Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 918, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to amend the Public Health Service Act to authorize a demonstration grant program to provide patient navigator services to reduce barriers and improve health care outcomes, and for other purposes.''.

A motion to reconsider was laid on the table.

NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING ACT OF 2004

Mr. BARTON of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3015) to amend the Public Health Service Act to establish an electronic system for practitioner monitoring of the dispensing of any schedule II, III, or IV controlled substance, and for other purposes, as amended.

The Clerk read as follows:

H.R. 3015

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National All Schedules Prescription Electronic Reporting Act of 2004''.

SEC. 2. CONTROLLED SUBSTANCE MONITORING PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding after section 399N the following:

''SEC. 399O. CONTROLLED SUBSTANCE MONITORING PROGRAM.

''(a) FORMULA GRANTS.—

''(1) IN GENERAL.—Each fiscal year, the Secretary shall make a payment to each State with an application approved under this section for the purpose of establishing and implementing a controlled substance monitoring program under this section.

''(2) DETERMINATION OF AMOUNT.—In making payments under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an amount which bears the same ratio to the amount appropriated to carry out this section for that fiscal year as the number of pharmacies of the State bears to the number of pharmacies of all States with applications approved under this section (as determined by the Secretary), except that the Secretary may adjust the amount allocated to a State under this paragraph after taking into consideration the budget cost estimate for the State's controlled substance monitoring program.

''(b) APPLICATION APPROVAL PROCESS.—

''(1) IN GENERAL.—To seek a grant under this section, a State shall submit an application at such time, in such manner, and containing such assurances and information as the Secretary may reasonably require. Each such application shall include—

''(A) a budget cost estimate for the State's controlled substance monitoring program;

''(B) proposed standards for security for information handling and for the database maintained by the State under subsection (d) generally including efforts to use appropriate encryption technology or other such technology;

''(C) proposed standards for meeting the uniform electronic format requirement of subsection (g);

''(D) proposed standards for availability of information and limitation on access to program personnel;

''(E) proposed standards for access to the database, and procedures to ensure database accuracy;

''(F) proposed standards for redisclosure of information;

''(G) proposed penalties for illegal redisclosure of information; and

''(H) assurances of compliance with all other requirements of this section.

''(2) APPROVAL OR DISAPPROVAL.—Not later than 90 days after the submission by a State of an application under paragraph (1), the Secretary shall approve or disapprove the application. The Secretary shall approve the application if the State demonstrates to the Secretary that the State will establish and implement or operate a controlled substance monitoring program in accordance with this section.

''(3) WITHDRAWAL OF AUTHORIZATION.—If a State fails to implement a controlled substance monitoring program in accordance with this section—

''(A) the Secretary shall give notice of the failure to the State; and

''(B) if the State fails to take corrective action within a reasonable period of time, the Secretary shall withdraw any approval of the State's application under this section.

''(4) VOLUNTARY DISCONTINUANCE.—A funding agreement for the receipt of a payment under this section is that the State involved will give a reasonable period of notice to the Secretary before ceasing to implement or operate a controlled substance monitoring program under this section. The Secretary shall determine the period of notice that is reasonable for purposes of this paragraph.

''(5) RETURN OF FUNDS.—If the Secretary withdraws approval of a State's application under this section, or the State chooses to cease to implement a controlled substance monitoring program under this section, a funding agreement for the receipt of a payment under this section is that the State will return to the Secretary an amount which bears the same ratio to the overall payment as the remaining time period for expending the payment bears to the overall time period for expending the payment (as specified by the Secretary at the time of the payment).

''(c) REPORTING REQUIREMENTS.—In implementing a controlled substance monitoring program under this section, a State shall comply with the following:

''(1) The State shall require dispensers to report to such State each dispensing in the State of a controlled substance to an ultimate user or research subject not later than 1 week after the date of such dispensing.

''(2) The State may exclude from the reporting requirement of this subsection—

''(A) the direct administration of a controlled substance to the body of an ultimate user or research subject;

''(B) the dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user or research subject involved for 48 hours or less; or

''(C) the administration or dispensing of a controlled substance in accordance with any other exclusion identified by the Secretary for purposes of this paragraph.

''(3) The information to be reported under this subsection with respect to the dispensing of a controlled substance shall include the following:

''(A) Drug Enforcement Administration Registration Number of the dispenser.

''(B) Drug Enforcement Administration Registration Number and name of the practitioner who prescribed the drug.

''(C) Name, address, and telephone number of the ultimate user or research subject.

''(D) Identification of the drug by a national drug code number.

''(E) Quantity dispensed.

''(F) Estimated number of days for which such quantity should last.

''(G) Number of refills ordered.

''(H) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

''(I) Date of the dispensing.

''(J) Date of origin of the prescription.

''(4) The State shall require dispensers to report information under this section in accordance with the electronic format specified by the Secretary under subsection (g), except that the State may waive the requirement of such format with respect to an individual dispenser.

''(5) The State shall automatically share information reported under this subsection with another State with an application approved under this section if the information concerns—

''(A) the dispensing of a controlled substance to an ultimate user or research subject who resides in such other State; or

''(B) the dispensing of a controlled substance prescribed by a practitioner whose principal place of business is located in such other State.

''(6) The State may notify the appropriate authorities responsible for drug diversion investigation if information in the database maintained by the State under subsection (d) indicates an unlawful diversion or misuse of a controlled substance.

''(d) DATABASE.—In implementing a controlled substance monitoring program under this section, a State shall comply with the following:

''(1) The State shall establish and maintain an electronic database containing the information reported to the State under subsection (c).

''(2) The database must be searchable by any field or combination of fields.

''(3) The State shall include reported information in the database at such time and in such manner as the Secretary determines appropriate, with appropriate safeguards for ensuring the accuracy and completeness of the database.

''(4) The State shall take appropriate security measures to protect the integrity of, and access to, the database.

''(e) PROVISION OF INFORMATION.—Subject to subsection (f), in implementing a controlled substance monitoring program under this section, a State may provide information from the database established under subsection (d) and, in the case of a request under paragraph (3), summary statistics of such information, in response to a request by—

''(1) a practitioner (or the agent thereof) who certifies, under the procedures determined by the State, that the requested information is for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a bona fide current patient;

''(2) any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, who certifies, under the procedures determined by the State, that the requested information is related to an individual investigation or proceeding involving the unlawful diversion or misuse of a schedule II, III, or IV substance, and such information will further the purpose of the investigation or assist in the proceeding;

''(3) any agent of the Department of Health and Human Services, a State medicaid program, a State health department, or the Drug Enforcement Administration who certifies that the requested information is necessary for research to be conducted by such department, program, or administration, respectively, and the intended purpose of the research is related to a function committed to such department, program, or administration by law that is not investigative in nature; or

''(4) any agent of another State, who certifies that the State has an application approved under this section and the requested information is for the purpose of implementing the State's controlled substance monitoring program under this section.

''(f) LIMITATIONS.—In implementing a controlled substance monitoring program under this section, a State—

''(1) shall make reasonable efforts to limit the information provided pursuant to a valid request under subsection (e) to the minimum necessary to accomplish the intended purpose of the request; and

''(2) shall not provide any individually identifiable information in response to a request under subsection (e)(3).

''(g) ELECTRONIC FORMAT.—The Secretary shall specify a uniform electronic format for the reporting, sharing, and provision of information under this section.

''(h) RULES OF CONSTRUCTION.—

''(1) FUNCTIONS OTHERWISE AUTHORIZED BY LAW.—Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

''(2) NO PREEMPTION.—Nothing in this section shall be construed as preempting any State law, except that no such law may relieve any person of a requirement otherwise applicable under this Act.

''(3) ADDITIONAL PRIVACY PROTECTIONS.—Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

''(4) CERTAIN CONFIDENTIALITY REQUIREMENTS.—Nothing in this section shall be construed as superceding the confidentiality requirements of programs defined by and subject to part 2 of title 42, Code of Federal Regulations.

''(5) NO FEDERAL PRIVATE CAUSE OF ACTION.—Nothing in this section shall be construed to create a Federal private cause of action.

''(i) RELATION TO HIPAA.—Except to the extent inconsistent with this section, the provision of information pursuant to subsection (c)(5), (c)(6), or (e) and the subsequent transfer of such information are subject to any requirement that would otherwise apply under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(j) PREFERENCE.—Beginning January 1, 2007, the Secretary, in awarding any competitive grant that is related to drug abuse (as determined by the Secretary) to a State, shall give preference to any State with an application approved under this section.

''(k) STUDY.—Not later than 2 years after the date of the enactment of this section, the Secretary shall—

''(1) complete a study that—

''(A) determines the progress of States in establishing and implementing controlled substance monitoring programs under this section;

''(B) determines the feasibility of implementing a real-time electronic controlled substance monitoring program, including the costs associated with establishing such a program; and

''(C) provides an analysis of the privacy protections in place for the information reported to the controlled substance monitoring program in each State receiving a grant for the establishment or operation of such program, and a comparison to the privacy requirements that apply to covered entities under regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, along with any recommendations for additional requirements for protection of this information; and

''(2) submit a report to the Congress on the results of the study.

''(l) ADVISORY COUNCIL.—

''(1) ESTABLISHMENT.—A State may establish an advisory council to assist in the establishment and implementation of a controlled substance monitoring program under this section.

''(2) SENSE OF CONGRESS.—It is the sense of the Congress that, in establishing an advisory council under this subsection, a State should consult with appropriate professional boards and other interested parties.

''(m) DEFINITIONS.—For purposes of this section:

''(1) The term 'bona fide patient' means an individual who is a patient of the dispenser or practitioner involved.

''(2) The term 'controlled substance' means a drug that is included in schedule II, III, or IV of section 202(c) of the Controlled Substance Act.

''(3) The term 'dispense' means to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, irrespective of whether the dispenser uses the Internet or other means to effect such delivery.

''(4) The term 'dispenser' means a physician, pharmacist, or other individual who dispenses a controlled substance to an ultimate user or research subject.

''(5) The term 'practitioner' means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he or she practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

''(6) The term 'State' means each of the 50 States and the District of Columbia.

''(7) The term 'ultimate user' means a person who has lawfully obtained, and who possesses, a controlled substance for his or her own use, for the use of a member of his or her household, or for the use of an animal owned by him or her or by a member of his or her household.

''(n) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated—

''(1) $25,000,000 for each of fiscal years 2006 and 2007; and

''(2) $15,000,000 for each of fiscal years 2008, 2009, and 2010.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BARTON) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BARTON).

GENERAL LEAVE

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material on the bill.

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

There was no objection.

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

Mr. Speaker, I rise in very strong support of H.R. 3015. All of us have deep concerns about the abuse of prescription drugs. Whether after surgery or in the treatment of chronic pain, ensuring that patients receive proper pain management is a critical component in the provision of health care. However, these medications can and sometimes are abused. The Committee on Energy and Commerce has heard about the problems prescription drug abuse has created in our communities throughout America. In some areas, the nonmedical use of prescription drugs presents a bigger problem than even cocaine and heroin. This is a serious issue that cannot be addressed through traditional drug control programs. We need to find a balanced approach that does not interfere with the doctor-patient relationship but also ensures that these potentially addictive drugs are not abused. Prescription drug monitoring programs can be a part of the solution to this public health challenge.

These programs help physicians better serve their patients because they can review the patient's prescription drug history. Drug interactions can often lead to adverse events for patients so that these monitoring programs serve as an additional safety check.

Only 21 States have implemented drug monitoring programs. While this is a good start, problems arise because illicit drug use shifts to contiguous States without monitoring programs. H.R. 3015 will strengthen prescription drug monitoring programs to eliminate gaps in systems between States and ensure that programs are interoperable so information is readily available across State lines.

I would like to thank the distinguished gentleman from Kentucky (Mr. WHITFIELD), the distinguished gentleman from New Jersey (Mr. PALLONE), the distinguished gentleman from Georgia (Mr. NORWOOD) and the distinguished gentleman from Ohio (Mr. STRICKLAND), all members of the Committee on Energy and Commerce, for their hard work on this legislation.

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At the appropriate time after the debate, I would urge that all of my colleagues support it.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2½ minutes.

Prescription drug pain relievers, stimulants, and other controlled substances play a crucial role in health care. But when misused, those same medicines can be enormously destructive, as we know. Some are addictive, life threatening; many are both.

As these medicines proliferate, so, unfortunately, does the risk of misuse. Over the last decade, use of prescription pain relievers has increased by nearly 200 percent, while the use of stimulants has increased by more than 150 percent. Some 6.2 million Americans misuse prescription medicines for nonmedical purposes. In 1999 a quarter of those who took prescription drugs for nonmedical purposes were new users. In other words, this problem is not just growing; simply, it is exploding.

To combat this problem, physicians and pharmacists need information. This legislation, which is the culmination of hard work and compromise by the gentleman from New Jersey (Mr. PALLONE), the gentleman from Kentucky (Mr. WHITFIELD), and the gentleman from Ohio (Mr. STRICKLAND) will provide the information and coordination necessary to stem the misuse of prescription medicines. The legislation creates grants to establish State-run programs for prescription monitoring that will be administered and will be coordinated at the Federal level.

Fighting prescription drug abuse, preventing nonmedical use together are a difficult problem that requires doctors and law enforcement authorities to acquire and to share information. I think this bill is an important step forward in this fight. I am pleased to support it.

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

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

I am going to yield to the gentleman from Kentucky (Mr. WHITFIELD), but before I do that I would like to announce to the House that one of the other cosponsors of this important legislation, the gentleman from Georgia (Mr. NORWOOD), as we speak, is awaiting a lung transplant, which may very well occur this afternoon and this legislation would have not gotten to the floor of the House without his strong commitment to it. So I would encourage all my colleagues to pray for the gentleman from Georgia (Mr. NORWOOD) that his surgery goes well and that he is back amongst us as soon as possible.

Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Kentucky (Mr. WHITFIELD).

Mr. WHITFIELD. Mr. Speaker, I thank the chairman for yielding me this time.

We are excited today to have on the floor this legislation relating to prescription drug abuse in the United States, which has reached epidemic proportions. Recent statistics show that 6.2 million Americans abuse prescription drugs. To help combat this problem, many States, such as my own State of Kentucky and about 20 others, have adopted prescription drug monitoring programs to assist physicians and law enforcement officials stop the abuse and prosecute those individuals who are breaking the law.

The cornerstone of most existing drug-monitoring programs is that they allow physicians access to the information before writing a prescription for a controlled substance. Physicians tell us that it is an invaluable tool in treating their patients. However, there is one glaring problem, and that is that these programs operate only intrastate. And as the gentleman from Texas (Chairman BARTON) mentioned, it is essential that we have an interstate program.

To that end, I have been pleased to work with the gentleman from New Jersey (Mr. PALLONE), the gentleman from Georgia (Mr. NORWOOD), the gentleman from Ohio (Mr. STRICKLAND), my colleagues on both sides of the aisle, on legislation to address this issue. This legislation, H.R. 3015, the National All Schedules Prescription Electronic Reporting Act, creates a grant program housed at the Department of Health and Human Services which will fund the establishment and operation of State-run prescription drug monitoring programs. It establishes standards for reporting data and governs who has access to such information and under what circumstances because of the privacy issues. From the beginning our goal has been to give physicians the tool they need to treat patients, which also provides a better mechanism to prosecute individuals who are allegedly using illegal controlled substances.

I believe this is a good bill, a balanced bill, and one that will provide States with an important tool to curb prescription drug abuse.

I would like at this time to thank all of the cosponsors and give particular thanks to the gentleman from Texas (Chairman BARTON) and the gentleman from Florida (Chairman BILIRAKIS); the gentleman from Michigan (Mr. DINGELL), ranking member; and the gentleman from Ohio (Mr. BROWN), without all of whom we would not have been successful without their efforts to get this legislation through the Committee on Energy and Commerce.

I would also like to recognize the hard work of our committee staff, particularly Chuck Clapton and Ryan Long and John Halliwell on my staff; and, of course, we could not have done it without the Democratic committee staff, and I would also like to thank them.

I would urge all Members to vote for this important legislation.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), who has been a leader on health care in this Congress.

Mr. PALLONE. Mr. Speaker, I thank the gentleman from Ohio (Mr. BROWN) for yielding me this time.

Mr. Speaker, as a sponsor of H.R. 3015, I rise today in strong support of this important piece of legislation and urge its passage in the House of Representatives. H.R. 3015, the National All Schedules Prescription Electronic Reporting Act, provides an avenue for addressing the illegal diversion and misuse of prescription drugs, which constitutes one of the fastest growing areas of drug abuse in our Nation today, affecting people of all areas of our Nation, all ages and all income levels.

Health care practitioners and pharmacists desperately need electronic prescription drug monitoring systems to ensure that they are prescribing and dispensing schedule II, III, and IV controlled substances that are medically necessary. This bill provides the resources to States to create and operate State-based prescription drug monitoring programs, allows physicians to access this information, and allows for States to communicate with one another. If enacted into law, this bill would help physicians prevent their patients from becoming addicted to prescription medications and would help law enforcement with criminal investigations in the illicit prescription drug market.

Mr. Speaker, H.R. 3015 represents a work of great bipartisan effort; and I thank the gentleman from Kentucky (Mr. WHITFIELD), of course the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Ohio (Mr. STRICKLAND) for their willingness to move forward with this effort. But I also want to thank our chairmen and our ranking members of the full committee as well as the subcommittee.

This is an effort to alleviate the prescription drug abuse problem plaguing our Nation. In addition, I want to applaud the leadership of the American Society for Interventional Pain Physicians for working with Congress in this significant public health initiative. I have to say I have never seen a more effective lobbying effort than what they put forth to try to move this bill.

Mr. WAXMAN. Mr. Speaker, I believe that H.R. 3015, legislation to support State controlled substance monitoring programs, is well intentioned. Non-medical use of controlled substances is a serious problem. Establishing State databases that contain information on prescriptions for such substances may help stem the practice of individuals seeking prescriptions from multiple providers for the purpose of non-medical use.

However, as we forge policies to facilitate controlled substance prescription information sharing among providers, States, and others, we must carefully consider the privacy implications of such steps. The databases H.R. 3015 supports potentially will contain a vast amount of personal medical information—including individually identifiable data regarding many individuals who are given prescriptions for legitimate medical reasons such as recovery from surgery. The last thing we want to do is deter individuals from seeking medical care out of fear that the privacy of their health information will not be protected.

I am pleased that, following up on concerns I expressed when the bill was under consideration in committee, sponsors of the measure agreed to add language that is a step forward

from earlier versions of the bill with respect to privacy protection. This language includes (1) a requirement that the Secretary of Health and Human Services study and report to Congress on the privacy protections regarding each State database that receives funding under the bill; and (2) requirements that the State grant applications submitted to the Secretary of HHS propose standards regarding redisclosure of information, penalties for illegal redisclosure of information, and other privacy related standards. These provisions increase focus by States and HHS on the privacy issues raised by the State controlled substance monitoring programs.

However, H.R. 3015's State-to-State disclosure and uniform electronic format provisions promote the development of, in essence, a national prescription database network. As such, it is particularly important that Congress work to ensure that appropriate privacy standards apply to databases in the network. The bill does not accomplish this task. It contains no minimum Federal standards or even a requirement that the HHS Secretary develop publicly reviewable criteria for assessing the sufficiency of the privacy standards that States must propose for their programs when applying for grants under the bill.

I do want to recognize and acknowledge the efforts of the sponsors to respond to the privacy concerns that I raised, particularly the efforts of Mr. PALLONE, Dr. NORWOOD, and Mr. WHITFIELD. And while I cannot support this bill at this point, I hope that with further consideration by the Senate and ultimately in conference, Members will carefully consider the privacy ramifications of controlled substance monitoring systems and make improvements in this area before the bill is enacted.

Mr. CHANDLER. Mr. Speaker, I am pleased to stand in support of H.R. 3015, the National All Schedules Prescription Electronic Reporting Act (NASPER).

As my Kentucky colleagues know, prescription drug abuse is one of the paramount challenges in our effort to curb substance abuse in our State. In 1997, as Attorney General of Kentucky, I established the Prescription Drug Abuse Task Force in order to examine the problem. Among the Task Force's accomplishments was the establishment of KASPER, the Kentucky All Schedule Prescription Electronic Reporting System.

KASPER was designed to stop the practice of ''doctor shopping,'' where abusers and dealers of illegally obtained prescription drugs visit multiple physicians in order to obtain multiple prescriptions. The success of KASPER has been impressive. In fact the program has been so successful that the Government Accounting Office described it as one of the Nation's best prescription drug abuse monitoring systems.

The result has been that it is now more difficult for people to fill multiple or fraudulent prescriptions in the Bluegrass State. However, ''Doctor Shoppers'' have circumvented KASPER by traveling to one of the seven States surrounding Kentucky. That is why without a national approach to this problem, Kentucky will not be able to truly succeed in its fight against prescription drug abuse.

For this reason, I salute Representative WHITFIELD for recognizing the strengths of KASPER and using it as a framework for a national system. That's why I have joined him as a cosponsor of this important legislation. I urge my colleagues to vote in favor of H.R. 3015 and help communities across America to combat the abuse of prescription drugs.

Mr. STUPAK. Mr. Speaker, as an original co-sponsor of the National All Schedules Prescription Electronic Reporting, or NASPER, Act of 2003, I rise today in strong support of its passage. The prescription drug abuse problem in our country has been well documented, and by passing the NASPER Act (H.R. 3015), Congress will take one step towards addressing the problem.

The NASPER Act will help ensure that Schedule II, and III, and IV controlled substances are used and prescribed safely and responsibly. The legislation will help States create electronic monitoring systems that will allow physicians and pharmacists to ensure that their patients are not being over-prescribed these powerful, yet potentially dangerous drugs. The legislation builds upon proven programs already started in 15 States, including Michigan. The Government Accounting Office (GAO) found in 2002 that these State programs are useful tools to help prevent the illegal distribution of these drugs.

However, the GAO also found a loophole that is often exploited. The States with electronic monitoring systems are often undermined by neighbor States who lack monitoring systems. The NASPER Act addresses this problem by allowing States to contact each other so that practitioners in one State can ensure that their patients are not receiving medications in another State.

I am proud to join with Congressmen PALLONE, WHITFIELD, STRICKLAND, and NORWOOD in providing leadership on this issue. I also applaud the tireless work of the American Society of Interventional Pain Physicians to combat the illegal use and inadvertent overprecribing of controlled substances and promote this legislation.

Mr. STRICKLAND. Mr. Speaker, I rise today to speak in support of H.R. 3015. I would first like to thank the Energy and Commerce Committee staff for their great work on this bill. I would also like to thank my colleagues Mr. PALLONE, Mr. NORWOOD, and Mr. WHITFIELD and their staff for their hard work. H.R. 3015 includes prescription monitoring provisions similar to those included in H.R. 3870, a bill Congressman NORWOOD and I introduced earlier this year. While, H.R. 3870 is a more comprehensive effort to close loopholes in current law that lead to prescription drug abuse, I am very pleased with the progress that has been made in H.R. 3015 on prescription drug monitoring.

I am particularly interested in deterring prescription drug diversion because of the immense problem of OxyContin abuse in many of the rural Appalachian Ohio counties I represent. I have received letters from constituents whose sons and daughters have died after taking a crushed OxyContin tablet. These tragedies cannot go unchecked. I am sure that OxyContin is not the only prescription drug that is abused in Appalachia, but its abuse is the most obvious example of the devastating consequences of prescription drug diversion.

H.R. 3015 would build on existing State prescription monitoring programs by providing grants through the Department of Health and Human Services for States to establish, operate, and update prescription monitoring programs. These grants are meant to ensure State monitoring systems can share information with other States, and our intention is to expand and improve current State monitoring programs without eliminating the work that, for example, Kentucky or Nevada has already done.

I believe that drugs like OxyContin are important advances in pain management, but we must work to stop the dangerous abuse of such drugs. H.R. 3015 is a positive step in that direction.

Again, I thank my colleagues and congratulate them on this compromise legislation.

Mr. PAUL. Mr. Speaker, I rise in opposition to H.R. 3015, the National All Schedules Prescription Electronic Reporting Act. This bill is yet another unjustifiable attempt by the Federal government to use the war on drugs as an excuse for invading the privacy and liberties of the American people and for expanding the Federal government's disastrous micromanagement of medical care. As a physician with over 30 years experience in private practice, I must oppose this bill due to the danger it poses to our health as well as our liberty.

By creating a national database of prescriptions for controlled substances, the Federal government would take another step forward in the war on pain patients and their doctors. This war has already resulted in the harassment and prosecution of many doctors, and their staff members, whose only ''crime'' is prescribing legal medication, including opioids, to relieve their patients' pain. These prosecutions, in turn, have scared other doctors so that they are unwilling to prescribe an adequate amount of pain medication, or even any pain medication, for their suffering patients.

Doctors and their staffs may even be prosecuted because of a patient's actions that no doctor approved or even knew about. A doctor has no way of controlling if a patient gives some of the prescribed medication away or consumes a prescribed drug in a dangerous combination with illegal drugs or other prescription drugs obtained from another source. Nonetheless, doctors can be subjected to prosecution when a patient takes such actions.

Applying to doctors laws intended to deal with drug kingpins, the government has created the illusion of some success in the war on drugs. Investigating drug dealers can be hard and dangerous work. In comparison, it is much easier to shut down medical practices and prosecute doctors who prescribe pain medication.

A doctor who is willing to treat chronic pain patients with medically justified amounts of controlled substances may appear at first look to be excessively prescribing. Because so few doctors are willing to take the drug war prosecution risks associated with treating chronic pain patients, and because chronic pain patients must often consume significant doses of pain medication to obtain relief, the prosecution of one pain doctor can be heralded as a large success. All the government needs to do is point to the large amount of patients and drugs associated with a medical practice.

Once doctors know that there is a national database of controlled substances prescriptions that overzealous law enforcement will be scrutinizing to harass doctors, there may be no doctors left who are willing to treat chronic pain. Instead of creating a national database, we should be returning medical regulation to local control, where it historically and constitutionally belongs. Instead of drug warriors regulating medicine with an eye to maximizing

prosecutions, we should return to State medical boards and State civil courts review that looks to science-based standards of medical care and patients' best interests.

H.R. 3015 also threatens patients' privacy. A patient's medical records should be treated according to the mutual agreement of the patient and doctor. In contrast, H.R. 3015 will put a patient's prescriptions on a government-mandated database that can be accessed without the patient's permission.

Instead of further eroding our medical privacy, Congress should take steps to protect it. Why should someone not be able to deny the government and third parties access to his medical records without his permission or a warrant?

One way the House can act to protect patients' privacy is by enacting my Patient Privacy Act (H.R. 1699) that repeals the provision of Federal law establishing a medical ID for every American. Under the guise of ''protecting privacy,'' the Health and Human Services' so-called ''medical privacy'' regulations allow medical researchers, insurance agents, and government officials access to your personal medical records—without your consent. Congress should act now to reverse this government-imposed invasion of our medical privacy.

Please join me in opposing H.R. 3015—legislation that, if enacted, will make us less free and less healthy.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. FOSSELLA). The question is on the motion offered by the gentleman from Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 3015, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to provide for the establishment of a controlled substance monitoring program in each State.''.

A motion to reconsider was laid on the table.

PANCREATIC ISLET CELL TRANSPLANTATION ACT OF 2004

Mr. BARTON of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3858) to amend the Public Health Service Act to increase the supply of pancreatic islet cells for research, and to provide for better coordination of Federal efforts and information on islet cell transplantation.

The Clerk read as follows:

H.R. 3858

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Pancreatic Islet Cell Transplantation Act of 2004''.

SEC. 2. ORGAN PROCUREMENT ORGANIZATION CERTIFICATION.

Section 371 of the Public Health Service Act (42 U.S.C. 273) is amended by adding at the end the following:

''(c) Pancreata procured by an organ procurement organization and used for islet cell transplantation or research shall be counted for purposes of certification or recertification under subsection (b).''.

SEC. 3. ANNUAL ASSESSMENT ON PANCREATIC ISLET CELL TRANSPLANTATION.

Section 429 of the Public Health Service Act (42 U.S.C. 285c–3) is amended by adding at the end the following:

''(d) In each annual report prepared by the Diabetes Mellitus Interagency Coordinating Committee pursuant to subsection (c), the Committee shall include an assessment of the Federal activities and programs related to pancreatic islet cell transplantation. Such assessment shall, at a minimum, address the following:

''(1) The adequacy of Federal funding for taking advantage of scientific opportunities relating to pancreatic islet cell transplantation.

''(2) Current policies and regulations affecting the supply of pancreata for islet cell transplantation.

''(3) The effect of xenotransplantation on advancing pancreatic islet cell transplantation.

''(4) The effect of United Network for Organ Sharing policies regarding pancreas retrieval and islet cell transplantation.

''(5) The existing mechanisms to collect and coordinate outcomes data from existing islet cell transplantation trials.

''(6) Implementation of multiagency clinical investigations of pancreatic islet cell transplantation.

''(7) Recommendations for such legislation and administrative actions as the Committee considers appropriate to increase the supply of pancreata available for islet cell transplantation.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BARTON) and the gentlewoman from Colorado (Ms. DEGETTE) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BARTON).

GENERAL LEAVE

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to include extraneous material on the bill.

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

There was no objection.

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

Mr. Speaker, I rise in strongest possible support of H.R. 3858, the Pancreatic Islet Cell Transplantation Act of 2004, introduced by the gentleman from Washington (Mr. NETHERCUTT).

The Pancreatic Islet Cell Transplantation Act is short and simple. It requires the pancreata donated for the purposes of islet cell transplantation or research be counted for purposes of certification or recertification of organ procurement organizations. Islet cell transplantation is a procedure where islet cells are removed from a donor pancreas and transferred into another person. Once implanted, the beta cells in these islets begin to make and release insulin. H.R. 3858 will help to increase the number of pancreatic and other organ donations, expanding the capabilities of pancreatic islet cell research.

My family is very active in raising the awareness of diabetes. My father, Larry Barton, died of complications from diabetes, and my wife, Terry Barton, is executive director of the Tarrant County Chapter of the American Diabetes Association. So I know personally how excited people are about islet cell transplantation. It may help people with certain type 1 diabetes live without daily injections of insulin, which is very exciting. It is my hope that this legislation will help to speed this research forward.

Mr. Speaker, I cannot urge in any stronger possible terms that all Members support this legislation.

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

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

Mr. Speaker, today this body can greatly improve the lives of more than 1 million Americans who are affected by juvenile diabetes. The Pancreatic Islet Cell Transplantation Act addresses a significant problem by reducing the nonscientific barriers standing in the way of this promising treatment.

Pancreatic islet cell transplantation is a procedure that infuses new insulin-producing cells into an individual with juvenile diabetes. This procedure has now been performed in over 300 people in this country. The results are nothing short of miraculous. A majority of those islet cell transplantation recipients no longer need to inject themselves with insulin.

For a person with juvenile diabetes this change is life altering. It means no more needles and no more worry. It means the question of what to eat no longer requires calculation or cause for alarm. For those patients islet cell transplantation means freedom, and ultimately islet cell transplantation will be a cure for type 1 diabetes.

As we know too well, Mr. Speaker, living with diabetes is challenging. Insulin is not a cure. It is only a means of managing the disease, and it is more complicated by the difficulties of monitoring glucose levels. Very serious complications like blindness and kidney disease are not uncommon. In fact, a staggering number of patients with juvenile, or type 1, diabetes suffer from some type of complication. Every year 82,000 individuals lose their foot or leg to diabetes. Heart disease is the leading cause of diabetes-related deaths. And diabetes is the leading cause of new blindness in people 20 to 74 years old.

This bill, which I was proud to introduce with the gentleman from Washington (Mr. NETHERCUTT), who, unfortunately, cannot be here with us today, takes us one step closer to preventing these devastating complications. H.R. 3858 will help increase the supply of pancreata for islet cell transplantation and better coordinate Federal Government efforts and information. These