eyes of the U.S. Drug Enforcement Administration and Department of Justice, is prohibited for U.S. exporters. This contrasts with the freedom of drug manufacturers throughout the rest of the world to readily move their products among and between international drug control treaty countries without limit or restriction.

These limitations put U.S. manufacturers at a disadvantage by requiring more frequent and costly shipments to each individual country of use. We are effectively discouraging domestic manufacturing while encouraging U.S. drug exporters to move production overseas.

Utah, with a small but growing pharmaceutical manufacturing industry, is committed to maintaining a strong domestic base so that U.S. businesses can compete on a level playing field with our international competitors. But this industry faces an uncertain future unless we do something.

S. 1395, the Controlled Substances Export Reform Act of 2005, is the companion legislation to H.R. 184 that Rep. JOE PITTS and I introduced in the House, and that passed the House Judiciary and Energy and Commerce Committees. This legislation advances that goal by permitting the carefully regulated international transshipment of exported U.S. pharmaceuticals. The bill retains full DEA control over all drug exports and establishes strict permitting requirements to ensure drug safety while removing an unnecessary barrier to U.S. production and the growth of well-paid jobs.

Mr. Speaker, on behalf of the 500 Utah workers whose jobs may be endangered by current law, and on behalf of the many more workers we stand to gain by updating an outdated statute, I am pleased to support S. 1395 and I urge the measure's immediate adoption.

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

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and pass the Senate bill, S. 1395.

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

A motion to reconsider was laid on the table.

PATIENT SAFETY AND QUALITY IMPROVEMENT ACT OF 2005

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 544) to amend title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect patient safety.

The Clerk read as follows:

S. 544

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Safety and Quality Improvement Act of 2005''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 912(c), by inserting '', in accordance with part C,'' after ''The Director shall'';

(2) by redesignating part C as part D;

(3) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(4) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(5) by inserting after part B the following:

''PART C—PATIENT SAFETY IMPROVEMENT

''SEC. 921. DEFINITIONS.

''In this part:

''(1) HIPAA CONFIDENTIALITY REGULATIONS.—The term 'HIPAA confidentiality regulations' means regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033).

''(2) IDENTIFIABLE PATIENT SAFETY WORK PRODUCT.—The term 'identifiable patient safety work product' means patient safety work product that—

''(A) is presented in a form and manner that allows the identification of any provider that is a subject of the work product, or any providers that participate in activities that are a subject of the work product;

''(B) constitutes individually identifiable health information as that term is defined in the HIPAA confidentiality regulations; or

''(C) is presented in a form and manner that allows the identification of an individual who reported information in the manner specified in section 922(e).

''(3) NONIDENTIFIABLE PATIENT SAFETY WORK PRODUCT.—The term 'nonidentifiable patient safety work product' means patient safety work product that is not identifiable patient safety work product (as defined in paragraph (2)).

''(4) PATIENT SAFETY ORGANIZATION.—The term 'patient safety organization' means a private or public entity or component thereof that is listed by the Secretary pursuant to section 924(d).

''(5) PATIENT SAFETY ACTIVITIES.—The term 'patient safety activities' means the following activities:

''(A) Efforts to improve patient safety and the quality of health care delivery.

''(B) The collection and analysis of patient safety work product.

''(C) The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices.

''(D) The utilization of patient safety work product for the purposes of encouraging a culture of safety and of providing feedback and assistance to effectively minimize patient risk.

''(E) The maintenance of procedures to preserve confidentiality with respect to patient safety work product.

''(F) The provision of appropriate security measures with respect to patient safety work product.

''(G) The utilization of qualified staff.

''(H) Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.

''(6) PATIENT SAFETY EVALUATION SYSTEM.—The term 'patient safety evaluation system' means the collection, management, or analysis of information for reporting to or by a patient safety organization.

''(7) PATIENT SAFETY WORK PRODUCT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'patient safety work product' means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements—

''(i) which—

''(I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or

''(II) are developed by a patient safety organization for the conduct of patient safety activities;

and which could result in improved patient safety, health care quality, or health care outcomes; or

''(ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

''(B) CLARIFICATION.—

''(i) Information described in subparagraph (A) does not include a patient's medical record, billing and discharge information, or any other original patient or provider record.

''(ii) Information described in subparagraph (A) does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product.

''(iii) Nothing in this part shall be construed to limit—

''(I) the discovery of or admissibility of information described in this subparagraph in a criminal, civil, or administrative proceeding;

''(II) the reporting of information described in this subparagraph to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes; or

''(III) a provider's recordkeeping obligation with respect to information described in this subparagraph under Federal, State, or local law.

''(8) PROVIDER.—The term 'provider' means—

''(A) an individual or entity licensed or otherwise authorized under State law to provide health care services, including—

''(i) a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, clinical laboratory, or health center; or

''(ii) a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner; or

''(B) any other individual or entity specified in regulations promulgated by the Secretary.

''SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTECTIONS.

''(a) PRIVILEGE.—Notwithstanding any other provision of Federal, State, or local

law, and subject to subsection (c), patient safety work product shall be privileged and shall not be—

''(1) subject to a Federal, State, or local civil, criminal, or administrative subpoena or order, including in a Federal, State, or local civil or administrative disciplinary proceeding against a provider;

''(2) subject to discovery in connection with a Federal, State, or local civil, criminal, or administrative proceeding, including in a Federal, State, or local civil or administrative disciplinary proceeding against a provider;

''(3) subject to disclosure pursuant to section 552 of title 5, United States Code (commonly known as the Freedom of Information Act) or any other similar Federal, State, or local law;

''(4) admitted as evidence in any Federal, State, or local governmental civil proceeding, criminal proceeding, administrative rulemaking proceeding, or administrative adjudicatory proceeding, including any such proceeding against a provider; or

''(5) admitted in a professional disciplinary proceeding of a professional disciplinary body established or specifically authorized under State law.

''(b) CONFIDENTIALITY OF PATIENT SAFETY WORK PRODUCT.—Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c), patient safety work product shall be confidential and shall not be disclosed.

''(c) EXCEPTIONS.—Except as provided in subsection (g)(3)—

''(1) EXCEPTIONS FROM PRIVILEGE AND CONFIDENTIALITY.—Subsections (a) and (b) shall not apply to (and shall not be construed to prohibit) one or more of the following disclosures:

''(A) Disclosure of relevant patient safety work product for use in a criminal proceeding, but only after a court makes an in camera determination that such patient safety work product contains evidence of a criminal act and that such patient safety work product is material to the proceeding and not reasonably available from any other source.

''(B) Disclosure of patient safety work product to the extent required to carry out subsection (f)(4)(A).

''(C) Disclosure of identifiable patient safety work product if authorized by each provider identified in such work product.

''(2) EXCEPTIONS FROM CONFIDENTIALITY.—Subsection (b) shall not apply to (and shall not be construed to prohibit) one or more of the following disclosures:

''(A) Disclosure of patient safety work product to carry out patient safety activities.

''(B) Disclosure of nonidentifiable patient safety work product.

''(C) Disclosure of patient safety work product to grantees, contractors, or other entities carrying out research, evaluation, or demonstration projects authorized, funded, certified, or otherwise sanctioned by rule or other means by the Secretary, for the purpose of conducting research to the extent that disclosure of protected health information would be allowed for such purpose under the HIPAA confidentiality regulations.

''(D) Disclosure by a provider to the Food and Drug Administration with respect to a product or activity regulated by the Food and Drug Administration.

''(E) Voluntary disclosure of patient safety work product by a provider to an accrediting body that accredits that provider.

''(F) Disclosures that the Secretary may determine, by rule or other means, are necessary for business operations and are consistent with the goals of this part.

''(G) Disclosure of patient safety work product to law enforcement authorities relating to the commission of a crime (or to an event reasonably believed to be a crime) if the person making the disclosure believes, reasonably under the circumstances, that the patient safety work product that is disclosed is necessary for criminal law enforcement purposes.

''(H) With respect to a person other than a patient safety organization, the disclosure of patient safety work product that does not include materials that—

''(i) assess the quality of care of an identifiable provider; or

''(ii) describe or pertain to one or more actions or failures to act by an identifiable provider.

''(3) EXCEPTION FROM PRIVILEGE.—Subsection (a) shall not apply to (and shall not be construed to prohibit) voluntary disclosure of nonidentifiable patient safety work product.

''(d) CONTINUED PROTECTION OF INFORMATION AFTER DISCLOSURE.—

''(1) IN GENERAL.—Patient safety work product that is disclosed under subsection (c) shall continue to be privileged and confidential as provided for in subsections (a) and (b), and such disclosure shall not be treated as a waiver of privilege or confidentiality, and the privileged and confidential nature of such work product shall also apply to such work product in the possession or control of a person to whom such work product was disclosed.

''(2) EXCEPTION.—Notwithstanding paragraph (1), and subject to paragraph (3)—

''(A) if patient safety work product is disclosed in a criminal proceeding, the confidentiality protections provided for in subsection (b) shall no longer apply to the work product so disclosed; and

''(B) if patient safety work product is disclosed as provided for in subsection (c)(2)(B) (relating to disclosure of nonidentifiable patient safety work product), the privilege and confidentiality protections provided for in subsections (a) and (b) shall no longer apply to such work product.

''(3) CONSTRUCTION.—Paragraph (2) shall not be construed as terminating or limiting the privilege or confidentiality protections provided for in subsection (a) or (b) with respect to patient safety work product other than the specific patient safety work product disclosed as provided for in subsection (c).

''(4) LIMITATIONS ON ACTIONS.—

''(A) PATIENT SAFETY ORGANIZATIONS.—

''(i) IN GENERAL.—A patient safety organization shall not be compelled to disclose information collected or developed under this part whether or not such information is patient safety work product unless such information is identified, is not patient safety work product, and is not reasonably available from another source.

''(ii) NONAPPLICATION.—The limitation contained in clause (i) shall not apply in an action against a patient safety organization or with respect to disclosures pursuant to subsection (c)(1).

''(B) PROVIDERS.—An accrediting body shall not take an accrediting action against a provider based on the good faith participation of the provider in the collection, development, reporting, or maintenance of patient safety work product in accordance with this part. An accrediting body may not require a provider to reveal its communications with any patient safety organization established in accordance with this part.

''(e) REPORTER PROTECTION.—

''(1) IN GENERAL.—A provider may not take an adverse employment action, as described in paragraph (2), against an individual based upon the fact that the individual in good faith reported information—

''(A) to the provider with the intention of having the information reported to a patient safety organization; or

''(B) directly to a patient safety organization.

''(2) ADVERSE EMPLOYMENT ACTION.—For purposes of this subsection, an 'adverse employment action' includes—

''(A) loss of employment, the failure to promote an individual, or the failure to provide any other employment-related benefit for which the individual would otherwise be eligible; or

''(B) an adverse evaluation or decision made in relation to accreditation, certification, credentialing, or licensing of the individual.

''(f) ENFORCEMENT.—

''(1) CIVIL MONETARY PENALTY.—Subject to paragraphs (2) and (3), a person who discloses identifiable patient safety work product in knowing or reckless violation of subsection (b) shall be subject to a civil monetary penalty of not more than $10,000 for each act constituting such violation.

''(2) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(3) RELATION TO HIPAA.—Penalties shall not be imposed both under this subsection and under the regulations issued pursuant to section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) for a single act or omission.

''(4) EQUITABLE RELIEF.—

''(A) IN GENERAL.—Without limiting remedies available to other parties, a civil action may be brought by any aggrieved individual to enjoin any act or practice that violates subsection (e) and to obtain other appropriate equitable relief (including reinstatement, back pay, and restoration of benefits) to redress such violation.

''(B) AGAINST STATE EMPLOYEES.—An entity that is a State or an agency of a State government may not assert the privilege described in subsection (a) unless before the time of the assertion, the entity or, in the case of and with respect to an agency, the State has consented to be subject to an action described in subparagraph (A), and that consent has remained in effect.

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to limit the application of other Federal, State, or local laws that provide greater privilege or confidentiality protections than the privilege and confidentiality protections provided for in this section;

''(2) to limit, alter, or affect the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under this section;

''(3) except as provided in subsection (i), to alter or affect the implementation of any provision of the HIPAA confidentiality regulations or section 1176 of the Social Security Act (or regulations promulgated under such section);

''(4) to limit the authority of any provider, patient safety organization, or other entity to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with this section;

''(5) as preempting or otherwise affecting any State law requiring a provider to report information that is not patient safety work product; or

''(6) to limit, alter, or affect any requirement for reporting to the Food and Drug Administration information regarding the safety of a product or activity regulated by the Food and Drug Administration.

''(h) CLARIFICATION.—Nothing in this part prohibits any person from conducting additional analysis for any purpose regardless of whether such additional analysis involves issues identical to or similar to those for which information was reported to or assessed by a patient safety organization or a patient safety evaluation system.

''(i) CLARIFICATION OF APPLICATION OF HIPAA CONFIDENTIALITY REGULATIONS TO PATIENT SAFETY ORGANIZATIONS.—For purposes of applying the HIPAA confidentiality regulations—

''(1) patient safety organizations shall be treated as business associates; and

''(2) patient safety activities of such organizations in relation to a provider are deemed to be health care operations (as defined in such regulations) of the provider.

''(j) REPORTS ON STRATEGIES TO IMPROVE PATIENT SAFETY.—

''(1) DRAFT REPORT.—Not later than the date that is 18 months after any network of patient safety databases is operational, the Secretary, in consultation with the Director, shall prepare a draft report on effective strategies for reducing medical errors and increasing patient safety. The draft report shall include any measure determined appropriate by the Secretary to encourage the appropriate use of such strategies, including use in any federally funded programs. The Secretary shall make the draft report available for public comment and submit the draft report to the Institute of Medicine for review.

''(2) FINAL REPORT.—Not later than 1 year after the date described in paragraph (1), the Secretary shall submit a final report to the Congress.

''SEC. 923. NETWORK OF PATIENT SAFETY DATABASES.

''(a) IN GENERAL.—The Secretary shall facilitate the creation of, and maintain, a network of patient safety databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other entities. The network of databases shall have the capacity to accept, aggregate across the network, and analyze nonidentifiable patient safety work product voluntarily reported by patient safety organizations, providers, or other entities. The Secretary shall assess the feasibility of providing for a single point of access to the network for qualified researchers for information aggregated across the network and, if feasible, provide for implementation.

''(b) DATA STANDARDS.—The Secretary may determine common formats for the reporting to and among the network of patient safety databases maintained under subsection (a) of nonidentifiable patient safety work product, including necessary work product elements, common and consistent definitions, and a standardized computer interface for the processing of such work product. To the extent practicable, such standards shall be consistent with the administrative simplification provisions of part C of title XI of the Social Security Act.

''(c) USE OF INFORMATION.—Information reported to and among the network of patient safety databases under subsection (a) shall be used to analyze national and regional statistics, including trends and patterns of health care errors. The information resulting from such analyses shall be made available to the public and included in the annual quality reports prepared under section 913(b)(2).

''SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFICATION AND LISTING.

''(a) CERTIFICATION.—

''(1) INITIAL CERTIFICATION.—An entity that seeks to be a patient safety organization shall submit an initial certification to the Secretary that the entity—

''(A) has policies and procedures in place to perform each of the patient safety activities described in section 921(5); and

''(B) upon being listed under subsection (d), will comply with the criteria described in subsection (b).

''(2) SUBSEQUENT CERTIFICATIONS.—An entity that is a patient safety organization shall submit every 3 years after the date of its initial listing under subsection (d) a subsequent certification to the Secretary that the entity—

''(A) is performing each of the patient safety activities described in section 921(5); and

''(B) is complying with the criteria described in subsection (b).

''(b) CRITERIA.—

''(1) IN GENERAL.—The following are criteria for the initial and subsequent certification of an entity as a patient safety organization:

''(A) The mission and primary activity of the entity are to conduct activities that are to improve patient safety and the quality of health care delivery.

''(B) The entity has appropriately qualified staff (whether directly or through contract), including licensed or certified medical professionals.

''(C) The entity, within each 24-month period that begins after the date of the initial listing under subsection (d), has bona fide contracts, each of a reasonable period of time, with more than 1 provider for the purpose of receiving and reviewing patient safety work product.

''(D) The entity is not, and is not a component of, a health insurance issuer (as defined in section 2791(b)(2)).

''(E) The entity shall fully disclose—

''(i) any financial, reporting, or contractual relationship between the entity and any provider that contracts with the entity; and

''(ii) if applicable, the fact that the entity is not managed, controlled, and operated independently from any provider that contracts with the entity.

''(F) To the extent practical and appropriate, the entity collects patient safety work product from providers in a standardized manner that permits valid comparisons of similar cases among similar providers.

''(G) The utilization of patient safety work product for the purpose of providing direct feedback and assistance to providers to effectively minimize patient risk.

''(2) ADDITIONAL CRITERIA FOR COMPONENT ORGANIZATIONS.—If an entity that seeks to be a patient safety organization is a component of another organization, the following are additional criteria for the initial and subsequent certification of the entity as a patient safety organization:

''(A) The entity maintains patient safety work product separately from the rest of the organization, and establishes appropriate security measures to maintain the confidentiality of the patient safety work product.

''(B) The entity does not make an unauthorized disclosure under this part of patient safety work product to the rest of the organization in breach of confidentiality.

''(C) The mission of the entity does not create a conflict of interest with the rest of the organization.

''(c) REVIEW OF CERTIFICATION.—

''(1) IN GENERAL.—

''(A) INITIAL CERTIFICATION.—Upon the submission by an entity of an initial certification under subsection (a)(1), the Secretary shall determine if the certification meets the requirements of subparagraphs (A) and (B) of such subsection.

''(B) SUBSEQUENT CERTIFICATION.—Upon the submission by an entity of a subsequent certification under subsection (a)(2), the Secretary shall review the certification with respect to requirements of subparagraphs (A) and (B) of such subsection.

''(2) NOTICE OF ACCEPTANCE OR NON-ACCEPTANCE.—If the Secretary determines that—

''(A) an entity's initial certification meets requirements referred to in paragraph (1)(A), the Secretary shall notify the entity of the acceptance of such certification; or

''(B) an entity's initial certification does not meet such requirements, the Secretary shall notify the entity that such certification is not accepted and the reasons therefor.

''(3) DISCLOSURES REGARDING RELATIONSHIP TO PROVIDERS.—The Secretary shall consider any disclosures under subsection (b)(1)(E) by an entity and shall make public findings on whether the entity can fairly and accurately perform the patient safety activities of a patient safety organization. The Secretary shall take those findings into consideration in determining whether to accept the entity's initial certification and any subsequent certification submitted under subsection (a) and, based on those findings, may deny, condition, or revoke acceptance of the entity's certification.

''(d) LISTING.—The Secretary shall compile and maintain a listing of entities with respect to which there is an acceptance of a certification pursuant to subsection (c)(2)(A) that has not been revoked under subsection (e) or voluntarily relinquished.

''(e) REVOCATION OF ACCEPTANCE OF CERTIFICATION.—

''(1) IN GENERAL.—If, after notice of deficiency, an opportunity for a hearing, and a reasonable opportunity for correction, the Secretary determines that a patient safety organization does not meet the certification requirements under subsection (a)(2), including subparagraphs (A) and (B) of such subsection, the Secretary shall revoke the Secretary's acceptance of the certification of such organization.

''(2) SUPPLYING CONFIRMATION OF NOTIFICATION TO PROVIDERS.—Within 15 days of a revocation under paragraph (1), a patient safety organization shall submit to the Secretary a confirmation that the organization has taken all reasonable actions to notify each provider whose patient safety work product is collected or analyzed by the organization of such revocation.

''(3) PUBLICATION OF DECISION.—If the Secretary revokes the certification of an organization under paragraph (1), the Secretary shall—

''(A) remove the organization from the listing maintained under subsection (d); and

''(B) publish notice of the revocation in the Federal Register.

''(f) STATUS OF DATA AFTER REMOVAL FROM LISTING.—

''(1) NEW DATA.—With respect to the privilege and confidentiality protections described in section 922, data submitted to an entity within 30 days after the entity is removed from the listing under subsection (e)(3)(A) shall have the same status as data submitted while the entity was still listed.

''(2) PROTECTION TO CONTINUE TO APPLY.—If the privilege and confidentiality protections described in section 922 applied to patient safety work product while an entity was listed, or to data described in paragraph (1), such protections shall continue to apply to such work product or data after the entity is removed from the listing under subsection (e)(3)(A).

''(g) DISPOSITION OF WORK PRODUCT AND DATA.—If the Secretary removes a patient safety organization from the listing as provided for in subsection (e)(3)(A), with respect

to the patient safety work product or data described in subsection (f)(1) that the patient safety organization received from another entity, such former patient safety organization shall—

''(1) with the approval of the other entity and a patient safety organization, transfer such work product or data to such patient safety organization;

''(2) return such work product or data to the entity that submitted the work product or data; or

''(3) if returning such work product or data to such entity is not practicable, destroy such work product or data.

''SEC. 925. TECHNICAL ASSISTANCE.

''The Secretary, acting through the Director, may provide technical assistance to patient safety organizations, including convening annual meetings for patient safety organizations to discuss methodology, communication, data collection, or privacy concerns.

''SEC. 926. SEVERABILITY.

''If any provision of this part is held to be unconstitutional, the remainder of this part shall not be affected.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 937 of the Public Health Service Act (as redesignated by subsection (a)) is amended by adding at the end the following:

''(e) PATIENT SAFETY AND QUALITY IMPROVEMENT.—For the purpose of carrying out part C, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2006 through 2010.''.

(c) GAO STUDY ON IMPLEMENTATION.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of part C of title IX of the Public Health Service Act (as added by subsection (a)) in accomplishing the purposes of such part.

(2) REPORT.—Not later than February 1, 2010, the Comptroller General shall submit a report on the study conducted under paragraph (1). Such report shall include such recommendations for changes in such part as the Comptroller General deems appropriate.

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

The Chair recognizes the gentleman from Georgia (Mr. DEAL).

GENERAL LEAVE

Mr. DEAL of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on S. 544, the Senate bill now under consideration.

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

There was no objection.

Mr. DEAL of Georgia. Mr. Speaker, I yield myself such time as I may consume, and I rise today in support of S. 544, the Patient Safety and Quality Improvement Act of 2005.

This bill reflects the bipartisan and bicameral agreement of the leadership of the Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor, and Pensions. The bill is identical to H.R. 3205, which was passed by the Committee on Energy and Commerce last week.

In 1999, the Institute of Medicine first identified that up to 98,000 Americans die every year as a result of preventable medical errors. In the report, entitled ''To Err is Human,'' the IOM recommended that Congress pass legislation to protect the development and analysis of information related to improving safety and quality. The Patient Safety and Quality Improvement Act of 2005 codifies the principal recommendations made in the IOM report.

This bill will assist in promoting a culture of safety and quality; and, more important, it will save lives. The bill encourages providers, such as hospitals and physicians, to share information with HHS-certified patient safety organizations to assess ways in which to improve the delivery of health care and reduce medical errors. Information regarding patients, providers, and reporters, called patient safety work product, would now remain confidential and protected.

Mr. Speaker, the bill fosters open and honest communications among providers and patient safety organizations to achieve an environment where providers are able to discuss errors openly and learn from them. The bill also provides a privilege from disclosing patient safety work product in most court or administrative proceedings.

In addition to enjoying bipartisan support, this bill is also supported by providers and consumer groups. These include the American Medical Association, the American Hospital Association, the American College of Surgeons, and the AARP.

This new language builds directly on the work of our colleague, the gentleman from Florida (Mr. BILIRAKIS), who worked to develop a bipartisan patient safety bill that passed by over 400 votes in the last Congress.

I also want to recognize Senators ENZI and KENNEDY; our House ranking member, the gentleman from Michigan (Mr. DINGELL); and the ranking member of the Subcommittee on Health, the gentleman from Ohio (Mr. BROWN), for their leadership in this effort. They, along with the staffs of the House Committee on Energy and Commerce and the Senate HELP Committee, deserve our thanks for producing this important bipartisan bill.

I also specifically would like to recognize Andrew Patzman and David Bowen from the Senate HELP Committee, along with Bridgett Taylor, Purvee Kempf, Nandan Kenkermath, Melissa Bartlett, and Brandon Clark for their important help on this bill.

Mr. Speaker, I yield 5 minutes to the gentleman from Florida (Mr. BILIRAKIS), the original sponsor of this legislation in the past Congress and one who has continued to work on it.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time; and I, too, obviously, support S. 544, which is the exact Senate counterpart to H.R. 3205, the legislation on which I and so many others have worked for several years to reduce medical errors and save lives.

The landmark 1999 Institute of Medicine report entitled ''To Err is Human,'' found that as many as 98,000 people die each year from preventable medical errors. The IOM report noted these errors may cost taxpayers as much as $29 billion each year, in addition to the incalculable pain and suffering experienced by those who lose loved ones as a result of them.

The Patient Safety and Quality Improvement Act will implement many of the IOM's recommendations for reducing medical errors. This legislation would establish a framework within which providers can voluntarily report medical errors to patient safety organizations, which in turn would analyze the data and recommend steps providers could take to prevent such errors from occurring in the future.

These patient safety organizations will be empowered to compile reports on errors and near-misses, determine the causes of these errors or near-errors, identify the changes that need to be made to the health care delivery system to prevent these errors in the future, and implement needed changes. Their work will be invaluable in identifying national trends on medical errors and recommending how to prevent them.

The legislation encourages providers to share information about medical mistakes by preventing the information that they have created specifically to report to patient safety organizations from being used against them. The bill would preclude this information, termed patient safety work product, from being used against providers in civil and administrative proceedings, disclosed pursuant to Freedom of Information Act requests, or used to carry out adverse personnel actions.

The bill does not shield other information outside this patient safety work product from use in court cases. I believe it strikes an appropriate balance between encouraging the reporting of valuable information, which will be used to save lives, and safeguarding the ability of individuals to access necessary information to seek judicial redress when appropriate.

I believe that Congress must pass the Patient Safety and Quality Improvement Act to encourage the voluntary reporting of information on medical errors. Doing so will help create a culture of awareness to expose and address the systemic causes of medical errors instead of continuing the culture of blame which hides and perpetuates them.

Mr. Speaker, I want to thank several individuals: Chairman of the Committee on Energy and Commerce, the gentleman from Texas (Mr. BARTON); and the chairman of the Subcommittee on Health, the gentleman from Georgia (Mr. DEAL). They have shared my commitment to making medical errors as rare as possible and minimizing the hurt they cause their families, as have the ranking member, the gentleman from Michigan (Mr. DINGELL), and the subcommittee ranking member, the

gentleman from Ohio (Mr. BROWN). This indeed has been a true bipartisan effort.

I also want to thank members of the staff, though the gentleman from Georgia (Mr. DEAL) already has done so: Nandan Kenkermath and Melissa Bartlett, as well as chief counsel Chuck Clapton and health policy coordinator Brandon Clark.

Mr. Speaker, I also want to thank Jeanne Haggerty, Jeremy Allen, and Steve Tilton, several former members of my staff, whose previous work on this legislation laid the groundwork for its enactment here today. All of these individuals, all should be proud their contributions to this legislation will ultimately save the lives of many they will never know.

Mr. Speaker, I urge all our colleagues to support the Patient Safety and Quality Improvement Act.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 3 minutes.

It is tragic when Americans die prematurely despite modern medicine. It is heartbreaking when Americans die because of modern medicine. Medical errors take lives, medical errors waste money, and medical errors are largely preventable.

Based on available data, medical errors kill up to 100,000 Americans every year. That number, for sure, is a ballpark estimate because we know that medical errors are underreported. That is disturbing, but hardly surprising. The reality is that the consequences of reporting medical errors can be onerous, which deters some who commit or witness medical errors from documenting them.

This legislation is intended to overcome that obstacle. To reduce the number of medical errors, we need to understand what causes them and address those causes. Accurate and complete information on medical errors is the first step. H.R. 3205, or S. 544, creates a secure voluntary medical error reporting system. The system is carefully crafted to encourage information-sharing without undermining the ability of patients to obtain justice when they are harmed and to help the health care system identify the root causes of medical errors without hindering the prosecution of criminal acts.

My friend, the gentleman from Florida (Mr. BILIRAKIS), and I have been working on this legislation for several years. I appreciate his leadership on this issue, as well as that of the subcommittee chairman, the gentleman from Georgia (Mr. DEAL), and our ranking member on the full committee, the gentleman from Michigan (Mr. DINGELL), along with the chairman of the full committee, the gentleman from Texas (Mr. BARTON).

I would also like to commend committee staff on both sides of the aisle for their hard work to reach a solid bipartisan, bicameral compromise on this bill. H.R. 3205/S. 544 will strengthen our health care system and save lives, and I urge my colleagues' support of this measure.

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

Mr. DEAL of Georgia. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in support of the Patient Safety and Quality Improvement Act of 2005. I am a proud cosponsor of this bill, and I know that this is a bill that my good friend, the gentleman from Florida (Mr. BILIRAKIS), has been working on for at least 5 years. And so now I am happy to see it finally come to the floor and will become law, hopefully.

Americans have the best doctors and technology in the world; yet it is reported every day that more than 250 Americans die because of preventable medical errors in hospitals alone. The cost of preventable medical errors is estimated between $17 billion and $29 billion annually.

Mr. Speaker, we must acknowledge that any error that causes harm to a patient is one too many. While our health care system may never be perfect, we must strive for the best care for our Nation's patients. I am happy that this legislation begins to improve the ability to connect information about errors and near-errors between doctors, researchers, and patients.

However, as I have stated for years, a key step to improving care should be also the passage of meaningful patient protections under Federal law. When insurers and employees are concerned about the cost of health care, the quality of patient care can be jeopardized for the bottom line. This breeds improper care, and it breeds medical error.

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In this light, this legislation is an important first step. This bill will encourage the creation of patient safety organizations that providers will contract with to provide patient safety information to a national patient safety database. While I will concede that I wish we were mandating more in this legislation about reporting errors and getting that information to patients, I stress that this is an essential, important first step.

The bill helps develop a culture of safety that encourages information sharing. When an error occurs, it is important to learn from it so as to not repeat it. We need to get everyone comfortable with reporting errors and near errors, and this bill begins to do just that.

This bill presents us with an opportunity to stand up for patients, and I urge all of my colleagues to join us in supporting it.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentleman from Rhode Island (Mr. KENNEDY) who has been a strong advocate during his several terms in Congress for patient safety and for patients generally.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would like to thank the gentleman from Ohio (Mr. BROWN) for his leadership in this area, as well as the gentleman from Florida (Mr. BILIRAKIS) for his, in addition to the committee chairman, the gentleman from Texas (Mr. BARTON), and the ranking member, the gentleman from Michigan (Mr. DINGELL).

Of the many bills we are talking about on the floor this week, this is the only one that is really addressing the root problem in our health care system. We stand here in the well of the House, all of us from both sides of the aisle, pontificating about the high cost of care, malpractice rates, access to prescription drugs, or the uninsured. All of these are serious problems with big negative impacts on people, but these issues are all symptomatic of a real problem in health care. Our system is not set up to get the right care at the right time to the right people.

Hundreds of our constituents will die today, tomorrow, and every day until we get this right. Millions will be priced out of care until we get this right. My friends just mentioned the statistics; the equivalent of a jumbo jet crashing every 3 days is how many people we lose in our health care system due to inadequate information because there is inadequate information technology to make the information intraoperable and transparent for all to see so there are not those medications that one is being prescribed by one doctor contravening the medications that are prescribed by another doctor because no one has an electronic medical record.

This bill is a step in the right direction. It aligns the incentives in health care to promote outcomes we want: higher quality, higher safety and higher efficiency. We have seen studies where Medicare has had a single procedure. That procedure has been done all around the country, and even in the markets where it costs us the most, we often see where we have the worst outcomes. We have to ask ourselves why is it that we are paying for more care and getting less results? This bill does a lot to address that problem. We need to learn from our mistakes and use them to make better decisions in the future.

This is a bill that is carefully designed to compromise so we do not have a situation where we close down people's right to seek redress for those that are seriously and grievously injured in the course of their health care.

I hope this patient safety bill is the tip of the iceberg in what we will do to transform health care. We need to pass a strong health care information technology bill. This bill was reported out of the committee and I think it will go a long way to getting us on that road, but I hope that we continue in this legislative session to move us even further, where we begin as a country to make our health care system come up to the same level of technology as every other area in our country is right now.

It is inconceivable that people can have an ATM card and get information

or dollars anywhere in the country, and yet they cannot get their medical record to the doctor that they need to have that medical record so that physician can make the right decision based upon all of the information that is there about their background, and that we are not having situations where there are drug overdoses because of lack of being able to read the orders. As is too often the case, we not only have people die, but also seriously injured.

One instance, a little girl named Josie King in Baltimore was seriously scalded when she went into the bathtub and the tub was too hot. Her mother took her to the hospital, and she got the best care because this country has the best health care in the world. She had the best professionals because this country has the best professionals in the world. But when it came to the system, the system is what is broken, and this system let Josie King down to the point where she was given the wrong medication because her physician did not have the right information before him. As a result, Josie King was in a coma and eventually had to be removed from life support.

Mr. Speaker, we need to learn from these tragedies if we are to prevent them in the future. This legislation moves us down that path. I ask my colleagues to support this legislation.

Mr. DEAL of Georgia. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS), a member of the Subcommittee on Health.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for yielding me this time, and thank the gentleman from Florida (Mr. BILIRAKIS) for his leadership, and the gentleman from Texas (Chairman BARTON), who is always evenhanded, played a big role in us finally getting this bill to the floor. I thank the ranking member, the gentleman from Ohio (Mr. BROWN), for his work on this bill as well.

Mr. Speaker, this is an important bill before us today. As a physician, I know that in order to improve safety, we have got to report errors. The gentleman from Georgia (Mr. NORWOOD) just pointed out how if you do not report the error, you cannot learn from the mistake and never prevent it from happening again.

We have an environment right now that punishes doctors for perceived or actual mistakes by lawsuits and regulation, and it has become nearly impossible to encourage true transparency in the practice of medicine. This opacity has not served anyone well with the possible exception of the plaintiff's bar.

I am pleased the United States Congress has finally come to an agreement on a level-headed approach to error reporting and will set quality standards in medicine. I believe this bill will be the first assault on the culture of fear that has permeated medicine for years now; doctors afraid of making a mistake, or doctors afraid of saying I am sorry for fear of being sued no matter how small the mistake, and this may lead to underreporting, overtreatment, and repetition of the same error again.

By permitting reporting, this bill takes a critical first step in improving the quality of care in this country. The research on patient safety unequivocally calls for a learning environment rather than the punitive environment that is present in this country.

Many organizations are currently collecting patient safety data, and this bill will give them the legal protections that will allow them to review protected information and collaborate on the development and implementation of patient safety and improvement strategies.

Mr. Speaker, this bill is long overdue. I agree with the gentleman from Georgia (Mr. NORWOOD) it is but a first step, but it is an important first step, and I am happy to put my support behind this bill that will improve the medical profession and improve the quality and safety of medical care for all Americans.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, S. 544 is identical to the bill passed out of the Committee on Emergency and Commerce, H.R. 3205. Therefore, the committee report we will be filing based on H.R. 3205 is directly relevant to S. 544. I wanted that part of the RECORD.

Mr. DINGELL. Mr. Speaker, in 1999, the Institute of Medicine (IOM) reported that as many as 98,000 people are estimated to die annually as a result of medical errors. The IOM recommended several changes, including the creation of a patient safety reporting system that would allow health care service providers to report information about medical errors in a non-punitive environment. This information would be reviewed by a patient safety organization that would then help providers learn from their mistakes without fear of reprisal.

The Committee has been working for many years on legislation to bring forward the building blocks of this system, and in the 108th Congress, we successfully passed bipartisan legislation in the House. Only this Congress, however, did we successfully reach a compromise with our colleagues in the Senate. I am pleased that today we will finally pass the Patient Safety and Quality Improvement Act of 2005, with the expectation that it will be enacted into law.

S. 544, the Senate companion bill to H.R. 3205, contains the same language as the House bill approved unanimously by the Committee on Energy and Commerce last week. The goal of H.R. 3205 is to set up an error reporting system for health care providers that brings real improvements in patient safety and the quality of health care. It will also help ensure accountability by raising standards and creating the expectation for continuous quality improvements in patient safety. This bill achieves these goals by creating a helpful and non-punitive atmosphere for health care providers to share information with entities specialized in patient safety and quality improvement. Yet, it continues to allow public access to information that is available today. Patient safety organizations will receive information about medical errors and then evaluate trends, such as infection rates and other quality measures, within provider organizations. This will help providers learn to avoid such errors in the future.

This is excellent and important legislation, and I urge its adoption.

Mr. DOOLITTLE. Mr. Speaker, I rise today to support the legislation introduced by my colleague from Vermont which, understandably, enjoys bipartisan support.

Last, year, President Bush called for the majority of Americans to have electronic health records within 10 years and established the role of the National Coordinator for Health Information Technology to help realize this target. The Patient Safety and Quality Improvement Act 2005 is a critical step toward this important goal and the nation's overall vision of providing safer, efficient healthcare for all Americans.

I am proud to report that a healthcare leader in my district is ahead of the curve in pursuit of this vision. In response to the need for leadership in the area of healthcare information technology, Adventist Health—a not-for-profit health care system headquartered in Roseville, California—made the decision to invest over $120,000,000 to implement a new state-of-the-art Clinical Information System for all their hospitals. Project IntelliCare is a groundbreaking, historical initiative and an important first step toward fulfilling patients' aspirations for safe, effective health care.

Long before the concept of healthcare information technology was being discussed nationally, Adventist Health committed to implementing this system— one of the largest single capital investments the health care system has ever made. I think it is extremely important that we support this legislation today. By establishing the refining our goals in this area with legislation like this, we allow health care providers like Adventist Health to easily adapt programs and projects that support patient safety and quality.

It would be my hope—and good public policy—that officials at the Department of Health and Human Services reach out to Adventist Health officers and solicit their guidance. This guidance would be based on the experience of a half a decade of success and challenges. I am proud of what Adventist Health is accomplishing in California. I look forward working with secretary Leavitt and the Department of Health and Human Services to assist in the implementation of Health Information Technology on a national level.

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

Mr. DEAL of Georgia. Mr. Speaker, I urge the adoption of this bill, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and pass the Senate bill, S. 544.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. DEAL of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

DRUG ADDICTION TREATMENT EXPANSION ACT

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 45) to amend the Controlled Substance Act to lift the patient limitation on prescribing drug addiction treatments by medical practitioners in group practices, and for other purposes.

The Clerk read as follows:

S. 45

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

SECTION 1. MAINTENANCE OR DETOXIFICATION TREATMENT WITH CERTAIN NARCOTIC DRUGS; ELIMINATION OF 30-PATIENT LIMIT FOR GROUP PRACTICES.

(a) IN GENERAL.—Section 303(g)(2)(B) of the Controlled Substance Act (21 U.S.C. 823(g)(2)(B)) is amended by striking clause (iv).

(b) CONFORMING AMENDMENT.—Section 303(g)(2)(B) of the Controlled Substance Act (21 U.S.C. 823(g)(2)(B)) is amended in clause (iii) by striking ''In any case'' and all that follows through ''the total'' and inserting ''The total''.

(c) EFFECTIVE DATE.—This section shall take effect on the date of enactment of this Act.

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

The Chair recognizes the gentleman from Georgia (Mr. DEAL).

GENERAL LEAVE

Mr. DEAL of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material in the consideration of this Senate bill.

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

There was no objection.

Mr. DEAL of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the Speaker for allowing us to consider the Drug Addiction Treatment Expansion Act, S. 45.

In 2000, Congress passed the Drug Addiction Treatment Act which has resulted in improved access to drug abuse treatment. This law has allowed qualified practitioners to prescribed addiction treatment medications from their office settings so long as the number of patients to whom the practitioner provides such treatment does not exceed 30 patients.

However, the Drug Addiction Treatment Act also limited the number of patients a group practice could treat to 30 as well. This limitation has created an unnecessary barrier to access to drug addiction therapy. Under current law, a practice of 500 doctors would still be limited to treating only 30 patients in the same way as a single physician. This policy effectively limits the ability of patients to get access to treatment for their drug addictions.

This legislation before us today would lift the 30-patient limit for group practices, but would still keep in place the 30-patient limit for individual physicians.

I thank the gentleman from Indiana (Mr. SOUDER) for his leadership on this legislation that further expands access to needed addiction therapy. The Committee on Energy and Commerce and the Committee on the Judiciary have both favorably reported companion bills to S. 45, and I urge my colleagues to support this legislation today.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2 minutes.

Drug addiction is a problem we must face both at the individual and the systemic level. We bear the cost of addiction as a society. These costs are measured in lives and unmet human potential; and, frankly, in dollars.

A recent study by the National Institutes of Health found the economic cost of drug abuse totaled some $100 billion a year, costs borne by all members of society by increased demand on our health care system and our criminal justice system.

H.R. 869, the Drug Addiction Treatment Expansion Act, addresses an anomaly in the current law that limits access to an effective drug addiction treatment.

To ensure proper oversight of drug addiction treatment, current law limits the number of patients any one doctor can treat. However, this restriction inadvertently limits group practices to the same 30-patient limit. This legislation clarifies that each doctor in a group practice is subject to the 30-patient limit, not the group practice as a whole.

This bill will expand access to effective addiction treatment. When we come together to fight addiction, we must use every means available. This bill gives doctors an improved and important tool. H.R. 869 has the support of a range of organizations, including the American Psychological Association and the Partnership for a Drug Free America. I am pleased to support its passage.

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

Mr. DEAL of Georgia. Mr. Speaker, I yield 5 minutes to the gentleman from Indiana (Mr. SOUDER), who is the author of the House companion legislation.

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Mr. SOUDER. I thank the gentleman from Georgia, and I appreciate his leadership in moving this through his subcommittee. We served together on the Drug Policy committee in Government Reform where he served ably as vice chairman before moving up to this important subcommittee chairmanship over in Energy and Commerce and understands directly the need for drug treatment.

Mr. Speaker, we can work for interdiction. We can work for eradication down in Colombia and Afghanistan. We can work to try to seize it as it moves through the Caribbean and through the Pacific. We can work to try to catch it at the borders. We can try to take down the delivery people.

We will continue to do that. We will continue to work through our national ad campaign, through school programs to try to prevent drug use. But ultimately many people in America become addicted. The question is, How can we treat them? As has already been explained, this was an unintended consequence of the original act. I appreciate Senator LEVIN's help on the Senate side in moving this bill that group practices were capped at 30 patients as well.

Between 1997 and 2000, the number of treatment admissions for primary heroin abuse increased 21 percent while treatment admissions for primary abuse of narcotic painkillers increased at an unprecedented 186 percent. In view of the skyrocketing numbers of treatment admissions for primary opiate addiction in recent years, it is imperative that measures be taken at the Federal level to provide adequate treatment options. Given this epidemic of drug abuse in America, drug addiction treatment programs must effectively correspond to the widespread nature of this problem. In order to expand drug treatment programs, please support this bill, the Drug Addiction Treatment Expansion Act, which will remove the 30-patient limit currently imposed on group practices.

According to the American Medical Association, the current 30-patient cap has limited access to effective substance abuse treatment services. There is a broad consensus according to AMA in the medical community that buprenorphine is a major new tool to fight addiction and does not have a high potential for misuse or fatal overdose. Lifting the cap would enable group practices to treat more patients with this highly effective drug.

There are 49 different, well-respected drug treatment organizations that back this bill, including the American Medical Association, the National Association of State Alcohol and Drug Abuse Directors, the American Psychiatric Association, the American Psychological Association, the Association of American Medical Colleges, the Alliance of Community Health Plans, and the American Medical Group Association.

And then in addition to all these medical groups, are almost all the major anti-drug groups in America, including the Partnership for a Drug-Free America, the Community Anti-Drug Coalitions of America, Drug-Free Schools Coalition, Drug Free America