get serious about working in a bipartisan way on an issue that ought to be tackled in a bipartisan way for the American people and that I have a long history, in particular, of wanting to be part of.

For the next several weeks, I will be on the floor drawing on our past experiences and underlining why the partisan approach underway right now is wrong.

People ought to know that TrumpCare is a betrayal of the promises they have heard time and time again. They heard it through hundreds of TV commercials all through the election period, and what they are now seeing is a betrayal of those promises they watched on campaign advertisements over the last year.

People ought to know that this is not a real effort at fixing our healthcare system. This is a masquerade. It is a masquerade to try to pretend that what is going on is about healthcare when it really is about making sure taxes can be cut for the most fortunate, while healthcare benefits for the middle class are slashed. TrumpCare is the opposite of good health policy. There is no grassroots campaign I know of clamoring for the Congress to pass another round of the same old handouts to special interests, donors, and powerful individuals.

The American people are counting on the Congress to improve the health system and make their care more affordable. Congress ought to be working together on injecting more competition into the insurance markets and reducing out-of-pocket costs for families. We ought to be working especially on bringing down prescription drug prices. In my view, you can't really build a modern health system unless you address the challenges posed by chronic conditions such as diabetes, cancer, and Alzheimer's.

We want it understood that Democrats want to work in a bipartisan way to improve the Affordable Care Act. That is the heart of the letter that all Senate Democrats signed today—we all went together—making it clear that we would like to see Republicans drop reconciliation and come together so we can find common ground. That would be in the country's interests, rather than using this go-it-alone process that is called reconciliation but specifically rejects bipartisanship.

I am going to be on the floor a lot over the next several weeks. I promised my constituents night and day over the course of last weekend—and people kept saying night and day, day and night—because the country feels that strongly about this.

I and others are going to hold our colleagues on the other side of the aisle accountable because we all ought to agree that this country cannot go back to the days when healthcare was for the healthy and the wealthy. Those preexisting conditions could be a death sentence. And that is because if you were healthy, you had no problem. If you were wealthy, you could write out the checks. But if you had a preexisting condition, you were in very serious straits. People told us about losing their homes and everything they had. We are not going back to the days in America when healthcare was for the healthy and wealthy.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

DRUG EPIDEMIC

Mr. PORTMAN. Mr. President, I rise today to continue a discussion we have had on the floor over the last year or so on the issue of opioids—that would be addiction to heroin, prescription drugs, and now this new form of synthetic heroin coming into our communities called fentanyl or carfentanil.

Sadly, I must say that things are not getting better. In fact, in the States we represent, in our communities, we see more and more evidence of not just addiction but overdoses and deaths. Fentanyl, in particular, is more deadly than heroin—30 to 50 times more powerful—and is resulting in not just more overdoses but more deaths per overdose. This has become a crisis to the point that it is the No. 1 cause of death in my home State of Ohio and across the country, surpassing car accidents.

This is the 35th time I have come to the floor to talk about this issue and what we ought to do. We have made progress. In the last year alone, we passed legislation, including the Comprehensive Addiction and Recovery Act, to help with prevention, treatment, and recovery, and to help our law enforcement and other first responders, with Narcan, be able to reduce the number of deaths—this miracle drug that reverses the overdoses—to be able to save lives.

We also passed the Cures legislation, which sent money straight back to the States that would help to provide the treatment that is so badly needed. Probably 8 out of 10 people who are addicted are not receiving treatment. Sadly, there is a revolving door where people are coming under the grip of this addiction, committing crimes, going to prison, getting out, getting into the addiction again, and going back into the criminal justice system once again.

This legislation we passed is now starting to be implemented. It takes a little while for things to get moving around here. I am happy to say that the States have now received some of this funding. Some of the programs—about half of those in the Comprehensive Addiction and Recovery Act are now implemented. I urge the administration to implement the other half of the programs, and I have done that every time I have come to the floor over the last few months.

Unfortunately, I also have to come to the floor today to talk about something that is going to make it harder to address this issue should it become reality. As some of you may know, recently it was reported that there was a document from the White House Office of Management and Budget saying that the White House is considering cutting funding dramatically for the Office of National Drug Control Policy, the ONDCP. This is the office that coordinates the drug issue for the White House, the administration. The proposal that was leaked to the media said that it would be a cut from $388 million a year to $24 million a year. That is a cut of 95 percent. What does that mean? It means the staff would be, obviously, reduced dramatically. They have 33 people who would lose their jobs, people who are out there every day on the frontlines, trying to use a relatively small number of people to expand this effort all over the country. It would eliminate a lot of grant programs, office administrators, including what is called the High Intensity Drug Trafficking Areas Program, or HIDTA, and a program called the Drug-Free Communities Support Program.

I want to touch on those two programs quickly and make the point as to how important they are, hoping that the administration is hearing us and hoping my colleagues on both sides of the aisle will help us ensure that this proposal does not become reality, that we don't end up, at a time when we have an unprecedented drug crisis in this country—the worst drug epidemic we have had in our lifetime—pulling back on these important programs.

Why does this matter? Again, having a drug czar, which is what the Director of the Office of National Drug Policy is called, is very important to coordinate the efforts. In fact, it is cost-effective to have a drug czar rather than having different agencies and departments competing and sometimes in duplication with each other, to have one person in the White House in charge, talking about the importance of this.

President Ronald Reagan and First Lady Nancy Reagan established the drug czar. The reason they did it was they wanted to be sure America and the White House were speaking with one voice on this issue. I have known every drug czar since then. I have known every one of them over the last—what would that be?—30 years. I think it is incredibly important to have this job filled with the right person to get out there and deliver this message that it is important that we work together on prevention and education to try to keep people out of drugs altogether, and should people become addicted, how do we maximize the chances of their success by getting them into treatment and recovery?

The program I mentioned a minute ago, the High Intensity Drug Trafficking Areas Program, is one that pretty much every Senator knows about. Why? Because in pockets of every State, there are areas in which there is a particular problem with drugs. This program, the High Intensity Drug Trafficking Areas Program, does something unique. It says: OK, we

are going to put Federal law enforcement together with State law enforcement and local law enforcement to intensely focus on this issue at the local level. As you know, that is necessary because so much of this is interstate, even international, and by having this intense focus, there has been enormous success in my State and States around the country.

Under the program, you have to have one full-time law enforcement officer at the Federal level, State level, and the local level. What I have found back home is that typically you have a sheriff or a police chief who runs this locally and has a lot of his officers involved but really is able to maximize what he or she can do because you have this involvement from the State highway patrol, you have this involvement from the FBI, you have this coordination.

The Ohio HIDTA alone has removed $90 million worth of illicit drugs from our streets. It has apprehended more than 4,000 fugitives involved in drug trafficking operations. Think about the difference that makes. It makes our communities safer; ultimately, of course, it is going to save a lot of lives.

So I think this is one that is really working. If you ask your law enforcement locally about it, they will tell you that if they don't have a HIDTA grant, they probably wish they did. It is very competitive; not everyone can get one. But if you can show that you can use the money effectively and if you have a really serious drug problem in your area, having that HIDTA program is important.

The second program I mentioned is called the Drug-Free Communities Support Program. What does this do? This supports community anti-drug coalitions all around the country. Often, people ask me: What is the solution to this problem? Why are we in the situation we are in? I turn to prevention and education because, if you think about it, once you get into that funnel of addiction, it is very costly and very difficult.

Wouldn't it be better if we had better programs out there? Frankly, we did back in the 1980s and even the 1990s—to tell young people and to tell others why it is such a mistake to get into this drug issue, why they must do everything they can to avoid, in the case of heroin and prescription drugs and other opioids, taking these painkillers, these prescription drugs that are addictive, to the point that you become addicted, which is so often where the heroin addiction and the overdoses start.

Four out of five heroin addicts in the country started with prescription drugs, they say. Getting that information out there, that awareness, is incredibly important. That is what this Drug-Free Communities Program is about.

I got involved in this program early on through a personal experience. I was a first-year Member of the House of Representatives 23 years ago. A woman whose son had died of an overdose came to see me. She came to see me because she wanted to talk about her experience and what were we going to do about it.

At the time, Bill Clinton was President. I went to an event where both President Clinton and I were given a gold ID bracelet by a young man. The young man's name was Jeffrey Gardner. I put Jeffrey Gardner's ID bracelet on, and then I prepared for my meeting with this mother, who was obviously very upset.

She was there with her younger son. She came to my office. I was prepared for her. My staff had done all the research, and we knew there was about $15 billion a year being spent on drug interdiction, interdicting drugs coming from other countries, incarcerations and prosecutions, and the eradication of drugs overseas in places like Colombia, where a lot of cocaine was being grown at that time. So I told her that. I said: Your tax dollars are being used well to fight this battle. This is what is happening with your dollars.

She looked at me and said: How does that help me? She said: I went to my church. I went to my school to get them to help, to mobilize people, to provide more prevention and education resources, to get the word out. They were in denial. They said: This does not happen here.

She said: I went to my neighbors and tried to get a community meeting together, and people did not show up.

She said: How does interdicting drugs help me? How does the work on eradication overseas help me?

I did more research and looked into it further and talked to people around the country who were experts on this and found out where there was this community-of-support network, bringing in all sectors of the community. It really made a difference to reduce drug abuse.

So we started this program. This program, the Drug-Free Communities Act, has to be made up of all sectors of the community. We are talking about the religious community, faith leaders—very important—but also teachers, police officers, parents, doctors, other community leaders who come together with this intense focus on education and prevention.

The program we put together has real accountability. You know, I am a Republican. I believe in accountability. I want to be sure tax dollars are being used wisely. To receive funding under this program, coalitions are required to be in existence for 6 months before they can even apply—get on their feet, be sure they are working. It is the only Federal drug abuse prevention program that requires that, by the way.

The coalition is required to go through a year-long training academy to ensure they have the skills necessary to effectively reduce drug rates, and they have to have data to show that their efforts are actually working. There have to be performance measures in place. In these coalitions, there are surveys done in schools to see what the results are.

These coalitions are made up of people who are on the front lines. They know their communities better than anybody else does. That is why they are more effective than anybody else. They know how to reach people in that setting, know how to respond quickly when problems begin.

In communities with these coalitions, use of alcohol, tobacco, prescription drugs, marijuana, and cocaine by our young people have declined: alcohol, 32-percent decline; tobacco, 38-percent decline; other drugs, including prescription drugs, 21-percent decline. So these things work.

I must say, I have seen it firsthand because, before drafting the legislation, I started my own coalition called the Coalition for a Drug-Free Greater Cincinnati. Twenty-three years ago, we started this coalition, and we did it with, again, all members of the community.

In my case, I reached out to the first lady, Hope Taft of our State; also to a religious leader in our community, Damon Lynch, Jr., one of the most respected community leaders and at that time head of the Baptist Ministers Conference; and the former CEO of Procter & Gamble, John Petter, so we brought in the business community as well.

We established this coalition not thinking that we were going to end up applying for Federal grant money because there was no Federal grant program then, but that we would focus on how to ensure we could actually make a difference. We set up a survey that went to two-thirds of the schools in our community and asked questions about drug use, so we would know if our efforts were working or not working, as the case might be, and how to target our efforts toward parents and teachers. We spent a lot of time in the faith community, but also with coaches and athletic directors.

This program is still going. It is called Prevention First. I chaired it for 9 years. I was on the board of the coalition again before I ran for the Senate. I know it works because I have seen it. We have gotten good results. The coalition tells me that since 2000, alcohol use among young people they worked with in Cincinnati has gone down 46 percent; tobacco use, 61 percent; marijuana use, 22 percent.

Since 2012, which is when we started focusing on the prescription drug issue, there has been a decline by 29 percent in the use of prescription drugs by our young people. So, I think, this program, which by the way, cost about 90 million bucks last year—as someone who was a distinguished military officer told me recently: That is about what we charge to keep the lights on in part of the Pentagon every day, not that I am not for more and smarter defense spending; I am, but $90 million is

what we are talking about for this program during the time of the worst drug crisis in the history of our country.

I just think this impact, which I have seen, really works. It means less crime, less strain on our healthcare system, more productivity in school, more productivity at work, more people who can pass a drug test and go to work. That benefits all of us, and it saves taxpayer dollars.

The success we had in this coalition, again, led me to the legislation. A Democratic Representative from Michigan, SANDY LEVIN, and I introduced the legislation, bipartisan in the House.

Here in the Senate, the leaders who were the leaders of this legislation are still here and continue to support it; that is, Senator CHUCK GRASSLEY and Senator PATRICK LEAHY—again a bipartisan group. The bill, the Drug-Free Communities Act, is, again, based on these lead documents from the administration, one of the programs they have proposed defunding altogether.

I am hopeful that this legislation, the Drug-Free Communities Act, which has really worked—it has provided funding that has spawned over 2,000 community coalitions around the country. Today, it currently mobilizes 9,000 community volunteers all around the country. I am hopeful that we will not be defunding this program but, instead, focusing more on the issues of prevention and education. That is going to be the long-term solution to this drug problem. Yes, we have to get treatment to those who need it, but if we are not working on prevention and awareness and education, the issues of drug addiction and drug abuse are going to continue to get worse, in my view.

I am a former Budget Director. I understand it is a tough job to look at all the different competing priorities when you are trying to save taxpayer dollars. I get that. But I also get that we don't want to take a program like this that is actually working, that has all of these accountability measures in place to be sure that taxpayer dollars are being spent right, and then get rid of it at a time that we have this growing crisis in our country.

When I first got involved in this issue 22 years ago, I became convinced pretty quickly that one reason the drug issue had raised its ugly head in the 1990s is that we took our eye off the ball. I think in the 1980s, under the leadership of President Reagan and First Lady Nancy Reagan and Bill Bennett, who did an awesome job as drug czar, we made real progress, particularly on the issue of cocaine.

I think there was sort of a sense that we had solved that problem, and it was time to focus on other things. So we took our eye off the ball. That is why you saw, in the 1990s when the Drug-Free Communities Act legislation was necessary, there was a big increase in drug use, particularly among our young people. So I was always worried that we might do that again, that when there was a reduction in drug use, we might say: Well, that problem is behind us; let's move onto the next one.

The problem was never behind us, sadly. It is like the tide. It just keeps coming in, so you have to keep your focus on it. But I will tell you, I never expected that at a time when we would have a substantial increase in drug use, in crime, in overdoses, in deaths—which is what we have experienced in this country over the past few years—that we would cut these programs. I just did not imagine it. So I am concerned about it. We can't take our eye off the ball, particularly at a time like this. We have to be sure that we are supporting these programs that work.

Let me show you a chart that tells you where we are today. This is the number of drug overdose deaths in our great country from 1999 to 2015, the most recent year for which we have data. Look at this line here. This is opioid painkillers, this is fentanyl, and this is heroin. You see this incredible increase. Sadly, I will tell you that in 2016 and 2017, it keeps going up.

This year, we have had more opioid overdose deaths over the first few months than we had in the same period last year. In fact, here is one example. In Cleveland, OH, in the last 10 months, we have had more overdose deaths from fentanyl than we had in the previous 10 years. So it is sad that it is not getting better; it is getting worse.

Drug overdoses are now the leading cause of accidental death in the United States, surpassing car accidents. This is, again, a troubling chart, but we need to look at it. We hear a lot about homicides, and gun homicides, in particular. We hear about car crashes. Here is an example of HIV/AIDS in 1995, a time that was the height of the HIV/AIDS crisis, when all of us reacted appropriately.

Here we are in drug overdoses in 2015—far worse than any of these. So between prescription painkillers, heroin, and synthetic forms of heroin, drug overdose is now the leading cause of accidental death in the United States of America.

According to CDC, the Centers for Disease Control and Prevention, more Americans died from drug overdoses in 2015, again, than died in the AIDS epidemic in 1995. A recent story in the New York Times said there are more than four times as many people dying every day from this epidemic than were dying at the peak of the crack epidemic.

Another way to look at it, sadly, is that more people died in the last 3 years than died in the Vietnam War. Those are tough things to compare, but the point is, this is not a time for us to be gutting these programs. Fortunately, we have these programs in place to help. Let's use them to try to encourage more prevention and more education.

Here is a chart that just shows where heroin and fentanyl are. Again, from 1999 to 2015, this is heroin, this is fentanyl. Look at the rise of this over the last few years. That is what we are dealing with. That is the reality. That is what is happening in the communities and in our streets.

You might ask yourself, why do we want to cut this back at this point? My understanding is that some have argued we don't need the program. They said this program is duplicative because we have other programs now, including great legislation passed last year that I mentioned earlier called the 21st Century Cures Act. In fact, the author of that legislation just joined us on the floor, Senator ALEXANDER of Tennessee.

They have said the Drug-Free Communities Act may be a duplication of that CURES Program. That is an entirely different program—again, $90 million a year. CURES is $500 million a year needed right now.

I was a strong supporter of the CURES Act, and I again thank my colleague for working with some of us who have been focused on this issue, as he has, to get that legislation passed on a bipartisan basis.

The 21st Century CURES Act provides $500 million, but it provides that funding over this year and next, over 2 years. It is a temporary increase in funding to deal with the real crisis. This will help fill the gaps, but it does not ensure that $1 of that money goes toward this evidence-based prevention we talked about today.

Second, these programs have distinct goals. The CURES grants can be used however a State wants, and that is appropriate. In Ohio, I know Governor Kasich and the State legislature are focused on using it in a smart way, focused mostly on treatment which is badly needed. As I noted, 8 out of 10 people who are addicted and need treatment are not getting the treatment they need. We need more treatment facilities in some communities where the treatment is not available.

The Drug-Free Communities Act is specifically focused on this prevention through education at the community level. Funding goes directly to these coalitions I talked about and their focus is on prevention. It is not duplication. One is a prevention program focused on the community level, and one is an open-ended grant to the States. There is no other Federal program that funds evidenced-based prevention at the community level and has these measures except this one.

The accountability measures we talked about are important, and that distinguishes it from CURES or anything else. We require that communities provide matching funds, a one-to-one match. So if a dollar of Federal tax dollars goes out, it has to be matched by a dollar of non-Federal tax dollars just to get the funding.

We put a cap on administrative expenses of 8 percent to ensure that we maximize the amount of funding going into these programs. If you want funding in your coalition, you have to keep

your funding below 8 percent. That ensures that a maximum amount of funding goes into these programs. We specifically included strict accountability measures to ensure the highest level of support in solving the substance abuse crisis every community faces. These programs are effective. They use taxpayer dollars well, and cutting them doesn't make sense.

One of the reasons I believe President Trump was elected was that he had the courage and foresight to talk about this issue on the campaign trail. He talked about addiction, whether he was in New Hampshire, Ohio, or other States where we have a high level of heroin, prescription drug, and fentanyl abuse and addiction. He spoke with a passion about this and the toll it has on our citizens and devastation to our communities. I think that was one reason he was elected. He focused on how we would stop this epidemic. This proposal apparently put forward by Members of his administration runs counter to what he talked about during the campaign.

Earlier today, my original House cosponsor of the Drug-Free Community Act, Congressman SANDY LEVIN, and I sent a letter to the Office of Management and Budget Director, Mick Mulvaney, encouraging him not to pursue this course of action.

More importantly, more than 219 nonpartisan public health groups—experts like the American Academy of Pediatrics, the American Public Health Association, the Northern Ohio Recovery Association, the Community Anti-Drug Coalition of America, and other groups sent a letter to the White House expressing their support for the work of the Office of National Drug Control Policy.

Mr. President, I ask unanimous consent to have this letter printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MAY 8, 2017.

Re Revise OMB's proposed budget slashing drug control funding

Mr. REED CORDISH,
Senior Adviser to the President,
The White House.

DEAR MR. CORDISH: We are thankful to the Trump Administration for prioritizing the reduction of drug use, drug trafficking, and its consequences. We represent former and current federal, state, and local officials, hundreds of community-based organizations, and tens of thousands of people working in drug prevention, drug treatment, drug treatment courts, mental health, recovery, medicine, law enforcement, and millions of individuals in recovery from alcohol and drug use disorders. Like the Administration, we believe drugs are a serious issue.

In light of the Administration's prioritization, we write in strong support of the Office of National Drug Control Policy (ONDCP) and the critically important Drug Free Communities (DFC) program, which provides funding directly to communities to prevent drug use. DFC-funded coalitions are proven to effectively reduce alcohol, tobacco, marijuana and prescription drug misuse among middle and high school-aged children. The High Intensity Drug Trafficking Area (HIDTA) program, which coordinates federal, state, and local law enforcement, streamlines efforts to dismantle drug trafficking organizations and brings drug traffickers to justice.

As we have written before, ONDCP brings essential expertise to the table on complex drug issues, expertise that would otherwise be missing or dispersed across multiple agencies. ONDCP holds all federal, state, and local agencies accountable for achieving specific goals to reduce drug trafficking, use, and other consequences.

At a time when drugs now kill more people than firearms or car crashes, it is more important than ever for ONDCP to remain a strong voice in the White House and a visible presence nationally. As plans are finalized for the Administration's proposed FY 2018 budget, we once again ask the Administration to maintain a strong commitment to ONDCP by proposing the highest level of funding possible for the agency and its programs given the importance of ONDCP's mission and the current opioid crisis.

Sincerely,

A New PATH, Addiction Haven, Addiction Medicine Foundation, Addiction Policy Forum, Advocates for Recovery Colorado, Alabama Citizens Action Program, Alano Club of Portland, American Academy of Addiction Psychiatry, American Academy of Pediatrics, American Association for the Treatment of Opioid Dependence, American Association of Child & Adolescent Psychiatry, American Association of Colleges of Pharmacy, American Congress of Obstetricians and Gynecologists, American Correctional Association, American Osteopathic Academy of Addiction Medicine, American Osteopathic Association, American Psychiatric Association, American Psychological Association, American Public Health Association, American Society of Addiction Medicine.

AmerisourceBergen Corporation, Association for Behavioral Health and Wellness, Association of Persons Affected by Addiction (APAA), Association of Prosecuting Attorneys, Association of Recovery Community Organizations, Association of Recovery Schools, Association of Schools and Programs of Public Health, Association of State and Territorial Health Officials, Bangor Area Recovery Network, Inc., Big Cities Health Coalition, California Academy of Family Physicians, California Consortium of Addiction Programs and Professionals, Capital Area Project Vox, Caron Treatment Centers, Catholic Charities Maine, Center for Recovery and Wellness Resources, Center for Substance Abuse Research, University of Maryland, Chicago Recovering Communities Coalition (CRCC), Collaborative for Effective Prescription Opioid Policies, College on Problems of Drug Dependence.

Communities for Recovery, Community Alliances for Drug-Free Youth, Community Anti-Drug Coalitions of America, Community Oriented Correctional Health Services, Connecticut Certification Board, Connecticut Community for Addiction Recovery (CCAR), Council on Prevention and Education: Substances, DarJune Recovery Support Services & Café, DC Recovery Community Alliance, Delaware Certification Board, Detroit Recovery Project, Inc., Dorchester Recovery Initiative, Drug Free America Foundation, Drug Free Schools Coalition, DUID Victim Voices, Easy Does It, Inc., El Paso Alliance, Engaged Recovery Community Services, Entertainment Industries Council, Inc., Faces & Voices of Recovery.

Facing Addiction, FAVOR Greenville, FAVOR Mississippi Recovery Advocacy Project, FAVOR Pee Dee, FAVOR Tri-County, FED UP Coalition to End the Opioid Epidemic, Fellowship Foundation Recovery Community Organization, Florida Coalition Alliance, Floridians for Recovery, Foundation for Recovery, Friends of Recovery—New York, Friends Research Institute, Inc., Gem County Recovery Community Center, Georgia Council on Substance Abuse, Gerontological Society of America, Greater Macomb Project Vox, Hazelden Betty Ford Institute for Recovery Advocacy, HOPE for New Hampshire Recovery, Illinois Alcohol and Other Drug Abuse Professional Certification Association, Institute for Behavior and Health.

International Certification & Reciprocity Consortium, International Nurses Society on Addictions, Jackson Area Recovery Community, Johns Hopkins Bloomberg School of Public Health, Juneau Recovery Community, Kentucky Office of Drug Control Policy, Latah Recovery Center, Legal Action Center, Life of Purpose Treatment, Lifehouse Recovery Connection, Long Island Recovery Association (LIRA), Lost Dreams Awaken Center, Inc., Lotus Peer Recovery/Sober Kerrville, Louisiana Association of Substance Abuse Counselors & Trainers, Inc., Maine Alliance for Addiction Recovery, Maine Immigrant and Refugee Services, Major Cities Chiefs Association, Major County Sheriffs of America, Maryland Recovery Organization Connecting Communities (M–ROCC), Massachusetts Organization for Addiction Recovery (MOAR).

Message Carriers of Pennsylvania, Inc., Mi-HOPE—Michigan Heroin & Opiate Prevention and Education, Michigan Recovery Voices, Milestone Foundation, Minnesota Recovery Connection, Missouri Recovery Network, Mothers Against Drunk Driving, Mothers Against Prescription Drug Abuse, National Alliance of State Drug Enforcement Agencies, National Alliance for Medication Assisted Recovery, National Association for Children of Alcoholics, National Association for Rural Mental Health, National Association of City and County Health Officials, National Association of Clinical Nurse Specialists, National Association of Counties, National Association of County Behavioral Health and Developmental Disability Directors, National Association of Drug Court Professionals, National Association of Police Organizations, National Association of Social Workers.

National Association of State Alcohol and Drug Abuse Directors, National Athletic Trainers' Association (NATA), National Center on Addiction and Substance Abuse, National Council for Behavioral Health, National Council on Alcoholism and Drug Dependence, Inc. (NCADD), National Criminal Justice Association, National District Attorneys Association, National Families in Action, National Fusion Center Association, National HIDTA Directors Association, National Hospice and Palliative Care Organization, National Minority AIDS Council, National Narcotics Officers Association Coalition, National Safety Council, National Sheriffs' Association, Navigate Recovery, New Evangelical Partnership for the Common Good, New York Association of Alcoholism and Substance Abuse Providers, Inc., Northern Ohio Recovery Association (NORA), NAADAC, the Association for Addiction Professionals.

Nurse Practitioner Healthcare Foundation, Oklahoma Citizen Advocates for Recovery & Treatment Association (OCARTA), Oklahoma Drug and Alcohol Professional Counselor Association, P.E.E.R Wellness Center, Inc., Partnership for Drug-Free Kids, PEER360 Recovery Alliance, Pennsylvania Certification Board, Pennsylvania Recovery Organization—Achieving Community Together—(PRO-ACT), Pennsylvania Recovery

Organizations Alliance (PRO-A), People Advocating Recovery—PAR, Phoenix House, Phoenix Multisport Boston, Physicians for Responsible Opioid Prescribing, PLR Athens, Proove Biosciences, RASE Project, Recover Project/Western MA Training, Recover Wyoming, Recovery—Friendly Taos County, Recovery Allies of West Michigan.

Recovery Cafe, Recovery Communities of North Carolina, Recovery Community of Durham, Recovery Consultants of Atlanta, Recovery Data Solutions, Recovery Idaho, Inc., Recovery is Happening, RecoveryATX, RecoveryNC (Governors Institute on Substance Abuse), Regroup, Rhode Island Certification Board, Rhode Island Communities for Addiction Recovery Efforts (RICAREs), ROCovery Fitness, Rosenthal Center for Addiction Studies, Safe Kids Worldwide, SAM Action, Save Our Society from Drugs, Shatterproof, Smart Approaches to Marijuana, SMART Recovery.

Solano Recovery Project, Spiritworks Foundation, Spread Hope Like Fire, Springs Recovery Connection, STEP Industries, Strengthening the Mid-Atlantic Region for Tomorrow (SMART), Substance Abuse Librarians and Information Specialists, T.O.R.C.H., Inc., Tennessee Overdose Prevention, Texas Association of Addiction Professionals, The Addict's Mom, The Alliance for Addiction and Mental Health Services, Maine, The Bridge Foundation, The DOOR—DeKalb Open Opportunity for Recovery, The Friends of NIDA, The MARS Project, The McShin Foundation, The Moyer Foundation, The National Center on Addiction and Substance Abuse, The Police Foundation.

Tia Hart Recovery Community Program, TASC of Illinois (Treatment Alternatives for Safer Communities), Treatment Communities of America, Trilogy Recovery Community, Trust for America's Health, Utah Support Advocates for Recovery Awareness (USARA), Verde Technologies, Vermont Recovery Network, Virginia Association of Recovery Residences, Virginia Certification Board, Voices of Hope for Cecil County, Voices of Recovery San Mateo County, WAIIAM, Inc. and RISE Recovery Community, Washtenaw Recovery Advocacy Project (WRAP), WestCare, Inc., WholeLife Recovery Community/Arizona Recovery Coalition, Wisconsin Recovery Community Organization (WIRCO), Wisconsin Voices for Recovery, Young People in Recovery, Zoe's Story Fund.

Mr. PORTMAN. Mr. President, these groups know that the proposed cuts would undermine our anti-drug efforts at a time when we need them more than ever. So I ask my colleagues to join me in urging the OMB Director and the folks in the White House who are making these decisions not to take this course of action but rather to support our proven community anti-drug coalition, to support ONDCP in doing the important work at a time of a growing epidemic. We have never needed these programs more than we do right now.

Thank you, Mr. President.

I yield back my time.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I congratulate the Senator from Ohio not just on his speech and his remarks but on his leadership on the opioid epidemic in our country and its progression into other areas. He speaks passionately about it publicly and privately to his colleagues, just as he did today at our lunch as we discussed healthcare. He was a leader last year when we passed the 21st Century Cures Act to try to move these medical miracles that we know are coming through the regulatory and investment process more rapidly and into medicine cabinets and doctors' offices.

Senator PORTMAN and Senator WHITEHOUSE and others, in a bipartisan way, worked to add at least $1 billion more funding for States to deal with opioids after they had passed the Comprehensive Addiction and Recovery Act earlier that year. So the opioid epidemic and the families who suffer from it have no more effective spokesman and advocate than the Senator from Ohio, and I am glad I had an opportunity to hear his remarks today.

Mr. President, I ask unanimous consent that the time until 4:30 be equally divided in the usual form; further, that all postcloture time on the Gottlieb nomination expire at 4:30 p.m. today; and that, if confirmed, the motion to reconsider be considered made and laid on the table, and the President be immediately notified of the Senate's action.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. ALEXANDER. Mr. President, while the Senator from Ohio is here, one more word on opioids.

Dr. Francis Collins, the head of the National Institutes of Health, has testified before the Senate that in the next decade we could have—we should have a discovery of a nonaddictive pain medicine.

I cannot think of anything that over the long run could deal more with opioid addiction than to find a substitute for opioids that wasn't addictive. So we have discussed that with the President, with the new head of the FDA—after today, Dr. Gottlieb, I hope—with Dr. Price, Senator PORTMAN, and with others, and, hopefully, in a bipartisan way, we can lean forward into accelerating the discovery of a nonaddictive pain medicine, and we can make that contribution in this effort.

Mr. President, the Senate will vote shortly at 4:30 p.m. on the President's nomination of Scott Gottlieb to serve as Commissioner of the Food and Drug Administration. He is the right person to lead the FDA in this vital mission and move the agency forward so America's patients can benefit from the remarkable discoveries—one of which I was just discussing—that our Nation's researchers are working on.

Dr. Gottlieb has impressive qualifications from every perspective. He was a practicing physician and hospitalist for many years, received his medical degree at Mount Sinai School of Medicine and completed his residency there. He held three positions in the Department of Health and Human Services, including two at the FDA as Deputy Commissioner, from 2005 to 2007, and before that, in 2003 to 2004, as a senior adviser to Commissioner Mark McClellan, and as the FDA's Director of Medical Policy Development.

Dr. Gottlieb has studied health policy as a resident fellow at the American Enterprise Institute. He is a prolific writer and speaker on medical innovations. He has testified in front of Congress 18 times on a variety of issues, including the drug approval process, drug costs, drug shortages, importation, and healthcare reform.

Dr. Gottlieb is also a cancer survivor. He knows firsthand how medical treatments affect patients and their families.

Dr. Gottlieb, like others who were nominated by Presidents, has been through an exhaustive vetting process. The President announced the Gottlieb nomination on March 10. We received the nomination March 27. On April 5, Dr. Gottlieb testified for 2½ hours in our Senate HELP Committee. I offered Senators an opportunity to ask any questions they wished. Following his hearing, he answered 189 follow-up questions. If you count all the subquestions, it was 372 questions.

On April 27, our committee approved his nomination by a vote of 14 to 9, readying that nomination for consideration by the full Senate today.

On March 28, more than a month ago, the independent Office of Government Ethics concluded that Dr. Gottlieb ''is in compliance with applicable laws and regulations governing conflicts of interest.''

Let me read from the Office of Government Ethics' website about what that agency does. It says: ''OGE provides an independent review of the financial disclosure reports of candidates for Senate-confirmed nominees. OGE makes sure that these individuals have complied with the extensive requirements for financial disclosure under the Ethics in Government Act. OGE ensures compliance with financial disclosure requirements and assists in the resolution of potential conflicts of interest. It carefully evaluates nominees' financial disclosure reports and works with agency ethics officials to prepare individualized ethics agreements.''

The website continues: ''After confirming with the agency that there are no unresolved conflicts of interest, OGE then transmits the financial disclosure report, the ethics agreement, and a cover letter directly to the Senate.''

That all arrived at our committee on March 28. So that should answer any questions about whether Dr. Gottlieb has a conflict of interest because the independent agency Congress set up to resolve that question says he has none—or if he has any, he will resolve them according to an agreement with that office.

I believe Dr. Gottlieb will help to move the FDA forward so patients can benefit from the remarkable medical discoveries that researchers are working on. The FDA affects nearly every

single American and regulates about a quarter of all consumer spending in our country, over $4 trillion annually.

It is responsible for areas as diverse as prescription drugs for humans and animals, medical devices, biologics, dietary supplements, cosmetics, over-the-counter medications, food, and tobacco products. In addition to drugs and medical devices, the FDA is responsible for protecting our Nation's food supply and working to reduce the number of people who get sick from foodborne illnesses.

Some of my Democratic colleagues have expressed concern about Dr. Gottlieb's prior work with companies that are regulated by the Food and Drug Administration, but the fact is, it is not so unusual to have an FDA Commissioner who has consulted with the food and drug industry. Dr. Califf, the distinguished former FDA Commissioner under President Obama, consulted for many companies prior to his confirmation from the Senate. That didn't disqualify Dr. Califf. I supported him. So did 89 other Senators. He was confirmed 89 to 4.

I think we should recognize the obvious fact that it is a good idea to have people serving in government with some experience in the types of industries they are in charge of. The other day we confirmed a Secretary of Agriculture. I think it helps that he is a farmer and a veterinarian. We confirmed the Secretary of Commerce. I think it helps that he has some background in business. Some of the same people who are criticizing Dr. Gottlieb for having a background in working with companies that manufacture drugs criticized President Trump's Secretary of Education because she had never been on the payroll of the people she was about to be in charge of. So you can't have it both ways.

I believe Dr. Gottlieb's background in understanding how drugs are manufactured, how they can be manufactured safely, how they can be moved through the regulatory and investment process more rapidly is vitally important to the opportunity we have in America—more than we have ever had before—of finding these new medical miracles and putting them in our medicine cabinets and our doctors' offices.

Dr. Gottlieb has broad support from an array of patient, industry, and research organizations. The supporters include three former FDA Commissioners and President Obama's Administrator of the Centers for Medicare & Medicaid Services.

On Friday, I received a letter of support for Dr. Gottlieb from 10 State attorneys general who particularly praised the nominee as ''a leader in the fight against opioid abuse,'' the subject Senator PORTMAN spoke on a moment ago.

Mr. President, I ask unanimous consent to have printed in the RECORD a list of 93 groups that support Dr. Gottlieb's nomination at the conclusion of my remarks.

Mr. President, here are a few examples of what some of these groups had to say.

Dr. Jeff Allen, the President and CEO of Friends of Cancer Research, said: ''Through his knowledge and experience, we have no doubt that Dr. Gottlieb will be the right person to ensure FDA keeps pace with science and innovation without sacrificing the safety and efficacy gold standard established by FDA.''

The Healthcare Leadership Council said: ''Dr. Gottlieb's qualifications to lead the FDA are extensive and indisputable. . . . Dr. Gottlieb has consistently demonstrated his vision for accelerated medical innovation in this country and greater patient access to the drugs and devices that improve lives.''

Dr. Mark McClellan, FDA Commissioner from 2002 to 2004, said: ''He's a very good nomination,'' adding ''he is very dedicated to finding better ways to protect and improve the health of the public, all of which are great prerequisites for FDA Commissioner.''

Andy Slavitt, who just stepped down as the Administrator of the Centers for Medicare & Medicaid Services under President Obama, said that Dr. Gottlieb is ''a very good choice.''

The FDA has always been important, but there never has been a more important time for this agency. It is responsible for making sure patients benefit from the promising research driven by significant funding Congress has given to medical research in last year's 21st Century Cures Act, which the majority leader called ''the most important legislation of the year.''

I don't want it to go unnoticed that last year Congress increased funding for the National Institutes of Health by $2 billion. Last week, Congress increased funding for the National Institutes of Health by another $2 billion. The 21st Century Cures Act, which Congress also passed last year, authorized a $4.8 billion increase in funding for the National Institutes of Health for President Obama's Precision Medicine Initiative and for the Cancer Moonshot the Vice President worked on. Speaker RYAN and Majority Leader MCCONNELL, President Obama, Vice President Biden, all of us want to see these medical miracles move forward, and having competent leadership in the FDA is absolutely essential to that effort.

I am very excited about the prospect of having Dr. Gottlieb and Dr. Francis Collins, who is the head of the National Institutes of Health, at the head of these two lifesaving agencies, which are important to every single American family.

The reason 21st Century Cures is such an important bill is that it will drive forward this extraordinary research, and Dr. Collins talked about some of the discoveries that will be possible in the next decade. I mentioned the possibility of nonaddictive pain medicine. Dr. Collins said that we will also have hearts that will be rebuilt from our own stem cells. We will have a universal flu vaccine. Did you know that the flu kills between 12,000 and 56,000 Americans a year? There will be a universal flu vaccine. There will be an HIV/AIDS vaccine and an artificial pancreas for patients with diabetes who have spent decades injecting themselves with insulin. These are the discoveries that are just over the horizon, not to mention medicine that will identify Alzheimer's before there are symptoms and then slow the progression of the disease. Think of the grief it would save families and the billions it would save the country. We have invested in that.

We have competent leadership to be approved by the Senate today, in working with Dr. Collins and Dr. Price, who can make sure those dreams become a reality perhaps even more rapidly.

The FDA plays a key role in this. At the committee hearing, I asked Dr. Gottlieb about the subject Senator PORTMAN and I just talked about. I asked him how the FDA can be forward-leaning in accelerating the finding of new nonaddictive pain medicines—the ultimate cure for the opioid epidemic. It is a heartbreaking issue that almost every Senator knows about. Dr. Gottlieb said that the opioid epidemic is ''having staggering human consequences.''

He also said:

> I think it's the biggest crisis facing the agency. It's going to require dramatic action by whoever steps into the agency. I think it's going to require an all-of-the-above approach that does include reevaluating the framework for how we can develop alternatives to opioid drugs. I think it also includes looking at device alternatives to opioid drugs and looking at devices in the context of drugs.

Dr. Gottlieb's first order of business will be to work with us on the reauthorization of the FDA user fee agreements, which experts at the FDA told members of our HELP Committee at one of the two bipartisan hearings on the agreements, are integral to helping patients and continuing the implementation of the 21st Century Cures Act.

Before September 30, four different agreements need to be reauthorized. They fund $8 billion to $9 billion over the next 5 years, which is about a quarter of the Food and Drug Administration's budget. If we do not move quickly to pass these agreements in late July, the FDA will be forced, by law, to send layoff notices to more than 5,000 FDA employees and notify them that they may lose their jobs in 60 days.

A delay in reauthorizing these agreements would delay the reviews of drugs and devices that were submitted after April 1—1 month ago. For example, if we do not pass these user fee reauthorizations on time, an FDA reviewer who gets started in reviewing, say, a cancer drug that was submitted to the agency in April would be laid off on October 1, which would be before the reviewer is able to finish his or her work.

In addition to harming patients and families who rely on medical innovation, a delay in reauthorization would

threaten America's global leadership in biomedical innovation.

After reviewing the recommendations from industry and the FDA, I believe these are good agreements for patients. The sooner we pass the legislation, the better so as to give patients, doctors, FDA reviewers, and companies' certainty.

At this moment, Washington, DC, is not a very bipartisan town on many issues, but on this issue—the issue of user fees to support the Food and Drug Administration—it has been.

I compliment Senator PATTY MURRAY and her staff. Senator MURRAY is the ranking Democrat on the HELP Committee. Our staffs have been working together for 15 months in a bipartisan way and working with the House of Representatives to try to make sure we can present to the full Senate our FDA user fee agreements. We have had two bipartisan hearings. Tomorrow, we have a markup at which we hope those agreements will be reported to the Senate floor.

The FDA has a vital and important mission, and I am confident Dr. Gottlieb is the right person to be leading the agency. We are fortunate that he is willing to serve. I look forward to the Senate's approving Dr. Gottlieb's confirmation this afternoon.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Dr. Gottlieb's nomination has received support from 93 groups—including a broad array of patient, industry, and research organizations.

Full list of supporters: Advanced Medical Technology Association (Advanced); Aduro Biotech; Alliance for Aging Research; Alliance for Patient Access; Alliance for Regenerative Medicine; Alliance of Specialty Medicine; American Academy of Facial & Plastic Reconstructive Surgery; American Association for Cancer Research; American Association of Neurological Surgeons; American Bakers Association; American Beverage Association; American Enterprise Institute; American Frozen Food Institute; American Society for Radiation Oncology; American Society of Cataract and Refractive Surgery; American Society of Echocardiography; American Society of Plastic Surgeons; Association for Accessible Medicines (AAM); Association of American Cancer Institutes (AACI).

Association of Black Cardiologists; Association of Clinical Research Organizations; Calorie Control Council; Can Manufacturers Institute; CancerCare; Cancer Support Community; CEO Roundtable on Cancer; The Children's Cause for Cancer Advocacy; Cigar Association of America; CNF Pharma LLC; Coalition of Cancer Cooperative Groups; Coalition of State Rheumatology Organizations; Community Oncology Alliance; Congress of Neurological Surgeons; Corn Refiners Association; EveryLife Foundation; FasterCures, a center for the Milken Institute; Fight Colorectal Cancer; Food Marketing Institute.

Friedrich's Ataxia Research Alliance (FARA); Friends of Cancer Research; Global Genes; Global Healthy Living Foundation; Grandparents in Action; Grocery Manufacturers Association (GMA); Healthcare Leadership Council; Healthcare Nutrition Council; Healthy Women; Hematology/Oncology Pharmacy Association; Independent Bakers Association; Infant Nutrition Council of America; International Bottled Water Association; International Dairy Foods Association; Intemational Food Additives Council; International Premium Cigar and Pipe Retailers; Kids v. Cancer; Kidney Care Association; The Leukemia & Lymphoma Society.

Lung Cancer Alliance; LUNGevity; Lupus and Allied Diseases Association, Inc.; Lymphoma Research Foundation; Manhattan Institute; Men's Health Network; National Association of Chemical Distributors; National Automatic Merchandising Association; National Coalition for Cancer Research (NCCR); National Coalition for Cancer Survivorship; National Confectioners Association; National Consumers League; National Fabry Disease Foundation; National Grocers Association; National Health Council; National Infusion Center Association (NICA); National Kidney Foundation; National Pasta Association; National Patient Advocate Foundation (NPAF).

National Restaurant Association; Natural Products Association; The Nicholas Conor Institute; North American Millers Association; Ovarian Cancer Research Fund Alliance; Personal Care Products Council; Pharmaceutical Manufacturers and Manufacturers Associations of America (PhRMA); Prevent Cancer Foundation; Produce Marketing Association; Research!America; Sarcoma Foundation of America; SNAC International; Society of Hospital Medicine; The Sugar Association; Susan G. Komen; Swifty Foundation; United Fresh Produce Association.

Mr. ALEXANDER. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, before I discuss why the nominee before us, Dr. Scott Gottlieb, is the wrong choice to lead the Food and Drug Administration, I want to take a minute to talk about the FDA's impact on the health and safety of patients and families nationwide and how that impacts my perspective on this nomination.

Our constituents rely on the FDA's work every single day. They trust that the food they buy from the grocery store is safe. They trust that when they go to the emergency room, the drugs and medical devices that are used in their care have been held to the highest standards of approval and that the FDA's decisions are based on science, not politics or ideology. In other words, they trust in FDA's gold standard of approval. So it is critical that the FDA continue to have strong, independent leadership, especially in light of President Trump's radical priorities.

Like many, I am deeply concerned by this administration's efforts to roll back the progress we have made to strengthen the FDA and to improve public health. Let me give two recent examples from last week alone. First, the FDA delayed the implementation of a rule on menu labeling requirements, which would have provided families access to critical nutritional information about the food they buy and eat. These requirements have been worked on for years by several Senators and the Obama administration, with the support of public health groups and restaurants. The rule was less than 1 week away from going into effect. On the very same day, the FDA announced that it would delay the enforcement of a rule to ensure greater oversight over tobacco products, including cigars, pipe tobacco, and e-cigarettes. Now is not the time for the FDA to be taking its foot off the gas when it comes to protecting our children and youth from harmful marketing and flavoring tactics. These are significant steps in the wrong direction.

Families have every reason to be worried about this administration, and they are making it clear that they want leaders who are prepared to stand up for them, which brings us back to Dr. Gottlieb.

At our HELP Committee hearing, after scrutinizing his past record, asking where he stands on key policy issues, and reviewing his answers to many of my questions, it has been made clear to me that Dr. Gottlieb is not that leader. He has not convinced me that he can withstand political pressure from this administration or that he will be truly committed to putting our families' health first. For these reasons, I will be voting no on Dr. Gottlieb's nomination today.

In reviewing Dr. Gottlieb's professional history and background, I have grown increasingly concerned about whether he can lead the FDA in an unbiased way given his unprecedented industry ties. On numerous occasions, Dr. Gottlieb has invested in or advised a company and then used his public platform to promote policies that will benefit that company in the future.

I know that, if confirmed, Dr. Gottlieb has agreed to recuse himself for 1 year from decisions involving some companies in which he has invested or held positions, but Dr. Gottlieb will still be allowed to weigh in on matters that involve other companies in which he had been previously invested. His complicated relationships with a venture capital firm and an investment bank specifically raise many questions, and he will not be recused from matters that involve a number of their clients. Companies Dr. Gottlieb has invested in have more than 60 drugs in development that could come before the FDA for approval, and the companies Dr. Gottlieb will be recused from have over 120 drugs in development.

The extent of these entanglements is unprecedented, and they are particularly troubling given this administration's clear willingness to skirt ethics rules and pressure Federal employees in order to jam their agenda through. Yet, as troubling as these entanglements are, they are not my only problems with this nomination. I am equally concerned about where Dr. Gottlieb stands on key policy issues.

For one, I do remain unconvinced that Dr. Gottlieb will ensure independent, science-based decisionmaking at the FDA if he is confirmed. While Dr. Gottlieb was at the FDA under the Bush administration, I was working very hard to ensure that, consistent

with expert recommendations, emergency contraception known as Plan B would be sold over the counter to all age groups. Yet the Bush administration ignored the science and made a decision, based on purely ideological grounds, on a so-called behind-the-counter option for Plan B, which allowed politics to interfere directly with women's access to the healthcare services that they need, and that was a position which Dr. Gottlieb defended.

I have had the opportunity to discuss this matter with Dr. Gottlieb on several occasions now, but regrettably my concerns remain unchanged. When I asked Dr. Gottlieb about this at our hearing—whether he would allow this administration to use the FDA to further its political agenda against women's health—Dr. Gottlieb said he would ''not relitigate settled approval decisions'' on this matter. When I made clear that I was asking about the future and how he would respond to future pressure from this administration to undermine women's health, Dr. Gottlieb did not give a clear answer. Given the Trump administration's commitment to undermining women's reproductive rights, which we have seen so clearly in these past 100 days, I find this aspect of Dr. Gottlieb's professional history especially troubling.

I have also raised concerns regarding Dr. Gottlieb's published positions on a number of important issues that focus on drugs and medical devices.

As I stated at the beginning of my remarks, I find the administration's recent decision to delay oversight on tobacco products to be especially concerning, which makes it all the more important that the next FDA Commissioner have a clear position on this issue. I asked Dr. Gottlieb about this at our hearing, specifically as it relates to flavored e-cigarettes that have flooded the markets in recent years. I have to say that I was disappointed by his response. I think it is clear that a line has been crossed when tobacco companies prey on children by coming out with e-cigarette flavors like gummy bear and cookies and cream. Yet, during his hearing, when I asked Dr. Gottlieb about this, he said he was not quite sure where that line gets drawn. That speaks volumes to me, and it is a pattern I have seen in Dr. Gottlieb's answers, whether I have asked him about off-label communications by drug companies or combating the opioid epidemic and what the FDA can do to help rein in drug costs.

I could go on, but I want to make one related point, which is that we still have many questions about where Dr. Gottlieb stands on pressing policy questions he will have to confront when he is confirmed.

As I said during our HELP Committee markup, we submitted many questions to Dr. Gottlieb following his hearing, and I was encouraged that in his answers to these questions, Dr. Gottlieb committed to upholding the gold standard and working with me on a number of priorities, like improving the postmarket surveillance of medical devices. Yet, in large part, I have to say we were left disappointed with the lack of specificity in his answers. Many of them were vague, and some questions were flatout ignored.

I just came back from hearing from families in my home State, and I can tell you that people are looking at what President Trump is doing. They are appalled, and they are looking for leaders to step up. Whether it is Dr. Gottlieb's unprecedented financial entanglements, his inability to withstand political pressure from the Bush administration in order to ensure science and not ideology drives decision-making at the FDA, or whether he will truly prioritize patient and consumer safety and the public health over the interests of corporations that stand to gain financially, I continue to doubt whether Dr. Gottlieb will be able to stand up to President Trump.

I believe that families and patients, rightly, expect more. They want independent, science-based leadership at the FDA. I stand with them and will oppose this nomination.

Mr. DURBIN. Mr. President, I wish to express concern with President Trump's nominee to serve as next Commissioner of the Food and Drug Administration, FDA.

The FDA Commissioner is responsible for overseeing our Federal agency tasked with protecting and promoting the public health through the regulation of food, tobacco products, dietary supplements, drugs, medical devices, cosmetics, and veterinary products. I am not convinced that Dr. Scott Gottlieb is the right person for this job, based primarily on his less than impressive record of defending women's access to healthcare, his association with an ecigarette—or vaping—company that has produced and marketed tobacco products to youth, his stated desire to expand ''off-label'' communications between drug companies and health providers, and his long-standing and vocal opposition to the Affordable Care Act, ACA. If confirmed, I hope he proves me wrong.

Of particular concern to me is protecting our Nation's food safety. I was pleased that, in 2001, then-President Obama signed into law the FDA Food Safety Modernization Act, marking the most comprehensive reform of our Nation's food safety system in decades. Every year, 48 million Americans suffer from preventable foodborne illness. More than 120,000 people are hospitalized each year because of food contamination and 3,000 die. Every 4 minutes, someone is rushed to the hospital because the food they ate made them sick, and at the end of the day, eight will die—which is why I have spent much of my career working on various bills to strengthen food safety structures at FDA and the U.S. Department of Agriculture, to create a single food safety agency, and to support increased inspection and protection of foreign food imports. Even with passage of the FDA Food Safety Modernization Act, more work remains to be done. We must further beef up both foreign and domestic facility inspections. We must ensure the FDA has sufficient staff and resources to carry out their responsibilities. We must do a better job of effectively tracking and tracing high-risk foods in the event of a foodborne illness outbreak.

In addition, the FDA can and must do more to better regulate dietary supplements. I was pleased that, in 2015, the FDA announced creation of the Office of Dietary Supplement Programs to increase focus on and regulation of the ever-growing dietary supplement industry. It is my hope that this FDA office continues to receive the funding they so desperately need to carry out their mission of regulating a $35 billion dietary supplement industry and aggressively pursue wrongdoing.

Finally, ecigarette products continue to be a growing threat to our Nation's youth. Last year, then-Surgeon General Vivek Murthy released a report, calling the skyrocketing use of ecigarettes among youth ''a major public health concern.'' Ecigarettes are now the most commonly used form of tobacco among young people in the United States. Over the past 5 years, the number of middle school and high school students who have used ecigarettes has tripled. Among young adults aged 18 to 24, the number has doubled. While some research indicates that ecigarettes contain fewer toxic substances than ecigarettes, vape from ecigarettes is not harmless, and these products are a gateway to smoking. The popularity of ecigarettes stems in part from aggressive marketing and products aimed at youth, including the marketing of bubble gum, tutti frutti, and marshmallow flavorings. The FDA must aggressively oversee these products and ensure that they are not being marketed to children or young adults. Any attempt to exempt these products from FDA regulation will be met with extreme resistance from me.

Mr. LEAHY. Mr. President, as the Senate continues to consider nominees to lead our Nation's top agencies, we are once again faced with the difficult decision to confirm an individual whose interests run counter to the mission of the agency he or she will be tasked to lead. Dr. Scott Gottlieb, the nominee for Commissioner of the U.S. Food and Drug Administration, FDA, is another such nominee.

Dr. Scott Gottlieb is a physician and current medical consultant for pharmaceutical, medical device, and other healthcare companies. From 2003 to 2007, Dr. Gottlieb was a senior adviser to the FDA Commissioner for Medical Technology. He was also the Deputy Commissioner for Medical and Scientific Affairs under two different FDA Commissioners. In 2013, Dr. Gottlieb served on the Federal Health IT Policy Committee for the Department of Health and Human Services. He also

worked as an adviser to Mitt Romney during his 2012 Presidential campaign.

While I appreciate that Dr. Gottlieb has qualifying experience, I remain concerned about his policies and conflicts of interest. For instance, while serving as the FDA's Deputy Commissioner, Dr. Gottlieb defended the Bush administration's position to deny the availability of certain contraceptive care drugs over-the-counter, despite the science that pointed to lifesaving benefits from such drugs. Additionally, while serving with Kure, a company that operates vaping and ecigarette products, Dr. Gottlieb was noncommittal in supporting regulations over commerce in such products, which directly targets young kids through marketing, when there is a lack of appropriate medical science to suggest vaping and ecigarettes are less harmful than tobacco products. He has also historically sought ways to ensure that the Family Smoking Prevention and Tobacco Control Act of 2009 can better support the industry instead of better protecting patients and their families. This is especially problematic, given that the law provided the FDA with the authority to regulate tobacco in order to further curb smoking.

I am also concerned with Dr. Gottlieb's public disagreement with proposals that would allow patients to access affordable medications through drug importation. I have always supported policies that would allow patients to access safe and affordable medications from Canada because this is a cost-effective method to provide patients with the resources they need to manage their health needs. Of course, Dr. Gottlieb has long been an outspoken critic of the Affordable Care Act, ACA, making troubling assertions along the way. He has been quoted as opposing the ACA's medical loss ratio, which ensures that the dollars consumers pay on their healthcare go to just that and not to CEO salaries and overhead costs. He has also publically opposed the individual mandate and has supported converting the ACA's premium tax credits from an income-based to an age-based rating system, which would significantly bar patient access to quality, affordable care.

Most concerning are Dr. Gottlieb's undeniable ties to some of the largest pharmaceutical companies in the marketplace. As an adviser for New Enterprises Associates, Dr. Gottlieb currently manages more than 40 drugs now in development that could come before the FDA for approval. He has also received compensation from many of these companies, earning more than $400,000 from multiple pharmaceutical and medical device companies from 2013 to 2015 alone. Dr. Gottlieb also served on six pharmaceutical company boards, two insurance company boards, one medical laboratory company board, and several other similar boards, all of which have hundreds of drugs currently awaiting FDA approval. Without proper recusal, which Dr. Gottlieb has not committed himself to in full, these conflicts are in direct contradiction to the ethics and objective work required of the Commissioner of the FDA.

The leader of the FDA has a firm responsibility in promoting policies and overseeing drug development with the purpose of enhancing the health and well-being of the American people. We should put ourselves in the shoes of the American people, our constituents, in evaluating nominees to head agencies that bear directly on the public's healthcare needs. Given Dr. Gottlieb's significant conflicts of interest, combined with his ideological approaches to public health policy, which suggest that he would rather deny patients access to lifesaving resources than support ways to improve healthcare and promote prevention efforts for all, I cannot in good conscience support his nomination.

Mrs. MURRAY. Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. HOEVEN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CRUZ). Without objection, it is so ordered.

CONGRESSIONAL REVIEW ACT RESOLUTION

Mr. HOEVEN. Mr. President, now is the time to get back to basics. The Federal Government doesn't exist for its own sake, it exists for the people, and if Federal regulation serves no useful function for the people, then it only serves to hold back our Nation's prosperity and growth.

With so many Americans hungry for good-paying jobs, now is the time to unleash our Nation's economic potential by getting government out of the way. It is just plain common sense to eliminate regulations that are duplicative, costly, and unworkable. We need to get back to the basics by getting rid of those kinds of regulations, and one of those regulations is the BLM methane rule.

Now, the BLM methane rule is one of those midnight regulations that the Obama administration put out as they were walking out the door. This new regulation from the Bureau of Land Management—or BLM—imposes new rules and royalty rates on methane emissions from oil and gas production on Federal and Indian lands.

For those wondering why methane emissions aren't already regulated, there is a simple explanation: They are. Under the Clean Air Act, the Environmental Protection Agency, in partnership with individual States, is tasked with regulating air quality, which includes methane emissions. In fact, States like my State of North Dakota and the State of Texas, where the Presiding Officer resides, currently have regulatory systems in place to govern oil and gas emissions. Critically, the North Dakota Industrial Commission has put in place flaring requirements that have successfully reduced the flaring in our State from 35 percent down to 10 percent as a result of their work, and they have a goal to take it even further. This flaring reduction is a big deal because to reduce methane emissions you need to reduce flaring.

Flaring sounds complicated, but it is very simple. When excess gas is produced along with oil and it can't be captured, then it gets burned off, or flared. Neither industry nor State officials like flaring because it wastes natural gas—it wastes a natural resource—of which methane obviously is the main component. As most Americans know, obviously, natural gas is a valuable commodity that is used to heat our homes and power our factories. That is why both industry and the States have worked hard to make big improvements. They want to capture that natural gas and that methane. That is not just in North Dakota. That is in other energy-producing States across the country.

Nationally, methane emissions from the oil and gas industry have been on the decline for a number of years. So we are already actively working at the State level under a regulatory regime where States have primacy to spend, authorized by EPA, to reduce natural gas flaring.

With methane emissions already being regulated and reduced by the States and industry, it is tough to figure out why this new BLM regulation has been passed and what it is accomplishing. This rule has been calculated to cost up to $279 million each year. So the cost of this rule is $279 million a year—a duplicative rule. That is in addition to the redtape. BLM estimates that the rule will impose an additional 82,000 hours of paperwork.

These numbers just might sound like the cost of doing business, if you will, but America's job creators know it is really costing us business, it is costing us economic growth, and it is costing us jobs. These aren't really numbers. There are livelihoods at stake.

What makes the BLM methane rule particularly burdensome is the fact that it is simply unworkable. The rule sets a maximum volume that each well can flare, which will lead to curtailment and shut-in wells, meaning actually having to shut down the wells. Of course, that decreases oil production and reduces royalty payments. So that means less energy, the owners get less revenue, and we have less jobs. Meanwhile, this rule treats all drilling spacing units the same, regardless of whether they have minimal Federal ownership. Remember, a lot of these wells they are trying to regulate are on minerals owned by the Federal Government, but they may also be on minerals owned by private individuals. So, once again, we have one of these Federal one-size-fits-all regulations that just does not work in practice.