,000 have a heroin addiction, and we've seen overdose deaths triple in the last 13 years. Opioid abuse touches every American and doesn't discriminate. It affects mothers, fathers, children and even newborn babies.

I've heard from substance abuse treatment facilities in my congressional district and they report that the number of young people walking through their doors with addiction have strikingly increased in the past decade. This is a national crisis. These drugs are crippling a generation of America's youth.

President Trump appropriately announced that he would declare it a national emergency in August, yet it has been 62 days since he made that announcement and no emergency declaration has been filed.

Instead, in the months since the President announced that he would declare the opioid crisis a national emergency, we've seen constant attacks on the very health care system that provides treatment and services to those suffering from opioid addiction. Medicaid and CHIP provide insurance coverage for 30 percent of people suffering from opioid addiction. Medicaid has repeatedly been targeted by attempts to repeal the Affordable Care Act and now, through the Majority's tax reform plan. It's hypocritical to claim that you are committed to fighting this catastrophic crisis and then, at every turn, undermine the systems in place to treat and support those who struggle with addiction.

Last Congress, we took important steps through the Comprehensive Addiction and Recovery Act and 21st Century Cures Act to address and treat opioid abuse, but both of these pieces of legislation must secure funding from Congress. We have to make good on the promises we made to those Americans who suffer from opioid addiction and fund the programs that they rely on to receive the treatment and support they need.

Any future approach this committee or the administration takes must address the entire spectrum of addiction, from prevention, to crisis response, to treatment and recovery. A law and order approach that only punishes prescription drug abusers does a disservice to our country and impedes progress toward addressing this epidemic.

PREPARED STATEMENT OF HON. ALCEE L. HASTINGS

Mr. Chairman, thank you for holding this important hearing about how the opioid epidemic is affecting communities nationwide. Today, I would specifically like to discuss the importance of repealing or reforming the Medicaid Institutions for Mental Diseases exclusion, which is a barrier to residential treatment for low-income people.

Unfortunately, Mr. Chairman, one of my counties, Palm Beach County, Florida, saw nearly 600 fatal overdoses last year, mostly related to opioids. The number of fatal opioid overdoses has gone up 230 percent in the past 2 years, overwhelming police, firefighters, hospitals, and morgues. In fact, the Opioid crisis has been declared a public health emergency by Florida Governor Rick Scott.

Recovering drug users are flocking to South Florida from everywhere—drawn by a world-renowned drug treatment industry. Some find good centers and a path to recovery. Others fall victim to corrupt operators and wind up homeless, without money, and in the most tragic cases, dead.

Substance use disorder (SUD) plagues the United States both socially and economically. The cost of substance abuse and drug addiction to our health care system totals \$705 billion annually, where the emotional costs of drug addiction, on family, friends and those battling addiction, cannot be calculated.

An estimated 23.1 million Americans ages 12 or older needed treatment for substance abuse in 2012; however, only 2.5 million of them actually received treatment.

This shortfall is due primarily to the limited availability of substance use disorder services, particularly for those in need of residential care to address chronic addiction.

Last year, I introduced a bill to amend title XIX of the Social Security Act and remove the exclusion of coverage for services in institutions of mental diseases (IMD) under Medicaid. My legislation is designed to enable more Americans who suffer from SUD to gain equal access to the treatment necessary for their long-term recovery.

Under current law, Medicaid beneficiaries are barred access to community-based residential treatment for severe conditions due to the IMD exclusion that prohibits reimbursement care of patients at facilities with more than 16 beds. This nonsensical exclusion has effectively deterred facilities from serving those in dire need of care.

Eliminating the IMD exclusion will allow those who suffer from severe substance use disorders to have equal access to treatment, to achieve stable, long-term recovery, and to become productive members of society. The IMD elimination will also reduce the health, public safety, and economic consequences associated with addiction.

Addiction must be treated like any other chronic disease in this country, with a full continuum of treatment options based on the person's level of need. Current Medicaid policy hinders States' efforts to make this continuum available to Medicaid patients. My legislation would remove this Federal payment prohibition for behavioral health services provided in residential settings. Such a removal would improve access to substance use treatment services for millions of Americans across the country.

The President's Commission on Combating Drug Addiction and the Opioid Crisis Interim Report recommended that all 50 States be granted waiver approvals to eliminate barriers resulting from the IMD exclusion. Providing health care services and treatment resources to those who suffer from substance abuse is critical. In the face of this opioid epidemic, our Nation cannot afford to continue to bear the unintended constraints of 50-year-old provision under Medicaid, which severely impedes availability and access to treatment.

Once again, Mr. Chairman, I want to thank you for holding this critically important hearing today, and greatly appreciate the opportunity to testify for your subcommittee.

PREPARED STATEMENT OF HON. DAVID P. JOYCE

I would like to thank Chairman Burgess, Ranking Member Green, and the other Members of the Energy and Commerce Subcommittee on Health for holding this important and timely hearing. As an Ohio Member of Congress, and a former prosecutor of 25 years, I have seen firsthand the devastation caused by this epidemic.

This is why I introduced my legislation, the Stem the Tide of Overdose Prevalence from Opiate Drugs Act of 2017, or the STOP OD Act. I went straight to the source to craft this bill, gathering input from the healthcare experts that are treating overdose patients on a daily basis. Cleveland Clinic, MetroHealth, and University Hospitals were instrumental in the drafting of the STOP OD Act, and endorsed it in its final form. The bill also has the support of the Fraternal Order of Police (FOP), Community Anti-Drug Coalitions of America (CADCA), and the Association of the United States Navy (AUSN). We wanted to know what our local communities needed, so we took their invaluable feedback, developed a bill that would provide resources where necessary, and then identified a savings measure to pay for those resources.

As a Congress, we have made progress in this arena, but there is more work to be done. As an original cosponsor of my colleague's Comprehensive Addiction and Recovery Act of 2015, I was proud when that piece of critical legislation passed both Chambers and was signed into law. My legislation is intended to be complementary to that effort. Although CARA roll-out is still a work in progress, more and more victims are overdosing every day, and our communities in Ohio are still communicating the need for more resources. The longer we wait to provide these resources, the harder this epidemic will be to address in the future. This is a downhill snowball and we need more firepower.

First and foremost, the STOP OD Act would make available grants for not more than \$150 million annually for 2 years to provide access to life-saving Naloxone, training in the administration of the drug, and for coroners and medical examiners to test for fentanyl so we can get a better idea of just how deep this problem runs. Further, the bill would attach a fee of \$80 to drug-related offenses to ensure crimi-

nals that are enabling the supply and demand of the drug trade pay into mitigating the consequences of their actions. The fee goes toward paying for the grant programs under this bill, and after 2 years toward paying down the Federal debt.

The STOP OD Act also makes available grants for not more than \$75 million annually for 2 years to expand educational efforts to prevent opiate abuse, promote treatment and recovery, and promote the understanding that addiction is a chronic disease. The educational grants, coupled with the Naloxone grants, total \$450 million. That's the maximum grant allocation. In addition to the fee for drug offenses, this bill contains a pay-for to completely cover the maximum grant allocation. I worked with GAO to identify savings of at least \$500 million by extending the current data center consolidation initiative. That effort is set to sunset in 2018, but the STOP OD Act would authorize the extension of that program for 2 more years, and would put those savings toward these grants, which will save lives and prevent further addiction. This bill works on the front end and the back end to address this crisis. Naloxone can resuscitate a victim of overdose. Meanwhile, we can utilize the other grant pool to educate our communities about the dangers of these drugs. We need a multifaceted approach to tackling this problem. This legislation is an important step toward our shared goal: ending the opiate drug overdose epidemic that is ravaging our great Nation. Moreover, I want to note that, as of this week, my legislation has a total of 46 bipartisan cosponsors, exactly evenly split between Republicans and Democrats, and spanning 20 States. It's clear that no matter which side of the aisle you are on, your community has probably been affected by this epidemic, and you want to take even more action to address it. That's what I am seeing when talking to my colleagues, and the bottom line here is: this bill will do some good.

Thank you again for holding this hearing, and for inviting members outside the committee to weigh in and contribute our legislative proposals for your deliberation moving forward. I am happy to answer any questions regarding my legislation. I appreciate your time and consideration.

Statement for the Record by Rep. Ann McLane Kuster
Before the House Energy & Commerce Committee
October 11, 2017

Thank you Mr. Chairman, Ranking Member, and distinguished Members of the Committee.

I appreciate your willingness to allow all Members of Congress to speak about the opioid epidemic, one of the worst public health crises in recent memory.

In fact, the Acting Director of the Office of National Drug Control Policy recently called the national opioid and heroin epidemic the worst drug crisis in this nation's history. This statement was confirmed by provisional data recently released by the Centers for Disease Control and Prevention – 2016 will be the worst year on record for this crisis. Over 60,000 people died due to drug overdose in 2016, up by about 20% from 2015. CDC now believes that fentanyl is the leading cause of drug overdose death in this country.

My home state of New Hampshire knows too well the impact of fentanyl. In 2015, New Hampshire was first in the nation for fentanyl deaths per capita. Synthetic opioids are cheap to acquire and incredibly potent. As you know, fentanyl is about 50 times more powerful than heroin.

As the founder and co-chair of the *Bipartisan Heroin Task Force*, I am here to ask the members of this Committee to take a look to our comprehensive legislative agenda that we released this summer to address the opioid. Our agenda contains common-sense, bipartisan legislation to address many facets of the opioid crisis. Included are five bills under the jurisdiction of the House Committee on Energy & Commerce:

1. Jessie's Law (H.R. 1554) would help doctors be better informed about the patients they are treating by ensuring doctors have access to the history of addiction for a consenting patient. The bill was named after a Michigan resident who sadly died due to an opioid-related overdose.
2. Road to Recovery Act (H.R. 2938) would improve access to greater resources for states to help their communities resolve this crisis. Specifically, this bill would eliminate the Medicaid Institutes for Mental Diseases (IMD) exclusion for substance use disorder. While this law had good intentions, it has negatively impacted access to inpatient treatment. I will note that the Road to Recovery Act was recently supported by dozens of Attorney Generals, including the New Hampshire AG.
3. Synthetic Drug Awareness Act (H.R. 449) would require the United States Surgeon General to provide Congress a report on the public health effects of synthetic drugs, like fentanyl, used by people aged 12 to 18.

4. CRIB Act (H.R. 2501) would establish residential pediatric care centers within Medicaid to treat infants with neonatal abstinence syndrome (NAS).
5. STOP OD Act (H.R. 664) would authorize \$75 million in annual grants for two years to improve education efforts to prevent opioid abuse and promote treatment. The bill would also provide \$150 million in annual grants for two years to improve access to naloxone and its administration, as well as improve testing for fentanyl.

Through the collaborative work of my Co-Chair Rep. Tom MacArthur, and our Vice Chairs Reps. Donald Norcross and Brian Fitzpatrick, we have increased the profile of this crisis and the strategies we will need to combat this public health emergency.

Thankfully, the private sector and the federal government have improved the response to this crisis. Innovative new treatments from companies like Smiths Medical and their peripheral nerve block technology offers hope for a future where we are less reliant on opioids to treat pain.

Notably, the National Institutes of Health has created the “Public-Private Initiative to Address the Opioid Crisis.” This group has directed the vast research resources of NIH to this crisis. And through it, they have developed new treatments for chronic pain and new techniques for treating opioid addiction. We must continue to support these public and private efforts.

The *Bipartisan Heroin Task Force* stands ready to assist you all in creating a comprehensive strategy to address this crisis.

Thank you again for the opportunity to testify before you all about this issue.

Bipartisan Heroin Task Force's Legislative Agenda
for the 115th Congress

JESSIE'S LAW

H.R.1554

Sponsor: Rep. Tim Walberg (MI)

Cosponsors: 4

Co-Lead: Dingell

GOP: Jenkins (WV), Mooney

Dem: Swalwell

Committees: House Committee on Energy and Commerce

Status: Referred to the Subcommittee on Health

Related Bills: S.581

Description: A bill named after Michigan resident Jessie Grubb who tragically died of an opioid overdose last year. Jessie's Law would help ensure doctors have access to a consenting patient's prior history of addiction in order to make fully informed care and treatment decisions.

STEM THE TIDE OF OVERDOSE PREVALENCE FROM OPIATE DRUGS
(STOP OD) ACT
H.R.664

Sponsor: Rep. David Joyce (OH)

Cosponsors: 32

Co-Lead: Ryan (OH)

GOP: Barr, Bost, Comstock, Donovan, Duncan, LaHood, Faso, Katko, Kelly (PA),
Meehan, Renacci, Stefanik, Stivers, Turner

Dem: Blumenauer, Bonamici, Dingell, Evans, Kuster, Gabbard, Hastings, Jackson
Lee, Jayapal, Kaptur, Khanna, Kilmer, Serrano, Slaughter, Soto, Wasserman Shultz

Committees: House Committees on Energy and Commerce, Judiciary, Oversight and
Government Reform, and Armed Services

Status: Referred to Relevant Subcommittees

Related Bills: NA

Description:

1. This bill would authorize not more than \$75 million annually in grants for two years to expand educational efforts to prevent opiate abuse, promote treatment and recovery, and promote the understanding that addiction is a chronic disease
2. This bill would also authorize not more than \$150 million annually in grants for two years to provide access to Naloxone, training in the administration of the drug, and testing for Fentanyl.
 - a. This grant would be paid for in part by a fee of \$80, the same cost as one unit of Naloxone, attached to conviction for certain drug offenses (manufacture, distribution, and possession with the intent to distribute). This fee ensures the criminals enabling the supply and demand of the drug trade pay into mitigating the consequences of their actions. After two years, the funds collected go toward paying down the federal debt.
3. Pay For: This bill would extend data center consolidation efforts for two more years, generating about \$500 million in savings.

ADDICTION RECOVERY THROUGH FAMILY
HEALTH ACCOUNTS ACT

H.R.1575

Sponsor: Rep. Tom MacArthur (NJ)

Cosponsors: 1

Co-Lead: Clark

Committees: House Committee on Ways and Means

Status: Referred to the Committee on Ways and Means

Related Bills: NA

Description: This legislation would give family members the option of using funds in their Health Savings Accounts, Flexible Spending Accounts, or similar accounts to pay for addiction treatment for any relative, even if they aren't a dependent. Currently, you are not permitted to use funds in your tax advantaged accounts to pay for a family member's rehab unless they are your spouse, dependent, or a dependent relative. This legislation will make sure any family member struggling with addiction can be helped by a relative with these tax advantaged funds.

ROAD TO RECOVERY ACT
H.R.2938

Sponsor: Rep. Brian Fitzpatrick (PA)

Cosponsors: 15

Co-Lead: Murphy (FL)

GOP: Kelly (PA), Knight, MacArthur, Murphy (PA),
Tenney

Dem: Boyle, Brady, Clark, Courtney, Foster, Kuster, S.
Maloney, Norcross, Shea-Porter

Committees: House Committee on Energy and Commerce

Status: Referred to the Committee on Energy and Commerce

Related Bills: NA

Description: This bill would eliminate the Medicaid Institutions for Mental Diseases (IMD) exclusion for substance use disorder and help states expand access to inpatient treatment for Medicaid enrollees.

INTERNATIONAL NARCOTICS TRAFFICKING
EMERGENCY RESPONSE BY DETECTING INCOMING
CONTRABAND WITH TECHNOLOGY (INTERDICT)
ACT
H.R.2142

Sponsor: Rep. Niki Tsongas (MA)

Cosponsors: 4

Co-Lead: Fitzpatrick

GOP: Buchanan, Comstock

Dem: Ryan (OH)

Committees: House Committee on Homeland Security

Status: Referred to the Subcommittee on Border and Maritime Security

Related Bills: S.708

Description: Authorizes the appropriation of \$15 million for U.S. Customs and Border Protection (CBP) to fund new screening devices, laboratory equipment, facilities, and personnel for the latest in chemical screening devices and scientific support to detect and intercept fentanyl and other synthetic opioids.

SYNTHETIC DRUG AWARENESS ACT

H.R.449

Sponsor: Rep. Hakeem Jeffries (NY)

Cosponsors: 19

Co-Lead: Gowdy, Butterfield, Collins (NY)

GOP: Allen, Bilirakis, Comstock, Cramer, Donovan, Joyce,
King (NY), McKinley, Mullin, Olson, T. Rooney,
Sensenbrenner, Stefanik, Thornberry

Dem: Kuster

Committees: House Committee on Energy and Commerce

Status: Referred to the Subcommittee on Health

Related Bills: NA

Description: This bill would require the United States Surgeon General to submit a report to Congress on the public health effects of the rise in synthetic drug use among young people aged 12 to 18.

CARING RECOVERY FOR INFANTS AND BABIES
(CRIB) ACT
H.R.2501

Sponsor: Rep. Evan Jenkins (WV)

Cosponsors: 6

Co-Lead: NA

GOP: McKinley, Poliquin, Tipton, Turner

Dem: Clark, Ryan (OH)

Committees: House Committee on Energy and Commerce

Status: Referred to the Subcommittee on Health

Related Bills: S.1148

Description: The bill would establish residential pediatric care centers within Medicaid to treat babies with neonatal abstinence syndrome (NAS) exposure to opioids during pregnancy. This legislation would establish a provider type for NAS treatment centers clearly defining residential pediatric recovery centers. This legislation also includes an emphasis on residential pediatric recovery centers offering counseling to the mothers and families to help build those important connections from birth.

VA PRESCRIPTION DATA ACCOUNTABILITY ACT
H.R.1545

Sponsor: Rep. Ann McLane Kuster (NH)

Cosponsors: 11

Co-Lead: Wenstrup

GOP: Bergman, Costello, Poliquin, Walorski

Dem: Brownley, Esty, Peters, Sablan, Shea-Porter, Takano

Committees: House Committee on Veterans' Affairs

Status: **Passed the House**, Received in the Senate, and referred to the Committee on Veterans' Affairs

Related Bills: NA

Description: This bill would clarify current law to stipulate that the Veterans Health Administration (VHA) is required to disclose information to state-controlled substance monitoring programs for anyone – veteran or non-veteran – who is prescribed these medications through VA.

U.S. DEPARTMENT OF VETERANS AFFAIRS
PAIN CENTER OF EXCELLENCE

Sponsor: Rep. Ann McLane Kuster (NH)

Cosponsors: 1

Dem: Norcross

Committees: House Committee on Veterans' Affairs

Status: Pending Draft

Related Bills: NA

Description: The bill would establish a new Center of Excellence for research into pain. The Center of Excellence would provide coordination across VA's existing and innovative research programs on reducing the use of opioids and improving alternative treatments to pain. The Center of Excellence would also conduct new research, especially in prescriber education regarding pain and substance use. The Center of Excellence is inspired in part by NIH's Pain Consortium which coordinates Pain related research across the institutes of NIH.

PREPARED STATEMENT OF HON. STEPHEN F. LYNCH

Good morning. Chairman Burgess, Ranking Member Green, and members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to submit my testimony for the record, and thank you for holding this important hearing.

Mr. Chairman, my State of Massachusetts was hit early on and has suffered greatly from this crisis. In the late 1990's, South Boston saw a disturbing uptick in the number of teen deaths, many of which were related to Oxycontin and heroin abuse. At the time, I worked to help establish the Cushing House Recovery Home for Adolescents, a drug and alcohol rehabilitation clinic in South Boston for teenagers. This initiative was just one of the many that the Commonwealth, at the State and local levels, has undertaken as part of a multifaceted approach to tackling this problem. Other initiatives include instituting a Prescription Monitoring Program, making addiction treatment facilities and services more accessible, increasing awareness of the scope of the epidemic, working with doctors to reduce the length of time that they prescribe opioids, and supporting innovative intervention efforts to reduce the rate of overdose deaths.

Recent State statistics are showing that we are making an impact, but that we cannot afford to pull back on these efforts. In 2016, 2,107 citizens of Massachusetts died from an overdose. That level was an increase of 17 percent compared to 2015, which saw an increase of 31 percent, and 2014 in which the death toll rose by 40 percent. We cannot be satisfied with only slowing down the rates of death: we must instead double down on the effective and proven initiatives that are saving lives.

This brings me to the concerns I have that the Majority is pushing legislation that will undercut the efforts being undertaken both in my State and across the country. Recent bills to repeal the Affordable Care Act have included provisions that undermine Medicaid, which, according to the Kaiser Family Foundation, covers 3 in 10 nonelderly adults with opioid addiction. In addition, these bills would have allowed States to opt out of covering addiction treatment and the mental health services that are necessary to ensure that recovery is sustainable. Legislative actions such as these will only worsen the crisis and threaten the still-fragile progress that has been made so far. Separately, I am also concerned by the recent omnibus spending package that included a cut of \$306 million to the Substance Abuse and Mental Health Services Agency (SAMHSA). These cuts in funding and in coverage will only worsen the epidemic.

Mr. Chairman, our country lost nearly 60,000 of our fellow Americans to the opioid epidemic last year. We must ensure that we are doing everything in our power to provide those families and individuals who are battling addiction with the support and help they need to overcome this destructive disease. In particular, we must ensure that the programs and initiatives that can help them will be funded and available.

Thank you very much for the opportunity to testify.

DAVID B. MCKINLEY, P.E.
1ST DISTRICT, WEST VIRGINIA
2239 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
TEL: (202) 225-4172
FAX: (202) 225-7864
www.mckinley.house.gov
COMMITTEE ON
ENERGY AND COMMERCE
SUBCOMMITTEE ON
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Congress of the United States
House of Representatives

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October 10, 2017

The Honorable Greg Walden
Chairman
House Energy and Commerce Committee
2325 Rayburn House Office Building
Washington, DC 20515

Chairman Walden:

In preparation for the Energy and Commerce Committee's full committee meeting in October, I wanted to share the attached recommendations on ways Congress can address the opioid and heroin epidemic plaguing so many of our communities. These ideas have come out of dozens of meetings with stakeholders including community leaders, school administrators, health care professionals and law enforcement officials across West Virginia.

Three main proposals that should be highlighted for the committee are:

- Creating a real-time, national prescription drug program
- Modifying HIPPA to allow health care professionals to report patients who have suffered an overdose
- Removing the Medicaid IMD exclusion

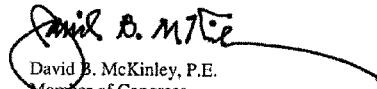
A real-time, national prescription drug monitoring program would allow local law enforcement officers to track the location of overdoses in their communities. This will help them in identifying particularly potent strains of drugs while also helping physicians to track the use of opioids by their patients.

A second recommendation would be to modify the Health Insurance Portability and Accountability Act (HIPPA) of 1996 to allow for reporting by health care professionals. Similar to proposals such as H.R. 1554, Jessie's Law, this recommendation would allow a medical professional to report a patient's overdose to allow for future treatment options.

Additionally, the Medicaid Institution for Mental Diseases (IMD) exclusion is preventing additional treatment facilities from opening across the country. A recurring theme that has been uttered by providers is the shortage of qualified treatment facilities for individuals who are addicted but wish to begin the recovery process. Removing this outdated restriction would allow states to work with treatment centers in ensuring that those who wish to seek recovery services are able to do so.

The attached list includes a number of good ideas in the areas of education, prevention, enforcement and treatment. Should you have any questions or require additional information, please contact my office at 202-225-4172.

Sincerely,



David B. McKinley, P.E.
Member of Congress

Enc.

DBM/ma

Policy Recommendations by Rep. David B. McKinley, P.E.

1. Education

- Create a real-time National Prescription Drug Monitoring Program. The database should provide the location of where overdose drugs (ex. naloxone) are administered. Allow for non-compliance in reporting requirements to impact reimbursements
- Develop a national Narcan database. Modeled off the Washington-Baltimore High Intensity Drug Trafficking Area (HIDTA). Perhaps as a requirement of receiving HIDTA funding.
- Institute a mandatory requirement for the existing prescriber workforce to undergo training on safe opioid prescribing and substance abuse disorders. Allow a qualifying physician, after one year, to request approval to treat an unlimited number of patients under specified conditions, including that he or she:
 - Agrees to fully participate in the Prescription Drug Monitoring Program of the state in which the practitioner is licensed
 - Practices in a qualified practice setting
 - Has completed at least 24 hours of training regarding treatment and management of opiate-dependent patients for substance use disorders provided by specified organizations.
- Creation of standardized treatment protocols and use of Medically Assisted Therapies and counseling
- Increase data collection, especially in rural communities.
 - Data drives decisions, an example of this is Huntington, West Virginia which has made great strides in searching for data
 - Each community is different and the ability to assist communities in gathering data would allow them and the federal government to make more informed decisions
- Require the Department of Veterans Affairs (VA) to use surveillance data base for narcotics

2. Prevention

- Increase the number of Substance Abuse Counselors in schools
 - Pleasants County, West Virginia has had a school-based mental health specialist for middle schools in place since 2004. They believe this is a crucial component to their success and have volunteered to serve as a model for other school districts
- Add a "drug" curriculum in schools

- Create multi-tiered drug education programs (ex. age-based)
- Slow or stop the legalization of marijuana. It creates mixed messages for young people as more communities legalize marijuana

3. Diagnosis

- Modify HIPPA regulations to allow hospitals/physicians to report patients who show signs of drug abuse or have experienced an overdose
- Create a HIPPA exception or require mandatory reporting for anyone who is fraudulently obtaining prescription medicine

4. Controlled Substance Act Changes

- Change the Uniform Control Substance Act's designation of Narcan from a drug that requires a prescription to one that can be purchased "over the counter" like in 14 other states.
- Reschedule more pharmaceuticals into the class referred to schedule II as defined in the Controlled Substances Act

5. Enforcement

- Continue funding the HIDTA program
- Increase funds to assist with Drug Court, Education and Law Enforcement-
- Increase the ability of local law enforcement to screen mail for drugs that come in from overseas. The drugs are changing so quickly that police dogs are unable to be trained to smell the drugs fast enough
- Work with local law enforcement to stop child trafficking in instances where children are trafficked in exchange for illegal drugs or opioids for their caregiver
- Reform criminal sentencing requirements upon the successful completion of a drug court participant
- Increase sentencing for drug dealers

6. Treatment

- Remove or change the Medicaid Institution for Mental Diseases (IMD) exclusion which is preventing more treatment facilities from opening

- Allow states to utilize section 1115 waivers to provide services not typically covered by Medicaid or allow states to individualize their Medicaid programming/ services
- Increase drug treatment centers. Limit of drug treatment paid by private providers
- Create outpatient model for treatment plans. Focus on long-term care/rehabilitation
- Allow an addiction recovery specialist to follow-up with the individual who has overdosed to engage his/her interest in going to a rehabilitation center for treatment
- Create incentives for more individuals to pursue careers as additional mental health and behavioral specialists. Allow for additional incentives for those that practice in areas of particular need
- Increase federal funding for drug courts. Allow a criminal record to be expunged after successful completion of a drug court program
- Create a Good Samaritan Law for Naloxone users
- Increase partnerships with faith based treatment (ex. AA)
- Focus on harm reduction treatments (ex. needle exchanges)
- Tax on the sale of legal drugs prescriptions and designate that funding for rehabilitation centers

PREPARED STATEMENT OF HON. RICHARD M. NOLAN

Chairs Walden and Burgess and Ranking Members Pallone and Green,
Thank you for inviting me to submit testimony for today's House Energy and Commerce Subcommittee on Health's Member Day.

Make no mistake about it—the abuse of opioids and other prescription drugs has become an epidemic and a crisis of major proportion in this country.

According to the latest figures from the Department of Health and Human Services, 33,000 people die every year from overdoses.

And 12.5 million people misuse and abuse opioids and prescription drugs every year.

The fact is—in just a very few generations, we've increased the life expectancy in this country from less than 50 years to nearly 80. And the Centers for Disease Control recently concluded that our life expectancy would be even higher but for this epidemic of prescription drug misuse.

With all that in mind—there is probably no more innovative or successful intervention program in the country than the community-based model being undertaken in Minnesota by CHI—St. Gabriel's & Morrison County Prescription Drug Abuse Project.

Their model—which at my invitation has been presented to Congressional staff twice now—has produced tremendous results by bringing together doctors, nurses, pharmacists, social workers, law enforcement, home health and skilled nursing professionals and educators in the communitywide effort you will hear about today.

The results speak for themselves.

In the community of Little Falls, the four participating pharmacies have experienced a 23 percent decrease in controlled substance prescriptions.

324 patients have tapered off controlled substances entirely, primarily through the use of suboxone.

And what that means is—370,000 fewer controlled substances have entered the community since the program began. At about \$7 per dose, that's a savings of about \$2.6 million every year for patients in Morrison County.

And what's more, in the first 8 months of the program alone, pain went from the number one reason people were being admitted to the Emergency Room—to not even in the top 20.

The fact is, doctors are not only managing pain better, but they are doing it with many new and effective options that don't include long term use of narcotics.

This program has become a model for our entire Nation, and I wanted to share it with the committee today for their awareness and examination.

In closing, thank you for convening this hearing today—and helping us all move forward to put an end to this crisis that is affecting so many lives and families and communities.

PREPARED STATEMENT OF HON. NIKI TSONGAS

Mr. Chairman, Ranking Member, and members of the House Committee on Energy and Commerce Subcommittee on Health, thank you for the opportunity to submit testimony today on the opioid epidemic, a health crisis indiscriminately affecting communities across this country.

In my home State of Massachusetts, there were an estimated 2,107 opioid-related deaths in 2016, an increase of over two-hundred percent in the last 10 years. To put that increase in perspective on a national level, according to news reports, in 2016, more Americans died of drug overdoses than have ever died from car crashes, gun violence, or HIV/AIDS during any single year.

Thanks to the work of this committee, Congress has taken several steps to begin to address this crisis, but the stunning rise in opioid misuse, addiction and deaths calls on us to do more.

When people become addicted to painkillers, and then lose access to their prescription drug, many turn to illegally obtaining cheaper, more potent opioids such as heroin and synthetic drugs.

According to the most recent data from the Centers for Disease Control and Prevention, across the United States, over 21,000 overdose deaths were caused by synthetic opioids between February 2016 and February 2017, twice as many as the previous 12-month period. One of the leading contributors to this number is fentanyl, a deadly synthetic opioid that can be up to 50 times stronger than heroin and 100 times more powerful than morphine. Fentanyl has become the leading cause of overdose deaths nationwide, surpassing heroin in the summer of 2016.

Although pharmaceutical fentanyl can be misused, most fentanyl deaths are linked to illicitly manufactured fentanyl and illicit versions of chemically similar compounds known as fentanyl analogs.

In Massachusetts, the proportion of overdose deaths attributed to fentanyl is rising at a meteoric rate. At its lowest, in the third quarter of 2014, fentanyl was present in 18 percent of opioid-related deaths in Massachusetts. However, in 2016, fentanyl was present in a staggering 69 percent of the State's opioid-related deaths, resulting in 1,400 fentanyl-related deaths in the Commonwealth.

The primary sources of fentanyl are outside the United States, principally Mexico and China. The drug is smuggled across the U.S. border or delivered through the mail or private carriers. Fentanyl can also be ordered online. And because of its extreme potency, fentanyl typically comes in small amounts, making it more difficult for authorities to detect.

That is why earlier this year I introduced bipartisan legislation with Congressman Brian Fitzpatrick (R-PA) to provide Customs and Border Protection (CBP) with the latest in chemical screening devices and scientific support to detect and intercept fentanyl and other synthetic opioids.

Not only would these devices allow law enforcement to detect and confiscate fentanyl before it enters the United States, but it would also protect law enforcement officers on the front lines from exposure to the deadly narcotic, which is so powerful that coming into contact with just a few grains can be fatal.

The House Committee on Homeland Security recently passed our bill, the International Narcotics Trafficking Emergency Response by Detecting Incoming Contraband with Technology, or INTERDICT, Act by voice vote and we are now urging House leadership to bring it to the floor.

The INTERDICT Act would be an important step towards stemming the rapid influx of illicit synthetic opioids, including fentanyl. However, to most effectively have an impact on this heart-wrenching epidemic, we must establish a comprehensive, fully funded plan at the local, State, and Federal level. Congress must continue to demonstrate its commitment to ending this epidemic by supporting the programs, agencies, organizations and individuals on the front lines.

We cannot afford to let our friends, family members and neighbors suffer under the burden and stigma of addiction and mental illness—especially given the scope and magnitude of the issue nationwide. My colleagues from all parts of the country, both Democrats and Republicans, have heard similar stories from their districts and we owe it to our communities to do all we can to head off this national epidemic.

10/10/2017

Wilson sees 2 recent heroin, opioid overdose deaths | The Wilson Times

The Wilson Times

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Wilson sees 2 recent heroin, opioid overdose deaths

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Posted Thursday, August 17, 2017 11:18 pm

By Olivia Neeley | olivia@wilsontimes.com

Law enforcement has seen an uptick in heroin and opioid overdoses, including two deaths in the past two weeks.

Wilson police have seen more than five overdoses in the past several days within the city, prompting officials to warn the community of the drugs' danger.

"Our community has suffered at least two fatal overdoses from heroin/opioid use," Capt. Kendra Howell said. "In the abundance of caution for everyone, it is imperative that we recognize the dangers of this drug and drug usage. The danger of this has always been real. However, the recent overdoses have been alarming."

Howell said officials are currently investigating the overdose deaths.

Authorities are urging everyone to avoid contact with heroin and/or opioids that may be available. Howell said heroin is a highly addictive drug both physically and mentally.

"A one-time experimental use could be at least addictive and the worst - deadly," Howell said. Heroin/opioid-type narcotics can be transdermal (absorbed through the skin) which creates a danger to anyone who touches it.

Howell said police are urging residents not to touch a substance they believe to be heroin. Instead, people should call 911 immediately.

Each Wilson Police Department patrol shift as well as sheriff's deputies are armed with naloxone - a life-saving antidote that reverses opioid overdoses. Howell said police officers have administered naloxone recently.

"We are working diligently to rid our streets of those type of drugs," she said.

SHERIFF'S OFFICE

The Wilson County Sheriff's Office has responded to nine overdose calls within the past three weeks, four of which were heroin-related, four were prescription-related and the remaining one was due to a suicide attempt, according to Wanda Samuel, sheriff's office chief of staff.

She said deputies have not had any fatal overdoses in the county during that period of time.

Sheriff Calvin Woodard said his office has also noticed an increase in heroin use within Wilson County.

"However, we are doing our part in removing drug dealers from our community and providing community resource information to overdose victims and their families," Woodard said. "We as law enforcement can't solve this problem alone, but ask for the families, friends and community to assist us by becoming familiar with the resources that would provide treatment for the abuse victim."



Comments

10/11/2017

As overdoses surge, agencies joining forces to help heroin, opioid addicts | The Wilson Times

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As overdoses surge, agencies joining forces to help heroin, opioid addicts

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(uploads/original/1503461185_8cc9.jpg)

Use of heroin has spiked in Wilson County, across North Carolina and the nation.
PHOTO ILLUSTRATION BY DREW C. WILSON | TIMES

Posted Wednesday, August 23, 2017 12:07 am

By Olivia Neesley | olivia@wilsontimes.com

In the last six weeks, officials have seen an upswing in heroin and opioid overdoses. They've also had two deaths believed to be a direct result. And the trend has been alarming.

On average, Wilson County Emergency Medical Services personnel administers naloxone - a life-saving antidote which reverses an opioid overdose, about 30 times per quarter. But the past six weeks has been different.

Medics have administered the antidote on 28 patients, reversing a suspected opiate overdose in 12 uses, said Chris Parker, EMS clinical affairs officer.

"That puts us on pace for twice what we have been on average," Parker said. "There is a definite increase in opiate use in Wilson County."

Naloxone is only effective on those in an opioid situation, but it does not harm those experiencing a different type of overdose. The increase in overdoses here in a such a short amount of time prompted Wilson police to warn the community of the drugs' danger last week.

Police say they are currently investigating the two heroin/opioid-related overdose deaths. There have been no deaths reported in the county as a result of overdoses.

Across the state, there were 500 opioid diagnoses in overdose emergency department visits in July, compared to 410 during that time last year, according to state figures. Also statewide, there were 527 heroin diagnoses in overdose emergency department visits last month, compared to 232 during July 2016.

<http://www.wilsontimes.com/stories/as-overdoses-surge-agencies-joining-forces-to-help-heroin-opioid-addicts,93159>

1/3

10/11/2017

As overdoses surge, agencies joining forces to help heroin, opioid addicts | The Wilson Times

Officials say during Wilson's six-week span, the overdose patients range widely in ages, including one as young as 13 suspected of a heroin/opioid overdose.

Police officers and sheriff's deputies are armed with naloxone kits thanks to a grant funded by the Healthcare Foundation of Wilson. Parker said he and EMS staff spent Tuesday morning training more law enforcement on how to administer the antidote.

While EMS is equipped with naloxone and its medics are usually first on the scene, arming law enforcement provides an extra level of protection. Officials have said law enforcement has administered naloxone in the past several weeks, too.

DON'T BE AFRAID TO CALL

Parker said he also believes that there are more overdoses occurring than first responders know about due to naloxone's availability.

"There are more overdoses that are happening that are being reversed by family and friends," he said.

But drug users aren't calling 911. He said even if you have a naloxone kit at home and administer it, officials still want you to call 911.

"There is always a chance it can wear off," he said about the reversal antidote. "If they call us, nobody is getting in trouble. No one is showing up there to arrest somebody. We want to help the people who are addicted to these drugs."

Parker said EMS, law enforcement and others continue to band together during calls where they know people who are addicted to the powerful drug desperately need help.

And together, they've been able to provide resources.

"Between us, law enforcement and the community as a whole, we want to try and help these people get help," Parker said. He said while EMS' duty is to make sure people are OK medically, the agency has also partnered with others in the community to ensure they can provide an avenue for patients to get the help they desperately need.

"The community is really coming together to find alternative ways to help people," he said. "It takes all of us."

Officials continue to spread the word regarding North Carolina's Good Samaritan law, which provides criminal and civil immunity to bystanders who call for emergency help and attempt to render aid during an overdose. Law enforcement officials say they don't want people to be afraid to reach out or have fear of being prosecuted when there is a life-and-death situation.

INITIATIVES UNDERWAY IN WILSON

There are several initiatives multiple agencies are working on to combat the problem in Wilson. From law enforcement to health agencies, as well as the Wilson County Substance Prevention Coalition, a united front has emerged.

Programs include the Wilson Police Department's Hope Alliance program, which is modeled after the Nashville Police Department's Hope Initiative. The program here will be a safe way for opioid and heroin addicts to get help without fear of being arrested or prosecuted as well as connecting those individuals to vital community resources.

Hape Alliance has many partners including the Willson County Substance Prevention Coalition, Wilson Medical Center's behavioral health department and Eastpointe. The goal is to reduce the barriers to substance abuse disorder treatment. A person who is ready to enter into detox or residential treatment will have an opportunity to seek help through the Wilson Police Department and its partners.

Many other programs are underway, too, including a syringe exchange program which will be headed up by the Wilson County Health Department along with partner agencies.

The Wilson County Substance Prevention Coalition also received more than \$150,000 in grant money from the Healthcare Foundation of Wilson last week to support a Community Recovery Resource Center for Wilson residents who suffer from substance abuse disorders. The center's role will include helping young adults address substance abuse, maintain their recovery and increase employment.

Mike and Becky Cannon, who founded the ICANS Foundation after their son, Jonathan, died as a result of a heroin overdose in 2015, are also a part of the growing number of people who are reaching out to those suffering from addiction. They too will be a part of the many initiatives in Wilson.

The Cannons, along with law enforcement and other community leaders, recently completed Recovery Coach Academy training, which was led by Recovery Communities of North Carolina. The 30-hour training, held at Barton College, was sponsored by the Wilson County Substance Prevention Coalition and Eastpointe. Recovery coaches help others initiate and sustain addiction recovery within the community.

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Elasticity of Consumption: Evidence from the U.S.

The New York Times

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A Choice for Recovering Addicts: Relapse or Homelessness

By KIM BARKER MAY 30, 2015

After a lifetime of abusing drugs, Horace Bush decided at age 62 that getting clean had become a matter of life or death. So Mr. Bush, a homeless man who still tucked in his T-shirts and ironed his jeans, moved to a flophouse in Brooklyn that was supposed to help people like him, cramming into a bedroom the size of a parking space with three other men.

Mr. Bush signed up for a drug-treatment program and emerged nine months later determined to stay sober. But the man who ran the house, Yury Baumbilit, a longtime hustler and two-time felon, had other ideas.

Mr. Baumbilit got kickbacks on the Medicaid fees paid to the outpatient treatment programs that he forced all his tenants to attend, residents and former employees said. So he gave Mr. Bush a choice: If he wanted to stay, he would have to relapse and enroll in another program. Otherwise, his bed would be given away.

“Do what you do’ — that’s what he told me,” Mr. Bush recalled.

Mr. Bush, rail-thin with sad eyes, wanted to avoid the streets and homeless shelters at all costs. He turned to his self-medication of choice: beer, with a chaser of heroin and crack cocaine. Then he enrolled in a new program chosen by Mr. Baumbilit.

In the past two and a half years, Mr. Bush has gone through four programs, just to hold onto his upper bunk bed.

Mr. Bush had fallen into a housing netherworld in New York City, joining thousands of other single men and women recovering from addiction or with nowhere to go. The homes are known as “three-quarter” houses, because they are seen as somewhere between regulated halfway houses and actual homes.

Virtually unnoticed and effectively unregulated, the homes have multiplied over the past decade, driven by a push to reduce shelter rolls, a lack of affordable housing and unscrupulous operators.

One government official estimated recently that there could be 600 three-quarter houses in Brooklyn alone. But precise numbers are elusive. The houses open and close all the time, dotting poor neighborhoods mostly in the Bronx, Brooklyn and Queens.

The homes, often decrepit and infested with vermin, overflow with bunk beds and people. Exits are blocked and fire escapes nonexistent. The homes are considered illegal because they violate building codes on overcrowding. Many have become drug dens, where people seem almost as likely to die of overdoses as they are to move on to a home of their own.

Opportunistic businessmen like Mr. Baumbilit have rushed to open new homes, turning them into vehicles for fleecing the government, an investigation by The New York Times found. The target is easy: vulnerable residents whose rents and treatments are paid for with taxpayer money.

Yet three-quarter homes are tolerated and even tacitly encouraged, pointing to a systemic failure by government agencies and institutions responsible for helping addicts and the poor.

Reputable hospitals, treatment programs and shelters regularly send people to the homes. So does the state’s Department of Corrections and Community Supervision. The city’s Human Resources Administration pays operators the \$215 monthly rent, known as a “shelter allowance,” for many tenants. The state’s Office of Alcoholism and Substance Abuse Services hands out millions in Medicaid money for their treatment.

But for years none have paid attention to what happens inside. There are no regular inspections. No requirements. No registry. The city's Department of Buildings, overwhelmed and ineffectual, often fines the landlords, but the city does little to collect.

The system, such as it is, dooms tenants to a perpetual cycle of treatment and relapse, of shuttling between programs and three-quarter houses.

"The city knows it's happening," said Paulette Soltani, who works at the Three-Quarter House Tenant Organizing Project, which advocates better housing conditions. "The city is sending people to these homes, but the city is not regulating these homes."

Over the past six months, The Times pieced together information about Mr. Baumbli's operation through interviews with more than 85 current and former tenants, a review of thousands of pages of court and medical records and a database of housing payments from the city's Human Resources Administration.

Steven Banks, commissioner of the Human Resources Administration, said on Friday that his agency had recently started investigating several three-quarter-home operators, including Mr. Baumbli's company.

"Unfortunately the state rental allowance for a single adult is \$215," Mr. Banks said. "And given the dynamics of the housing market in New York City, there are landlords that victimize our clients because all they can afford to pay is the shelter allowance."

Mr. Baumbli's company, the Back on Track Group, is not the biggest in the three-quarter housing world. But the paper trail on him offers a detailed look at how such a business works and how little scrutiny it gets. Among advocates and tenants, Mr. Baumbli has acquired a reputation as a particularly brutal operator.

He and his employees at Back on Track declined to comment. But Matthew S. Aboulafia, a lawyer for Mr. Baumbli, said on Wednesday in written responses to questions from The Times that Back on Track provided a service, and had not

acted illegally. Mr. Aboulafia also said that the company did not receive kickbacks from treatment providers and denied that any residents were told to relapse.

Mr. Bush was one of about 120 people who lived at any one time in Mr. Baumblyt's biggest operation, a row of six identical beige houses on New Lots Avenue in East New York, Brooklyn. Like Mr. Bush, some were addicts. Others were simply homeless, people who did not need treatment but who wanted to avoid the shelter system. Some had serious mental illnesses.

Birshon Daley, 34, who has paranoid schizophrenia, moved onto New Lots more than three years ago. Fond of wearing an orange lei and blasting Spanish lessons on a boombox, he appeared to hear voices and responded to questions not asked. He spoke in non sequiturs, such as: "I have a dysfunctional friend. I'm good at math."

Mr. Daley was one of 10 people in his apartment. He slept in a bottom bunk, on a grimy mattress with no sheets, in a room so run-down that the doorknob was a dirty sock tied through a gaping hole. At Mr. Baumblyt's request, Mr. Daley said, he made a house manager responsible for administering his disability check. Mr. Baumblyt took the money for rent and then gave Mr. Daley an allowance.

"Five dollars a day," Mr. Daley explained. "After cleaning the yard, taking out the trash."

Mr. Baumblyt, 64, a bald fire hydrant of a man who sports a yellow windbreaker and a blue baseball cap, even in winter, evicted tenants on a whim, they said. He threatened others if they fiddled with the thermostat, if they used the gas burners for heat, if they did not do their chores or obey the rules. At one house, he forced a recovering crack addict to sleep on the hardwood floor for months, and removed the couches as punishment. At another, he head-butted a man.

But residents had little recourse. Mr. Baumblyt was more than their landlord. He was their overseer, their guardian. He determined whether they had a home.

The Landlord

In 1981, Mr. Baublitz left Russia for Brighton Beach, a Russian enclave in Brooklyn.

He opened a deli there but was sued by his partner, who wanted to dissolve the business and accused Mr. Baublitz of forging her signature on checks and slapping her. An import business he invested in barred him from entering its offices for what the company's lawyer described as an "unprofessional demeanor."

An avid gambler, Mr. Baublitz at one point went on a spree in Atlantic City, cashing \$880,000 in bad checks at five casinos, according to court records. He was ordered to pay the money back, but it was unclear how much progress, if any, he had made.

Mr. Baublitz went on "disability retirement" in 2000, according to a doctor's note in a court filing five years later. (Mr. Aboulafia said on Wednesday that his client, who had a heart attack in 2002, had not gone on federal disability until 2012.)

Behind the scenes, though, Mr. Baublitz began running medical clinics with his wife, Rimma.

In late 2005, the state accused the Baublitzs of being the masterminds in a plot to use their clinics to defraud insurance companies with fake injury claims. Eliot Spitzer, then the state attorney general, said the couple would be "prosecuted to the fullest extent of the law."

Though facing up to 25 years in prison, the Baublitzs embarked on a new business, one in which they did not have to deal with government regulators.

Three-quarter houses, also called sober or transitional homes, are a product of the murky world of outpatient substance abuse treatment for the poor. Their numbers have grown in the past decade, as the administration of Mayor Michael R. Bloomberg pushed to reduce shelter rolls and the economy sank.

The homes promise a better future, with aspirational names like Freedom House and Miracle House. But sex offenders live in some three-quarter homes. Fires have damaged others. In May 2014, parole officers sent a mentally ill man to

a three-quarter house run by a group called MCM Faith. Nine days later, in a crime that attracted widespread attention, he fatally stabbed a boy and injured a girl in an elevator of a Brooklyn housing project, the police said.

No one knows exactly how many of these homes exist today. Robert Kent, chief counsel for the state substance abuse services agency, mentioned a colleague's estimate that there might be 600 in Brooklyn, while testifying in a case involving three-quarter homes in December. Mr. Banks, of the Human Resources Administration, said that the figure seemed high but that the homes are difficult to track because "they pop up and go away."

The troubled people who wind up in the homes have few options. Many see the city's shelter system as even more dangerous. Single people on public assistance have received the same housing allowance since 1988, \$215 a month, not enough for much of anything in a city where the median monthly rent is more than \$1,200.

In 2007, companies controlled by the Baumblits rented out three houses on Miller Avenue in East New York, marking the couple's start in the business. People on public assistance were charged only their housing assistance checks. But anyone on disability — and, increasingly, Mr. Baumblit sought out such tenants — paid a total of \$300 a month.

Mr. Baumblit then made deals with treatment providers and required his tenants to go where he told them, according to tenants and former employees. By law, people are supposed to be able to choose their own provider.

A few people in Back on Track did not have to attend a group, tenants said, but they had to pay more in rent — \$450 a month.

After pleading guilty to two felonies in the insurance-fraud scheme, Mr. Baumblit was sent to jail for three months in September 2009. His wife pleaded guilty to one felony and served nine days in jail.

Soon, the couple's three-quarter homes began drawing complaints. In December 2010, MFY Legal Services, a nonprofit that has represented three-

quarter-house tenants, filed a class-action lawsuit that is still continuing.

But Mr. Baumbilit bulldozed through such problems.

A week after the lawsuit was filed, the Baumbilit formed a new company, Steps to Better Living, which ran the homes for more than a year. Soon after a fire at a Steps to Better Living home in Queens in April 2012, the Baumbilit formed the Back on Track Group.

The Addict

In November 2012, Mr. Bush landed at New Lots, just off the end of the No. 3 subway line in Brooklyn, in one of the city's most violent neighborhoods.

His road to Back on Track was not unusual. Mr. Bush grew up in an abusive home in the Bronx, the son of an alcoholic former Marine and the woman he beat. At 6 or 7, he started drinking alcohol. At 15, he started using cocaine and heroin. At 26, he first tried to quit. At 55, he saw his first psychiatrist.

"Mr. Bush is friendly with melancholy disposition," an evaluation report from one inpatient center said, noting he had depression. "His persona is grieving."

Mr. Bush, a former construction worker and handyman, said he learned about Back on Track at Mount Sinai Beth Israel's inpatient rehabilitation program. A Back on Track staff member made a presentation for patients "and asked if anybody cared to go to this place," he recalled.

Soon after, Mr. Bush moved into the lower apartment at 698 New Lots Avenue. He brought with him a few bags and a talisman, a tiny red stuffed bear that came with a Russell Stover chocolate box, which he had bought for himself one Valentine's Day to celebrate more than a year of sobriety. The bear, dubbed Russell, was a reminder to Mr. Bush of when he was doing well. He liked to talk over his problems with Russell, because Russell didn't talk back.

Back on Track worked hard to snag men like Mr. Bush. Over the years, the company's staff members visited inpatient programs, rehabilitation centers and

hospitals, promoting Back on Track as the next step in recovery. They said they would help addicts with housing, treatment and job placement.

Tenants said that reputable places had referred them: inpatient programs like Arms Acres in Carmel, N.Y., and Samaritan Village in New York; nonprofit advocacy groups like the Fortune Society; hospitals like Mount Sinai St. Luke's. Six tenants said they were sent by the Bowery Residents' Committee, a nonprofit that helps homeless people in Manhattan. Six others were sent by Narco Freedom, the largest Medicaid outpatient substance-abuse-treatment provider in the city.

One man said he was one of 30 picked up from a Salvation Army in Newark by Mr. Baumbli's employees in two vans.

It is not clear how much the referring organizations knew about Back on Track's business model. Officials said in interviews that they recommended three-quarter houses because there was nowhere else.

"Three-quarter houses are, in my opinion, the frying pan for people who are in the fire," said JoAnne Page, president of the Fortune Society, which helps people coming out of prison. "Many of them are firetraps, many are very dangerous and many are brutally exploitive. They crowd people beyond anything they could justify. But they are better than what else is out there, so we use them reluctantly."

Back on Track gave residents letters to hand to the city's Human Resources Administration, listing the address where the city could send the rent and a photograph of a country estate with a manicured lawn and a stately porch.

In reality, bunk beds with dirty, cigarette-scarred mattresses blocked windows. Mold stained the ceiling of a bathroom at New Lots. Bureaus were missing drawers. Some homes had broken sinks, holes in the wall and other problems requiring tenants to be creative: A clothes hanger could flush a toilet.

One resident at another Back on Track house caught two mice with the same trap at the same time, naming them Mickey and Minnie. Others made videos of bed bugs crawling on walls and beds.

Each of the six houses at New Lots had two apartments with three bedrooms. The two larger bedrooms each slept four people; two others shared a bunk bed in the tiniest room, which had no window. Two apartments housed women.

“No standing in front of facility,” warned a rule sheet in each apartment. “No Hanging out in front of the beauty Salon. No Hanging out in front or near Gas Station. You will be discharged if caught near these locations.”

The tenants rarely complained, not if they wanted to stay. The homes were revolving doors of people kicked out in the middle of the night or early morning. “Sheets, pillow, blanket,” Mr. Baumblyt would tell a house manager, a recovering addict paid \$75 a week. That was the signal to strip the bed and pack up a person’s belongings in garbage bags.

Mr. Aboulafia said residents were not allowed to touch the thermostats because they would “likely break from constant changes.” He argued that the owners of the buildings were responsible for making sure they met code — not Back on Track, which rents the buildings. Back on Track’s lawyers have said in housing court that the company had the authority to evict residents for any reason, at any time, but judges have rejected that argument.

Mr. Bush did not want to return to the shelter system, where he had been beaten and robbed. He did not want to move in with his sister, who lived down South.

So he did what he was told. Mr. Bush made his sliver of his room his home, setting up a computer out of parts scavenged from the garbage. There, he wrote his thoughts in a file called “My Daily Writings.” Russell the bear was perched above.

Mr. Baumblyt first sent Mr. Bush to an outpatient program called New York Service Network. Within five months, he was given a letter that said he was doing well, with “consistent negative toxicology results.” Medicaid paid out almost \$13,000 for Mr. Bush to attend the program an average of four times a week, records show.

Joseph LaBarbera, New York Service Network's lawyer, denied that the program paid Mr. Baumbilit money for clients. A ProPublica article from 2013 about the treatment program raised similar allegations.

No one at Back on Track helped Mr. Bush with permanent housing, and by the time he was supposed to graduate from New York Service Network in August 2013, he had no place to go.

'Go to Group'

Around 4:30 a.m. on weekdays, Mr. Baumbilit usually left his five-bedroom house a block from Brighton Beach, and headed for New Lots in a leased black Mercedes sedan that retails for nearly \$100,000.

With his right-hand man, Edwin Elie, Mr. Baumbilit checked to see if tenants had submitted slips proving they had attended their addiction treatment support groups the previous day. He ordered a house manager to wake those who had not. "Go to group," Mr. Baumbilit told them.

"The slips is how he proves people went to group," said a former house manager, who spoke on the condition of anonymity because he feared retaliation. "In passing, he mentioned, 'If I don't get my slips, I don't get paid.'"

The former house manager's assertion was backed up by other former employees and tenants.

Group was everything. Tenants still recovering from surgery had to go. Even non-addicts had to go to group or pay extra. Some said they were told to drink a couple beers on their way to a new program so they would test positive for alcohol.

A dozen sober residents of New Lots told The Times they were still forced to go to group, including a minister who had lost his apartment in a flood; a chef who was unable to keep his job because he had to go to group almost daily; and a dishwasher who said he was sent to Back on Track after complaining about the conditions at his homeless shelter.

"I don't need those groups, not at all," said the chef, Portland Ramseur, 52, who last used crack cocaine eight years ago and went to Back on Track after his company failed and he lost his apartment. "It's a waste of my time. It's stopping me from getting on my feet."

Once tenants finished their treatment program, most were evicted. But a dozen tenants said they had been told, by Mr. Baumblyt or Mr. Elie, to relapse. They were the recyclables, constantly shuttling through programs.

"Either Mr. Ed will come and tell you or Mr. Yury will come and tell you, 'You know that your time is almost up, and we'll have to move you out, or put you someplace else. And to get someplace else, you have to have a relapse, maybe even go into detox,'" Mr. Bush recalled. "And then they'll put you back into a program, and they'll get your Medicaid authorization back up. And they work on you from there. And you just keep going around and around."

In August 2013, after Mr. Bush relapsed to keep his bed the first time, Mr. Baumblyt sent him to Narco Freedom.

Several months later, Mr. Bush was sent to Canarsie Aware, a small nonprofit. Then, in April 2014, Mr. Bush enrolled in NRI Group, a slightly larger for-profit program in Midtown Manhattan.

Even though the programs had different names, the same cluster of people controlled them, according to court records. Medicaid paid a total of almost \$20,000 for Mr. Bush's treatment at the three programs, records show.

Officials from NRI and Narco Freedom, which has since changed management, did not return calls asking for comment on their relationships with Back on Track. Patricia Charles, the program director of Canarsie Aware, said she did not know of any arrangement. She referred questions to Anthony Cornachio, the executive director of Canarsie Aware and an owner of NRI, who did not return repeated calls.

For all these programs, the goal was volume, because Medicaid did not pay much. The hourlong sessions were available for up to 12 hours a day, even on

Christmas and Thanksgiving.

At NRI, groups were so important that if an English-language group was full, clients who only spoke English could go to a Spanish-language one.

Another tenant, who worked as a house manager for Mr. Baumblyt and spoke on condition of anonymity because he was afraid of retribution, said he had also been told to relapse. Like Mr. Bush, he had attended four programs. But this man said Mr. Baumblyt had given him \$20.

“He’d give you money and say, ‘Do what you do,’” the man said.

Some residents said they pretended to relapse to get into a new program.

Modesto Cotto, 47, graduated from Canarsie Aware on Aug. 21. Two weeks later, Mr. Cotto signed up at NRI, lying to intake workers about relapsing because he wanted to keep a roof over his head. “I wasn’t giving up my sobriety,” he said.

Even just a small bender was a psychological blow for tenants struggling to keep their new sobriety in the face of temptations that had always won out in the past.

“Oh, my demons — I fight and I fight and I fight and I lose,” Mr. Bush said. “And Mr. Yury takes advantage of it. This whole three-quarter system does. It’s made for us to fail.”

The Officials

In October 2011, a caller asked the city’s Department of Buildings to inspect the “illegal living spaces” at one of Mr. Baumblyt’s houses for women in Queens.

Five weeks later, an inspector knocked on the door but a woman refused to let him inside. After another failed try, the complaint was closed. In April 2012, a fire gutted the basement. Only then was the house shut down.

New York’s safety net for the poor relies on three-quarter homes to solve a problem: They take in the people no one else wants. Yet, essentially, nobody

regulates these homes.

The city's Human Resources Administration paid Back on Track \$148,000 in housing assistance in 2014. But it does not usually examine landlords' backgrounds. It often mails checks to anonymous limited-liability companies at post office boxes.

As a way to identify operators of three-quarter homes, Mr. Banks said the agency had in the last year begun looking at places that housed more than 10 people on public assistance. But so far, despite opening several investigations, the department has not taken action against anyone.

The state Office of Alcoholism and Substance Abuse Services regulates supportive housing for people in treatment. But it does not approve three-quarter houses, because they do not provide any services.

"These houses are not something that we regulate or certify," Mr. Kent, the chief counsel for the agency, said in an interview on Thursday. "And they are pretty strict and restrictive on letting people in who don't live there."

Parole officers often visit parolees at three-quarter homes, overlooking the fact that most tenants have rap sheets and that parolees are not supposed to knowingly be around anyone with a criminal record. A spokeswoman for the corrections department said "all parolee residencies are closely monitored by parole officers."

The main people responsible for checking conditions at the homes are inspectors from the city's Department of Buildings and Department of Housing Preservation and Development, agencies inundated with complaints.

But even when inspectors do get inside and find problems, little changes. Buildings Department inspectors have fined the owner of the six New Lots buildings more than \$145,000 since August 2010. Eighteen of those 22 violations were considered "immediately hazardous," for overcrowding and failure to have proper exits.

Nothing was paid. Nothing was done.

The housing preservation department, responsible for investigating renters' complaints, is similarly impotent. Of 28 complaints in the past year, only three led to violations being issued. But tenants photographed many of the problems, including peeling plaster, a ceiling leak and a bad bathtub faucet.

At a City Council hearing in 2009, the chief of fire prevention for the Fire Department called for a list of three-quarter homes to help firefighters know if a home was overcrowded or had blocked exits.

Still, no list exists.

In 2009, Bill de Blasio, then chairman of the Council's general welfare committee, pushed for guidelines to prevent shelters from referring people to three-quarter homes with building violations. The measure passed the following year.

But as the city's housing crisis has worsened, shelters have continued to send people to Back on Track.

Four men said that the same case manager at Willow Men's Shelter in the Bronx, Abdul Bangura, referred them to Back on Track, which sent them to New Lots.

"He told me they were going to send me to a place that was better for me, because the shelter was very violent," said Jose Perez, 48, who went to Back on Track in November, just after a bicycle accident landed him in the hospital.

Mr. Bangura did not respond to requests for comment. A spokeswoman for the city's Department of Homeless Services, which oversees shelters, said they did not refer people to three-quarter houses. She described Back on Track as a "rehab and drug treatment program."

With little supervision, many three-quarter homes have devolved into havens for drug use.

In 2014, the police responded 159 times to the stretch of houses on New Lots — mainly because of disputes and people who needed medical aid, often because

of drugs.

Residents traded prescription pills and sold their methadone. At least two house managers at New Lots used heroin while living there, tenants said. One former house manager said that he continued to smoke marijuana daily while working for Mr. Baumbliit.

Overdoses were not uncommon.

Michael Seaman, 42, was on methadone but otherwise clean for eight months when he moved in July to a Back on Track home in Bedford-Stuyvesant, Brooklyn. Within two days, Mr. Seaman started using drugs.

"My brother said you could get more drugs in there than on the street," his sister Janice Ortiz said.

On Nov. 14, Mr. Seaman overdosed, likely from a combination of Xanax and methadone. Roommates found him in the morning, cold and motionless in his bottom bunk.

"No one even showed up from Yury's office," said Ramon Ruiz, a housemate.

7 "It was like Michael never existed. I had to verify the family." body. I had to
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Mr. Aboulafia, Mr. Baumbliit's lawyer, said Back on Track's secretary "notified the family as soon as possible."

Mr. Seaman's relatives from Staten Island said they never heard from Back on Track and waited six hours before they were allowed into the house to collect his belongings. For more than two weeks, his mattress was left as it was, along with his striped sheets and blanket with tigers and a jungle scene. And then, the mattress was given to someone else.

The Cash Machines

If Mr. Baumbliit's tenants were all potential moneymakers, those with serious problems represented the easiest money of all: They often didn't understand how

they were being used.

Some had mental illnesses like schizophrenia or bipolar disorder. At least two were developmentally disabled. One had severe hemophilia. One resident was described on a mental capacity assessment for federal disability as having “psychotic symptoms, very low frustration tolerance and tendency towards violence.” A few others used canes and walkers.

Birshon Daley, 34, who has paranoid schizophrenia, lived in the house next to Mr. Bush. Mr. Daley had an unkempt beard and a large bump on his forehead that he said was from when his great-grandmother threw a can at him. He wandered the neighborhood collecting cigarette butts to smoke, asking people for money and occasionally eating food from the garbage. At one point, Mr. Daley punched out the glass at a bus stop.

Mr. Daley said he used to live at his aunt’s house nearby, but landed in a shelter when his father left Brooklyn and his grandfather died. About three years ago, he said, that shelter “sent me to this program here.” Mr. Daley and his housemates all said that he did not use illicit drugs.

He said his federal disability check was about \$645 a month. The federal government had deemed him incapable of managing it, so he needed a “payee” who would receive his check and make sure his needs were met. Mr. Daley said that Mr. Baublitz asked him to designate the house manager, Lisa Short, as the payee. In return, Mr. Baublitz gave him \$5 a day to live on, Mr. Daley and two housemates said.

Another housemate, John McLeod, 58, was given the job of administering Mr. Daley’s medications — an anti-psychotic, a mood stabilizer and a blood pressure pill — stored in a plastic shopping bag with “Daily” scrawled on it. Mr. McLeod, who had no medical training and no idea what pills he was handing out, sometimes hit Mr. Daley or threw spoons at him, housemates said. Efforts to reach Mr. McLeod were unsuccessful; there are no phone numbers or current addresses available for him.

Julian Caraballo, 55, said that he, too, made Ms. Short the payee of his disability check, which was for \$762 a month. He said Mr. Baumblyt handed him his daily allowance.

“He gave me \$10 every day, for eat,” Mr. Caraballo said.

Mr. Aboulafia said residents who picked Ms. Short did so on their own. He said that if people received only \$5 or \$10 a day, it was because the rest of the check was deducted “for participating in Back on Track’s program.” Ms. Short could not be reached for comment at several phone numbers listed for her and her relatives, nor did she respond to a certified letter mailed to Back on Track.

Mr. Baumblyt also steered tenants who were not on disability to a psychiatrist and lawyer who could get them qualified, tenants said. One tenant still had the psychiatrist’s card. Another had directions to her office in Gravesend, Brooklyn, provided by Back on Track. The lawyer’s office was next to a Social Security Administration branch in Staten Island.

Mr. Aboulafia said some tenants at Back on Track “asked for help with qualifying for disability so we provided them with some names of people that we thought could help.”

In the fall, Mr. Baumblyt added another requirement for tenants at New Lots. They had to go to a new doctor’s office: a storefront at 887B East New York Avenue, bearing the name of a family doctor, Kevin Custis.

On an afternoon in January, patients in a crowded waiting room said they came for free pizza — and because they were paid \$20 in cash, an illegal incentive. One man said he was a “recruiter” who drove a van around to find patients from shelters, churches and welfare offices, “where there are people who have Medicaid and don’t have money.”

Seventeen New Lots tenants said they were driven to the clinic in a Back on Track van and forced to undergo three or four hours of testing to get a bed. They said they were given ultrasounds and sent to one doctor after another.

Mr. Perez went to the clinic on Nov. 6, even though he had just been thoroughly evaluated by doctors because of his bicycle accident. Medicaid paid doctors more than \$1,700 that day for 19 procedures, records show, including ultrasounds of cerebral arteries and tests for an involuntary eye movement known as “dancing eye.”

“I think that’s why they’re affiliated with Yury,” Mr. Perez said. “They get rich off all of us.”

In an interview, Dr. Custis said he made an agreement with Back on Track about a year ago to recruit patients for a clinical study on hepatitis C and H.I.V. screening. He said he paid Back on Track \$20 for each patient out of his own pocket.

Dr. Custis said he was the only doctor on the study and named a researcher from “the centers for health care disparities out of Mount Sinai” that he said was helping him evaluate the results. But a spokesman for Mount Sinai Hospital in Manhattan said the center did not exist and that no one by the name given by Dr. Custis worked there.

Mr. Aboulafia denied that Back on Track received any money from the doctor. He also said tenants were required to get physicals “to prevent the spread of infection and disease at the facility.” He did not explain why scans and ultrasounds were necessary.

End of the Line

In 2013, Mr. Baublitt stopped paying his lease at New Lots, even as he continued to collect rent.

By last summer, Back on Track owed Paradigm Credit Corporation, the owner of the buildings, more than \$300,000.

“All we asked Back on Track to do was pay the rent that they were obligated to pay, and every time that I’ve had a discussion with Yury he tells me to go ‘F’

myself,” David Kushner, the head of Paradigm, told a Housing Court judge last year.

Mr. Aboulafia said that Back on Track did pay its rent, but to a former owner who lost the buildings in foreclosure, “and our rent was absconded in the process.” When asked whether Back on Track complained to the police about the rent being taken, Mr. Aboulafia said “no comment.”

Last June, Back on Track agreed in court that it would move out by Halloween and “make best efforts to relocate the occupants” to other three-quarter homes.

But none of the residents were told. Eviction notices were thrown away, and Mr. Baumblit kept moving in new tenants.

On Dec. 17, the city marshals showed up. They locked up six of the 12 apartments, giving the few residents who were not at group 15 minutes to grab what they could. On the streets, tenants huddled, wondering whether this was really happening. The week before Christmas, 60 people were suddenly homeless.

In the days that followed, they were allowed to pick up their belongings. Some squeezed into the apartments that were still open, spreading blankets over mattresses in living rooms.

Many wandered off, heading for shelters, other three-quarter houses or the streets. Some used drugs and went into inpatient treatment.

Mr. Baumblit initially tried to collect slips for the tenants who remained. But he quickly abandoned New Lots. On Dec. 23, Mr. Baumblit showed up with a van to take those on disability to other Back on Track homes.

Several who stayed behind went to court to postpone the evictions. They also went to the city’s Human Resources Administration to ask that it stop paying Back on Track. They said they were told that they needed a new address before stopping payments to the old address.

For months, Mr. Kushner also complained to the city.

“The worst part of this is, I contacted every city agency — every city agency — they all told me nothing,” Mr. Kushner said. “They couldn’t help me. They don’t know who Back on Track is, they don’t know what it is. And basically they gave me no help whatsoever.”

At the end of February, when most of the residents of New Lots were long gone, the Human Resources Administration was still paying Mr. Baumbilit to house 65 people.

Mr. Banks said the agency started investigating Back on Track after learning of the mass eviction. But, he said, the agency continued to pay Back on Track for housing because it did not want people who needed housing to lose it. “We didn’t want to render more people homeless,” he said.

Mr. Baumbilit continued to operate, even as his associates ran into trouble. The state tried to shut down New York Service Network last year for billing Medicaid for unnecessary services. The state’s attorney general also recently charged Narco Freedom executives with kickback schemes and Medicaid fraud involving their own three-quarter homes.

This year, Mr. Baumbilit put his house near the beach, with its chandeliers, bar and swimming pool, on the market for \$3.5 million. He told tenants he planned to shut down another three-quarter home, this one on Glenmore Avenue in East New York, and ripped out parts of the stove so nobody could cook there. He continued to evict tenants, even after police charged him with two misdemeanors for unlawful evictions. The cases are pending.

Meanwhile, Back on Track opened two new homes in Brooklyn, including one on Schenck Avenue in East New York. Its owner was a New York City police officer, De’Shawn Ware, whose father was a former house manager for Back on Track.

“I have no involvement whatsoever,” Mr. Ware said, adding that Mr. Baumbilit “just rents the location.”

Life grew increasingly dire for the squatters remaining at New Lots. Mr. McLeod, the man who had dispensed Mr. Daley’s pills, kicked him out of their

apartment. Mr. Daley, off his medications, spent more than a month surfing the subways and sleeping where he could. After he fell on the ice and landed in an emergency room in February, Mr. Daley was given a shot of his anti-psychotic medication and a mood stabilizer and released.

Mr. Daley returned to New Lots, where Mr. McLeod refused to let him inside. Mr. Bush and his housemates let Mr. Daley stay in their living room and fed him. He had gotten no disability money since mid-December because Mr. Baumbli's employee remained the payee.

Mr. Bush, who had qualified for disability in 2013, refused to move to another of Mr. Baumbli's houses. He often walked to the library a block away, submitting subsidized housing applications online for places where his disability payments barely reached half the minimum income needed. He called numbers for programs catering to seniors, and for houses that said they would charge him \$500 a month for a bed. No one called back.

At the end of March, the marshals locked up the apartment where he and Mr. Daley were staying. Most tenants went to other three-quarter houses or shelters.

Mr. Daley packed up his worldly possessions into two plastic bags and moved next door, to the lone New Lots apartment that remained open, crashing there with three others, even after the electricity was cut off, until they all finally left.

Mr. Bush, now 65, put his suitcases, including one with a strip of tape that read "Bush Traveling Clothes," into a shopping cart. He would soon go to a residential treatment program, one he had already been through twice. To qualify, he knew what he had to do: He had to use. "There's nowhere else for me to go," he said.

When he moved, he brought Russell, his talisman, his reminder of better days, placing the bear near his bed in his new room. This time, he told Russell, he would get clean. This time, he said, things would be different.

Susan C. Beachy contributed research.

A version of this article appears in print on May 31, 2015, on Page A1 of the New York edition with the headline: Choice for Addicts: Use Again, or Lose Home.

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FOR IMMEDIATE RELEASE

Wednesday, May 17, 2017

Owner Sentenced to More than 27 Years in Prison for Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers

Wife and Fellow Owner Sentenced to 3 Years in Prison

Two owners of sober homes and alcohol and drug addiction treatment centers were sentenced to 27 and 3 years in prison, respectively, for their participation in a multi-million dollar health care fraud and money laundering scheme that involved the filing of fraudulent insurance claim forms and defrauded health care benefit programs.

Benjamin G. Greenberg, Acting United States Attorney for the Southern District of Florida, George L. Piro, Special Agent in Charge, Federal Bureau of Investigation (FBI), Miami Field Office, Kelly R. Jackson, Special Agent in Charge, Internal Revenue Service, Criminal Investigation (IRS-CI), Dave Aronberg, State Attorney, Palm Beach County State Attorney's Office, Jeff Atwater, Florida Chief Financial Officer, William D. Snyder, Sheriff Martin County Sheriff's Office, George L. Dorsett, Assistant Inspector General for Investigations, Amtrak Office of Inspector General, Isabel Colon, Regional Director, United States Department of Labor, Employee Benefits Security Administration (DOL-EBSA), and Dennis Russo, Director of Operations, National Insurance Crime Bureau (NICB), made the announcement.

After hearing victim impact statements from a number of parents whose children suffered fatal and non-fatal overdoses, U.S. District Judge Donald M. Middlebrooks sentenced **Kenneth Chatman**, a/k/a "Kenny," 46, of Boynton Beach, to 330 months in prison, to be followed by 5 years of supervised release. Chatman was also ordered to register as a sex offender. He had previously pled guilty to conspiracy to commit health care fraud in violation of Title 18, United States Code, Section 1349; conspiracy to commit money laundering in violation of Title 18, United States Code, Section 1956(h); and conspiracy to commit sex trafficking, in violation of Title 18, United States Code, Section 1594(c). His wife, **Laura Chatman**, 44, of Boynton Beach, was sentenced by Judge Middlebrooks to 36 months in prison, to be followed by 3 years of supervised release, after having pled guilty to two counts of making a false statement related to a health care matter, in violation of Title 18, United States Code, Section 1035(a)(1).

"Kenneth Chatman will spend the next 27 years in prison for orchestrating an egregious fraud scheme that denied addicts and their families the legitimate treatment and supportive services they desperately

10/16/2017 Owner Sentenced to More than 27 Years in Prison for Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes an...

needed," stated Acting U.S. Attorney Benjamin G. Greenberg. "Instead of helping his patients to achieve sobriety, Chatman exploited the vulnerable victims to satisfy his personal greed. He provided drugs to addicts, solicited and accepted kickbacks and bribes, and used his position of power to sexually exploit his patients. The U.S. Attorney's Office and our law enforcement partners will continue to shut down and hold accountable the unscrupulous sober home owners, treatment facility providers and medical labs that carry out fraudulent and abusive treatment practices."

"Kenneth Chatman took advantage of persons with serious addiction problems to satisfy his greed. He exploited people who were vulnerable and weak," said Michael A. D'Alonzo, Assistant Special Agent in Charge, FBI Miami. "Instead of providing a safe and sober living environment, Chatman gave his patients illegal drugs, fraudulent insurance bills and demanded they engage in illegal prostitution under duress. The FBI and our partners are serving notice to sober home operators, treatment facility owners and medical professionals who choose to engage in these types of fraud schemes, you will be investigated and criminally prosecuted to the fullest extent of the law."

Kelly R. Jackson, Special Agent in Charge, IRS Criminal Investigation (IRS-CI), stated, "This is an appalling case of pure greed where these defendants tore families apart and put patients' health and safety at risk. As the Chatmans were living a lavish lifestyle funded by their fraud scheme, patients suffering from addiction were utilized as mere pawns in a master plan to defraud insurance companies. IRS-CI will continue to provide our expertise in conducting financial analysis in money laundering cases to combat the huge healthcare fraud compliance issue facing South Florida."

"Sober homes are meant to be a place of refuge for those recovering from addiction, but some of these facilities are anything but a sanctuary," said Chief Financial Officer Jeff Atwater. "Many do nothing more than siphon residents' insurance benefits until there's nothing left to be paid, only to return the newly-recovering back to the streets. I am proud of the collaborative state, local, and federal efforts to hold the line on this crime, and I hope this sentencing sends a shockwave to others who may be engaging in similar behavior."

"It's shameful and disgusting that a treatment home, which should be a place of healing and recovery, could be so badly corrupted as a vehicle for fraud," said Regional Director for the Department of Labor's Employee Benefits Security Administration Isabel Colon. "We are gratified to be part of the effort of so many state and federal agencies to put a stop to this sort of criminal activity."

"Our office, in partnership with our fellow investigative agencies, will continue to uncompromisingly investigate and bring to justice the people who perpetrate these criminal acts," said Amtrak Inspector General Tom Howard. "Their actions take advantage of a vulnerable population that is seeking treatment. Our office will remain vigilant in protecting Amtrak employees, retirees, and their dependents, and ensuring that our health care dollars are not wasted on these fraudulent providers."

According to court documents, defendant Kenneth Chatman established a series of sober homes, including Stay'n Alive, Inc., Total Recovery Sober Living LLC, and several other multi-bed residences operating as sober homes in Palm Beach and Broward Counties. These sober home facilities were purportedly in the business of providing safe and drug-free residences for individuals suffering from drug and alcohol addiction. Kenneth Chatman conspired with others to obtain patients who would receive ineffective and medically unnecessary substance abuse treatment and testing that could be billed to the patients' insurance in order to enrich Chatman and the members of the conspiracy.

To achieve this goal, defendant Kenneth Chatman paid kickbacks and bribes to other sober home owners for referring their residents to Reflections Treatment Center LLC in Margate, Florida and Journey to Recovery LLC in Lake Worth, Florida for treatment, and disguised these kickbacks and bribes as "case management fees," "consulting fees," "marketing fees," and "commissions." The co-defendants met with

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Kenneth Chatman on a weekly basis to collect their kickbacks and bribes, which were based on the number of insured patients that received treatment each week.

To obtain residents for the sober homes, defendant Kenneth Chatman and others involved in the conspiracy provided kickbacks and bribes, including free or reduced rent, gift cards, and controlled substances to individuals with insurance who agreed to reside at the sober homes, attend drug treatment, and submit to regular drug testing that members of the conspiracy could bill to the residents' insurance plans. Although the sober homes were purportedly drug-free residences, some of the defendants permitted the residents to continue using drugs as long as they attended treatment and submitted to drug testing, and Kenneth Chatman marketed his treatment facilities as places where patients could continue to use controlled substances while receiving "treatment."

Defendants Kenneth and Laura Chatman submitted to the Florida Department of Children and Families fraudulent applications for licensure for Journey to Recovery and Reflections Treatment Center, stating that Laura Chatman was the sole owner of those entities, thereby hiding the fact that Kenneth Chatman, a convicted felon who was prohibited from owning and operating treatment centers, managed all aspects of these facilities including the hiring and firing of personnel; admitting and discharging patients and making financial decisions.

Defendant Laura Chatman appeared at Reflections and Journey for audits and inspections by DCF and other accrediting agencies to make it seem that she was the sole owner and officer of the companies. Defendant Laura Chatman also filed corporate documents and opened bank accounts in the name of Reflections and Journey to allow co-defendant Kenneth Chatman access to deposit proceeds from the health care fraud scheme and to conduct transactions meant to promote the scheme. .

Defendant Kenneth Chatman dictated which patients were admitted and discharged and the type and frequency of different types of lab testing that would be performed based on the kickbacks and bribes that he was receiving from different clinical laboratories rather than based upon the individual patients' needs. Kenneth Chatman dictated that confirmatory urine drug testing; duplicative saliva drug testing, DNA and allergy testing occur regardless of whether patients complained of allergies. These tests were medically unnecessary and not used to direct the treatment of patients. Many of the test results were never reviewed and new samples were submitted before older tests were received and reviewed. In some instances when a patient's insurance benefits were about to run out, Kenneth Chatman would provide controlled substances to the patient so that the patient would have a positive drug test. Kenneth Chatman would then inform the patient's insurance provider that the patient had "relapsed" so that additional treatment benefits would be approved and Chatman could continue billing services.

Defendant Kenneth Chatman also recruited and coerced female patients and residents into prostitution, telling them that they would not have to pay rent or participate in treatment or testing so long as they would allow him to continue to bill their insurance companies for substance abuse treatment and testing that the patients did not receive.

Defendants Kenneth Chatman and other co-conspirators recruited, enticed, harbored, transported, provided, obtained, and maintained some female patients into performing commercial sex acts. The defendant provided housing for the female patients, who would be made to perform sex acts in exchange for money that would then have to be paid to defendant Kenneth Chatman as "rent." The commercial sex activity occurred at some of the sober homes controlled by the defendant or at hotels and motels. Kenneth Chatman provided condoms and advertised and caused the advertisement of the commercial sexual activity. Kenneth Chatman and other co-conspirators provided controlled substances to these addicted patients to induce them to perform sexual acts.

Kenneth Chatman also used intimidation tactics and threats of legal process, including evicting the patients from his sober homes to maintain their compliance. These patients were not required to attend treatment

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at Reflections or provide bodily fluid samples for testing but he submitted and caused the submission of claims to the patients' Insurance Plans for substance abuse treatment and testing that they did not receive.

Kenneth Chatman further maintained control over patients who attended Reflections and Journey by threats and confiscating their belongings, car keys, telephones, medications, and food stamps, in order to maintain the ability to continue billing their Insurance Plans.

The proceeds of the health care fraud scheme were deposited into bank accounts that Kenneth Chatman and co-defendant Laura Chatman opened at Wells Fargo Bank in the name of Reflections and Journey. Kenneth Chatman and the co-conspirators agreed to use the proceeds to promote the ongoing fraud scheme including the making of kickback and bribe payments in the form of checks to sober home owners. These checks were for the referral of insured clients to Reflections for treatment and often noted that they were for "case management." Kenneth Chatman, Laura Chatman and their co-conspirators also made payments to the medical directors, clinical directors, employees and others to continue their involvement with the fraud. Monies from these accounts were also used to pay kickbacks and bribes to patients, including providing prescription and illicit drugs to patients and potential patients.

Mr. Greenberg commended the investigative efforts of the Greater Palm Beach Health Care Fraud Task Force. Agencies of the task force include the FBI, IRS-CI, the Palm Beach County State Attorney's Office Sober Homes Task Force, Florida Division of Investigative and Forensic Services, Martin County Sheriff's Office, Amtrak OIG, DOL-Office of Inspector General, DOL-EBSA, NICB, Palm Beach County Sheriff's Office, West Palm Beach Police Department, Delray Beach Police Department, Florida Attorney General Office of Statewide Prosecution, and Office of Personnel Management, Office of Inspector General. This case was prosecuted by Assistant United States Attorney A. Marie Villafañá.

Related court documents and information may be found on the website of the District Court for the Southern District of Florida at <http://www.flsd.uscourts.gov> or on <http://pacer.flsd.uscourts.gov> at <http://www.usdoj.gov/usao/fls>

Topic(s):

Healthcare Fraud

Component(s):

USAO - Florida, Southern

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