Programs, PDMPs, at the point of care. As its name suggests, PDMPs help physicians and other providers make appropriate prescribing decisions while ensuring that patients with legitimate pain management needs have access to necessary care. We are in the middle of an epidemic of prescription drug opioid misuse and overdose. According to the Centers for Disease Control and Prevention, in 2013, more than 16,000 Americans died from an opioid-related overdose.

PDMPs are an integral part of our Nation's effort to combat the ongoing opioid and prescription drug epidemic. They allow for the early identification of at-risk patients and timely intervention to prevent prescription drug abuse. States have recognized that PDMPs are a vital tool to address this public health crisis as demonstrated by their universal adoption amongst the States.

H.R. 1725 reauthorizes grants to States to enhance their PDMPs, and it makes further improvements to the programs. Funding for PDMPs is needed to help States utilize this effective tool, to incentivize information sharing across State lines, and to further the implementation of best practices.

I want to thank Ranking Member PALLONE and Representatives KENNEDY, WHITFIELD, and BUCSHON for their leadership. I also want to thank my colleagues on the Energy and Commerce Committee for their commitment to addressing our Nation's opioid epidemic. I urge my colleagues to support H.R. 1725.

I reserve the balance of my time.

□ 1615

Mr. GUTHRIE. Mr. Speaker, I yield 4 minutes to the gentleman from Kentucky (Mr. WHITFIELD), who has worked tirelessly on these issues in the Energy and Commerce Committee and back home to try to address the prescription drug problem in our State.

Mr. WHITFIELD. Mr. Speaker, I rise today in support of H.R. 1725, the National All Schedules Prescription Electronic Reporting Reauthorization Act, as we call it, NASPER.

I introduced this legislation earlier this year with my colleagues, Congressman LARRY BUCSHON of Indiana, FRANK PALLONE of New Jersey, and JOE KENNEDY of Massachusetts.

I want to thank Chairman UPTON, Ranking Member PALLONE, as well as Subcommittee Chair PITTS, Ranking Member GREEN, and Congressman GUTHRIE for helping move this bill through the committee and subcommittee.

It has already been stated, the importance of this legislation to reauthorize NASPER. Prescription drug overdose death is reaching an epidemic proportion. Tragically, it has increased in America by fivefold since 1980, and drug overdose now kills more Americans than automobile accidents.

In my home State of Kentucky, more than 1,000 individuals die each year from prescription drug overdose, which is the third highest rate in the country.

Ten years ago NASPER was signed into law to assist States in combating prescription drug abuse through the creation and improvement of prescription drug-monitoring programs, which experts agree are one of the most promising clinical tools to address this epidemic.

So today we come to the floor to reauthorize this important legislation, and I hope that we can continue our efforts to obtain adequate funding from the Appropriations Committee for NASPER.

While there is no silver bullet to solve the problem, we do have an opportunity to make a difference by advancing this reauthorization act. I urge my colleagues to join me in supporting that effort.

Mr. GENE GREEN of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. BUCSHON), a colleague, friend, neighbor—our districts are joined on the Ohio River—who is a physician who understands these issues.

Mr. BUCSHON. Mr. Speaker, I rise today as an original coauthor of this legislation, H.R. 1725. The reauthorization of NASPER would allow SAMHSA to provide grants to States for the establishment, implementation, and improvement of prescription drug-monitoring programs, or PDMPs, offering timely access to accurate prescription information for healthcare providers.

As a physician, I understand this is critical to a provider's ability to screen and treat patients at risk for addiction.

The NASPER program also promotes greater information sharing among States by requiring grantees to facilitate these monitoring programs with at least one bordering State while simultaneously protecting against unauthorized access to patient records.

This reauthorization language would also encourage States to explore ways to incorporate access to their PDMPs into provider workflow systems, such as electronic health records and e-prescribing. Given the growing problem of prescription drug abuse, this is a commonsense measure to protect the public.

I want to thank Mr. WHITFIELD, Mr. KENNEDY, and Ranking Member PALLONE for their work on this legislation.

I urge all of my colleagues to support this important bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I have no further speakers.

I yield back the balance of my time.

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

I appreciate Mr. WHITFIELD, Dr. BUCSHON, certainly Mr. KENNEDY, and Mr. PALLONE for bringing this forward. It is important. It is important to my State, and it is important to our neighboring States and citizens throughout this country.

I urge my colleagues to vote for H.R. 1725.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I am pleased to support H.R. 1725, the ''National All Schedules Prescription Electronic Reporting (NASPER) Reauthorization Act,'' which helps States establish and maintain prescription drug monitoring programs in order to combat prescription drug abuse, a public health crisis affecting communities across the country. I have been a long-time champion of this bill with my colleague Representative WHITFIELD and I am pleased that Representatives KENNEDY and BUCSHON joined our efforts this Congress to reauthorize the NASPER program.

Prescription drug monitoring programs help prescribers, pharmacists, and law enforcement track and prevent the misuse of prescription drugs. Forty nine states currently have laws authorizing these programs and they are playing a critical role in our efforts to combat the opioid crisis. This bill, however, once passed into law, will need funding and investment by appropriators in order to be effective. I urge Members to ensure that investment is met.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 1725, as amended.

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

A motion to reconsider was laid on the table.

PROTECTING OUR INFANTS ACT OF 2015

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1462) to combat the rise of prenatal opioid abuse and neonatal abstinence syndrome.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1462

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 ''Protecting Our Infants Act of 2015''.

SEC. 2. FINDINGS.

Congress finds as follows:

(1) Opioid prescription rates have risen dramatically over the past several years. According to the Centers for Disease Control and Prevention, in some States, there are as many as 96 to 143 prescriptions for opioids per 100 adults per year.

(2) In recent years, there has been a steady rise in the number of overdose deaths involving heroin. According to the Centers for Disease Control and Prevention, the death rate for heroin overdose doubled from 2010 to 2012.

(3) At the same time, there has been an increase in cases of neonatal abstinence syndrome (referred to in this section as ''NAS''). In the United States, the incidence of NAS has risen from 1.20 per 1,000 hospital births in 2000 to 3.39 per 1,000 hospital births in 2009.

(4) NAS refers to medical issues associated with drug withdrawal in newborns due to exposure to opioids or other drugs in utero.

(5) The average cost of treatment in a hospital for NAS increased from $39,400 in 2000 to $53,400 in 2009. Most of these costs are born by the Medicaid program.

(6) Preventing opioid abuse among pregnant women and women of childbearing age is crucial.

(7) Medically appropriate opioid use in pregnancy is not uncommon, and opioids are often the safest and most appropriate treatment for moderate to severe pain for pregnant women.

(8) Addressing NAS effectively requires a focus on women of childbearing age, pregnant women, and infants from preconception through early childhood.

(9) NAS can result from the use of prescription drugs as prescribed for medical reasons, from the abuse of prescription drugs, or from the use of illegal opioids like heroin.

(10) For pregnant women who are abusing opioids, it is most appropriate to treat and manage maternal substance use in a non-punitive manner.

(11) According to a report of the Government Accountability Office (referred to in this section as the ''GAO report''), more research is needed to optimize the identification and treatment of babies with NAS and to better understand long-term impacts on children.

(12) According to the GAO report, the Department of Health and Human Services does not have a focal point to lead planning and coordinating efforts to address prenatal opioid use and NAS across the department.

(13) According to the GAO report, ''given the increasing use of heroin and abuse of opioids prescribed for pain management, as well as the increased rate of NAS in the United States, it is important to improve the efficiency and effectiveness of planning and coordination of Federal efforts on prenatal opioid use and NAS''.

SEC. 3. DEVELOPING RECOMMENDATIONS FOR PREVENTING AND TREATING PRENATAL OPIOID ABUSE AND NEONATAL ABSTINENCE SYNDROME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this Act as the ''Secretary''), acting through the Director of the Agency for Healthcare Research and Quality (referred to in this section as the ''Director''), shall conduct a study and develop recommendations for preventing and treating prenatal opioid abuse and neonatal abstinence syndrome, soliciting input from nongovernmental entities, including organizations representing patients, health care providers, hospitals, other treatment facilities, and other entities, as appropriate.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Director shall publish on the Internet Web site of the Agency for Healthcare Research and Quality a report on the study and recommendations under subsection (a). Such report shall address each of the issues described in paragraphs (1) through (3) of subsection (c).

(c) CONTENTS.—The study described in subsection (a) and the report under subsection (b) shall include—

(1) a comprehensive assessment of existing research with respect to the prevention, identification, treatment, and long-term outcomes of neonatal abstinence syndrome, including the identification and treatment of pregnant women or women who may become pregnant who use opioids or other drugs;

(2) an evaluation of—

(A) the causes of and risk factors for opioid use disorders among women of reproductive age, including pregnant women;

(B) the barriers to identifying and treating opioid use disorders among women of reproductive age, including pregnant and postpartum women and women with young children;

(C) current practices in the health care system to respond to and treat pregnant women with opioid use disorders and infants born with neonatal abstinence syndrome;

(D) medically indicated use of opioids during pregnancy;

(E) access to treatment for opioid use disorders in pregnant and postpartum women; and

(F) access to treatment for infants with neonatal abstinence syndrome; and

(3) recommendations on—

(A) preventing, identifying, and treating neonatal abstinence syndrome in infants;

(B) treating pregnant women who are dependent on opioids; and

(C) preventing opioid dependence among women of reproductive age, including pregnant women, who may be at risk of developing opioid dependence.

SEC. 4. IMPROVING PREVENTION AND TREATMENT FOR PRENATAL OPIOID ABUSE AND NEONATAL ABSTINENCE SYNDROME.

(a) REVIEW OF PROGRAMS.—The Secretary shall lead a review of planning and coordination within the Department of Health and Human Services related to prenatal opioid use and neonatal abstinence syndrome.

(b) STRATEGY TO CLOSE GAPS IN RESEARCH AND PROGRAMMING.—In carrying out subsection (a), the Secretary shall develop a strategy to address research and program gaps, including such gaps identified in findings made by reports of the Government Accountability Office. Such strategy shall address—

(1) gaps in research, including with respect to—

(A) the most appropriate treatment of pregnant women with opioid use disorders;

(B) the most appropriate treatment and management of infants with neonatal abstinence syndrome; and

(C) the long-term effects of prenatal opioid exposure on children; and

(2) gaps in programs, including—

(A) the availability of treatment programs for pregnant and postpartum women and for newborns with neonatal abstinence syndrome; and

(B) guidance and coordination in Federal efforts to address prenatal opioid use or neonatal abstinence syndrome.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the findings of the review described in subsection (a) and the strategy developed under subsection (b).

SEC. 5. IMPROVING DATA ON AND PUBLIC HEALTH RESPONSE TO NEONATAL ABSTINENCE SYNDROME.

(a) DATA AND SURVEILLANCE.—The Director of the Centers for Disease Control and Prevention shall, as appropriate—

(1) provide technical assistance to States to improve the availability and quality of data collection and surveillance activities regarding neonatal abstinence syndrome, including—

(A) the incidence and prevalence of neonatal abstinence syndrome;

(B) the identification of causes for neonatal abstinence syndrome, including new and emerging trends; and

(C) the demographics and other relevant information associated with neonatal abstinence syndrome;

(2) collect available surveillance data described in paragraph (1) from States, as applicable; and

(3) make surveillance data collected pursuant to paragraph (2) publically available on an appropriate Internet Web site.

(b) PUBLIC HEALTH RESPONSE.—The Director of the Centers for Disease Control and Prevention shall encourage increased utilization of effective public health measures to reduce neonatal abstinence syndrome.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

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

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself as much time as I may consume.

I rise today in support of H.R. 1462, the Protecting Our Infants Act of 2015, introduced by my colleagues, Ms. CLARK of Massachusetts and Mr. STIVERS.

Over the past several years, opioid addiction has risen dramatically in the United States, reaching epidemic proportions. The death rate for heroin overdose doubled in just 2 years, from 2010 to 2012.

One of the issues that has arisen as a result of this epidemic is neonatal abstinence syndrome, known as NAS.

These are infants born addicted to opioids and suffer medical issues associated with drug withdrawal. Symptoms can last for weeks, keeping otherwise healthy infants confined to the hospital at the start of their lives.

NAS can result from the use of prescription drugs or from the use of illegal opioids. Sadly, over the past 15 years, a prevalence of NAS has tripled in the United States. This is a rapidly growing problem that needs to be addressed for the safety of our mothers and children.

H.R. 1462 would address the increasing problem of prenatal opioid abuse and neonatal abstinence syndrome. Preventing opioid abuse among pregnant women and women of childbearing age is crucial in addressing NAS.

The Government Accountability Office has identified that more research is needed in this area to help treat babies born with NAS and mothers addicted to opioids.

This legislation would help fill this research gap by studying issues and developing recommendations for preventing and treating prenatal opioid abuse and neonatal abstinence syndrome.

Mr. Speaker, I urge my colleagues to support this bill. I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself as much time as I may consume.

I rise in support of H.R. 1462, the Protecting Our Infants Act, led by Representatives KATHERINE CLARK and STEVE STIVERS.

The Centers for Disease Control and Prevention has found drug overdose to be the leading cause of injury death in the United States.

According to a recent study by the New England Journal of Medicine, from 2004 to 2013, the incidence rate of neonatal abstinence syndrome, NAS, has quadrupled.

NAS refers to medical complications in newborns associated with drug withdrawal due to exposure to opioids and other drugs during pregnancy.

Babies born with NAS often require weeks of hospitalization and can suffer from seizures and other severe complications.

There is an urgent need for further research to facilitate the identification and treatment of infants with NAS and determine long-term health impacts.

The GAO and other experts identified specific research gaps related to best practices for treating pregnant women with opioid use disorders, the long-term effects of prenatal drug exposure, and best practices in the screening, diagnosis, and treatment of NAS.

The Protecting Our Infants Act takes proactive steps to help reduce the number of newborns born exposed to opioids and other drugs and to improve their care if they are exposed.

It will facilitate the development of recommendations for treatment and coordinate a national strategy to close the known gaps in research and coordination. It will also help States improve data collection and surveillance activities.

I want to thank Representatives CLARK of Massachusetts and STIVERS for their leadership. I also want to thank Chairman UPTON, Ranking Member PALLONE, Chairman PITTS, and my colleagues on the Energy and Commerce Committee for advancing this important legislation.

I urge my colleagues to support H.R. 1462. I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from West Virginia (Mr. JENKINS).

Mr. JENKINS of West Virginia. Mr. Speaker, every day in hospitals across the Third Congressional District of West Virginia and the country babies begin their lives going through drug withdrawal because they were exposed during pregnancy. As you have heard, it is the diagnosis known as neonatal abstinence syndrome, or NAS.

No baby—no baby—deserves to start his or her life in withdrawal from heroin or other opioids. But, sadly, the rate of babies born with NAS, again, as you have heard, has skyrocketed nationally.

Doctors, nurses, and caregivers are providing innovative care for newborns with NAS, but there are still gaps in research and our understanding of how best to care for our most vulnerable.

The Protecting Our Infants Act makes significant strides in addressing this nationwide gap and developing these strategies, and I am proud to be a cosponsor of this bill.

West Virginia has been at the forefront of this epidemic, with NAS rates much higher than the national average.

Our nurses and doctors are tirelessly working to care for newborns with NAS, and having additional resources and research will only further their efforts in providing the best possible care.

I have met with caregivers throughout my district to discuss their approaches to treating NAS, and I know this legislation will help in their efforts to treat these babies.

While we must continue to guarantee that newborns receive the absolute best care, we must also address the issue of addiction in pregnant and postnatal women.

This legislation will help identify and develop treatment methods for expectant mothers with opioid addictions, leading to healthier outcomes for mother and baby alike.

NAS is a nationwide crisis, one that impacts urban, rural, and suburban areas. Nearly every district in America has been touched by heroin and opioid addiction. We must address the impact this addiction has on our most vulnerable in society, our newborn babies.

I commend Congresswoman CLARK for her efforts on this important legislation, and I urge my colleagues to support this bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Massachusetts (Ms. CLARK), the cosponsor of the bill.

Ms. CLARK of Massachusetts. Mr. Speaker, I thank the gentleman from Texas for yielding.

Our Nation is experiencing a deadly opiate epidemic, an epidemic that knows no boundaries and destroys lives, families, and communities.

Today 58 babies—one baby every 25 minutes—will be born suffering from the same pain adults describe as the worst pain of their lives. It is the pain of drug withdrawal.

Neonatal abstinence syndrome, or NAS for short, occurs when babies are born dependent on opioids, and it is one of the chief causes of the significant surge of newborns in neonatal intensive care units across the Nation.

Over the last decade, the number of infants born dependent on powerful drugs has grown nearly fivefold. In States like Massachusetts, NAS is occurring at a rate three times the national average.

NAS births are five times more costly than healthy ones. Costs have risen to more than $1.5 billion a year, 80 percent of which are paid for by Medicaid.

Because of this skyrocketing rise of NAS cases and costs, doctors are desperately trying to find the most effective method of diagnosis and treatment.

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There is little coordination of data and best practices and protocols among States, healthcare systems, and practitioners; and no medications have been approved by the U.S. Food and Drug Administration for treating these babies.

The Protecting Our Infants Act is the first Federal bill to take proactive steps in addressing the rise of NAS. With broad bipartisan support in both Chambers, this is an opportunity for Congress to make a difference for babies suffering from opioid exposure and the families struggling with addiction.

This bill directs the Department of Health and Human Services to develop the protocols for treating and preventing NAS. The Protecting Our Infants Act helps babies suffering from opioid withdrawal by making sure they get the best care available.

This act will ensure that every hospital has access to the best practices and that States have the public health data they need to address this crisis. This is good for families, good for our healthcare providers, and good for our Nation's bottom line.

I want to thank my colleagues in the House and, in particular, Congressman STEVE STIVERS for his partnership in this bill. I am grateful for his deep commitment to addressing this problem and crafting a solution. I am also grateful to Senators MCCONNELL and CASEY for sponsoring this legislation in the Senate.

Today, we have a chance to help the youngest of those suffering from the opioid crisis.

I urge my colleagues to pass the bipartisan Protecting Our Infants Act.

Mr. GENE GREEN of Texas. I reserve the balance of my time.

Mr. GUTHRIE. I yield 5 minutes to the gentleman from Ohio (Mr. STIVERS), my friend.

Mr. STIVERS. Mr. Speaker, I rise today to support a bill that my colleague from Massachusetts, Representative KATHERINE CLARK, and I introduced, H.R. 1462, the Protect Our Infants Act. I want to thank Representative CLARK for her leadership, her hard work, and her commitment to protecting America's children.

This bill has the support of 95 bipartisan cosponsors. It is a targeted effort to address a national epidemic of babies being born addicted to drugs.

Recent data has shown that this issue, called neonatal abstinence syndrome, is sadly on the rise throughout the country. A baby is born with neonatal abstinence syndrome every 25 minutes, and symptoms can last for months and lead to weeks of hospitalization and have a lifelong impact.

A report by the Journal of the American Medical Association showed that the number of newborns diagnosed with NAS tripled from 2000 to 2009. In my home State of Ohio, the rate of neonatal abstinence syndrome grew over 600 percent between 2004 and 2011.

It has taken a heavy toll on Ohio's healthcare system and Ohio's families. Treating newborns with NAS was associated with over $70 million in charges and approximately 19,000 hospital stays, and that was back in 2011. It has been on the rise ever since.

This issue is especially devastating to our families and especially devastating to the youngest among us, the

babies who are born addicted to drugs. I recently heard from a grandmother to three babies who were born with NAS. She was pleading for help for her innocent grandchildren, and she wanted to make sure we did something about this terrible disease.

I am proud to say that the response in my district has been strong to our bill. There is a healthcare system called Adena Regional Medical Center in Chillicothe, Ohio, and they actually have an incredible program which was piloted with a bunch of OB/GYNs, and they started with just 15 pregnant women who were addicted to drugs, and they have served those women. Now, they are on their second class to try to get those women off of drugs before they deliver.

I am happy to report that, because of the support of the Adena Health System, none of the women in that group delivered a baby with NAS. Due to the success of the pilot, there is a permanent program that is starting now, and it already has a wait list, so I am really excited to say that there are people out there showing real leadership.

Last week, I hosted my fourth annual opiate roundtable in my district to bring together a lot of issues, and we talked about this bill and how important it was, so I am so proud that it is on the floor today.

Mr. Speaker, I urge all my colleagues to support the Protecting Our Infants Act, H.R. 1462, to help our Nation's most innocent citizens. Again, I want to thank KATHERINE CLARK for her incredible leadership on this bill and her commitment.

Mr. GENE GREEN of Texas. Mr. Speaker, I have no other speakers, and in closing, I encourage our colleagues to support this bill.

I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, during the hearing in the Committee on Energy and Commerce, one of the physicians testifying, a neonatologist, turned out to practice with my first cousin, so I got to do research further into what is moving forward in this bill.

I learned even more from personal stories about how important it is and how critical this is and how sad it is for children to be born addicted and how the opportunity is for us to help.

I certainly appreciate my friend from Massachusetts, Ms. CLARK, and my friend from Ohio, Mr. STIVERS. I would encourage all my colleagues to vote for H.R. 1462, Protecting Our Infants Act of 2015.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I support H.R. 1462 the "Protecting Our Infants Act of 2015." This legislation would address the urgent need for a comprehensive strategy for one of the harmful outcome of our nation's opioid epidemic. Neonatal abstinence syndrome, or NAS, occurs in newborns who were exposed to opioids, including pain killers, while in their mother's womb. NAS is associated with negative health outcomes like preterm births and low birthweight.

I'm saddened to say that the opioid epidemic has resulted in a steep increase in the occurrence of NAS over the past decade. H.R. 1462 would require HHS to develop recommendations for the treatment and prevention of prenatal opiate abuse and neonatal abstinence syndrome. It would also require the collection of data to better monitor the problem.

I want to thank Representative KATHERINE CLARK for her leadership on this issue and I urge my colleagues to join me in supporting this necessary legislation.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 1462.

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

A motion to reconsider was laid on the table.

STEM CELL THERAPEUTIC AND RESEARCH REAUTHORIZATION ACT OF 2015

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2820) to reauthorize the Stem Cell Therapeutic and Research Act of 2005, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2820

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 ''Stem Cell Therapeutic and Research Reauthorization Act of 2015''.

SEC. 2. AMENDMENTS TO THE STEM CELL THERAPEUTIC AND RESEARCH ACT OF 2005.

(a) CORD BLOOD INVENTORY.—Section 2 of the Stem Cell Therapeutic and Research Act of 2005 (42 U.S.C. 274k note) is amended in subsection (h)—

(1) in paragraph (1)—

(A) by striking ''$23,000,000 for each of fiscal years 2011 through 2014 and''; and

(B) by inserting before the period at the end the following: ''and $23,000,000 for each of fiscal years 2016 through 2020''; and

(2) in paragraph (2), by striking ''2011 through 2015'' and inserting ''2015 through 2020''.

(b) NATIONAL PROGRAM.—Section 379B of the Public Health Service Act (42 U.S.C. 274m) is amended by striking ''2011 through 2014'' and inserting ''2016 through 2020''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and insert extraneous materials into the RECORD on the bill.

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

There was no objection.

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

Mr. Speaker, I rise today in support of H.R. 2820, the Stem Cell Therapeutic and Research Reauthorization Act of 2015, introduced by my colleagues CHRIS SMITH and DORIS MATSUI.

Bone marrow transplantation has been used for more than 50 years to treat blood-related diseases, such as leukemia, different anemias, and lymphoma. It is a rich source of blood stem cells. In more recent years, breakthroughs have been made using blood stem cells from umbilical cord blood in the treatment of those various blood-related diseases and conditions.

It can be very difficult to find a bone marrow transplant match, and in some cases, cord blood can be used instead. Bone marrow and cord blood donation are critical to ensure those in need of transplant can find a match. The need for this lifesaving transplantation has risen 25 percent since 2005.

H.R. 2820 reauthorizes the National Marrow Donor Program and creates a national network of public cord blood banks. The legislation also provides healthcare professionals the ability to search for bone marrow and umbilical cord blood units for transplantation.

H.R. 2820 also bolsters patient and advocacy services; provides for public and professional education; and collects, analyzes, and reports data on transplant outcomes.

Mr. Speaker, I urge my colleagues to support this important legislation.

I reserve the balance of my time.

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

Mr. Speaker, I rise in support of H.R. 2820, the Stem Cell Therapeutic Research Reauthorization Act. This important legislation is championed by Representatives DORIS MATSUI and CHRIS SMITH.

According to the Health Resources and Services Administration, nearly 20,000 patients in the United States need a bone marrow or cord blood transplant each year. Stem cells from both cord blood and bone marrow are used to treat nearly 80 lifesaving diseases, including cancers, blood diseases, and immune disorders.

H.R. 2820 provides Federal support for cord blood donation, the continuation of the national bone marrow registry, and critical medical research. This legislation reauthorizes the C. W. Bill Young Cell Transplantation Program, which includes the National Marrow Donor Program.

The program helps patients in need of lifesaving transplants find matching bone marrow donors or cord blood units. It also includes a stem cell therapeutic outcomes database, which facilitates research to better understand the matching process. This legislation will give hope of access to patients and their families in need of a curative transplant.

I want to thank Representatives MATSUI and SMITH for their leadership