Mr. Speaker, I rise in support of H.R. 5925, the Coordinated Response through Interagency Strategy and Information Sharing Act, or the CRISIS Act.

This bill reauthorizes the Office of National Drug Control Policy, which has not been reauthorized in a very long time. It makes needed overhauls and updates to the office and even streamlines the name of the office to the Office of National Drug Control, or ONDC.

Mr. Speaker, I commend Chairman GOWDY and Ranking Member CUMMINGS for working in a bipartisan manner. I also thank Representative MITCHELL and Representative RASKIN for working with me to incorporate the first two recommendations of the President's opioid commission into the CRISIS Act.

I introduced a separate bill, the Coordinated Overdose and Drug Epidemic Response to the Emergency Declaration Act, or CODE RED Act, that authorizes ONDC to address those commission recommendations.

ONDC will now be authorized to implement a coordinated tracking system of all federally-funded initiatives and grants. This will help identify barriers and gaps in Federal efforts responding to the opioid crisis and it identifies places where efforts are being duplicated and potentially wasted. This legislation improves the grant application process by standardizing and streamlining it.

The mission here is to deploy Federal resources to localities that need them quickly and efficiently instead of localities wasting valuable time and resources filling out various agency applications.

More broadly, the CRISIS Act will foster better government coordination and strategic planning. ONDC has cross-agency jurisdiction to coordinate the efforts among different agencies, like HHS and DOJ. When agencies work together, the force-multiplying effect can make a huge difference.

We are making progress on the opioid crisis. Bipartisan bills like the CRISIS Act will help win this fight and help the people engage in the fight, like the North Hills of Pittsburgh's Tracy Lawless.

Tracy participated in the President's Commission on Combating Drug Addiction and continues to help find solutions back in Pennsylvania.

Mr. Speaker, I thank her and everyone else who is making a difference.

Mr. MITCHELL. Mr. Speaker, I want to make the gentleman from Maryland aware that I have no further speakers and I am prepared to close.

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

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

Mr. Speaker, in closing, I must point out that my Republican colleagues say they want to address the opioid crisis, yet they are standing silent as the Trump administration actively tries to destroy the Affordable Care Act protections for people with pre-existing conditions, which, by the way, includes substance use disorders.

If we aren't going to take available steps to expand access to addiction treatment, at least we should all agree that we shouldn't roll back protections that prevent insurance companies from discriminating against people with substance use disorders. Therefore, we should all be working to protect the Affordable Care Act from the Trump administration's effort to destroy the essential protections it provides.

Again, I remind all of us that ONDCP is a very important entity and it has a job to do, and it must be properly funded.

A lot of people, when they give statistics about opioids and drugs, Mr. Speaker, they find themselves speaking about the dead. Well, I am here to tell you that there are pipelines to death, and those are the people who are addicted now. Those are the ones who are thinking about it, about to start using those drugs. So we must address not only the deaths and the statistics, but we must address treatment that is effective and efficient.

Mr. Speaker, again, I am urging my colleagues to vote for this bill, but I want it to be clear that we should not dust our hands off and say it is done.

It is not done. There is so much more to do.

Mr. Speaker, I urge all Members to vote for this legislation, and I yield back the balance of my time.

Mr. MITCHELL. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I appreciate my colleague's support of the bill. In my brief time here, a year and a half, it has become abundantly clear to me that rarely do we get to dust off our hands and say we are done around here.

It has also become clear to me that the debate of the bill rarely stays on the topic of the bill or solely on the topic of the bill. You see, the ACA, the Affordable Care Act, is not the sole approach to addressing healthcare issues in this country, preexisting conditions, or the preexisting conditions that are affected by drug abuse.

I believe when we passed the American Health Care Act in this House, that that addressed preexisting conditions, treatment for substance abuse, and, using the words of my colleague, did so more effectively and efficiently than the Affordable Care Act does now.

We clearly disagree on that. I respect that, and will continue to work on it.

Today, we are dealing with this bill.

Mr. Speaker, I urge my colleagues to support passage of this bill, because I believe that H.R. 5925 is an important step not only in reauthorizing the Office of National Drug Control, but also in providing additional resources to do so.

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

The SPEAKER pro tempore (Mr. MEADOWS). The question is on the motion offered by the gentleman from Michigan (Mr. MITCHELL) that the House suspend the rules and pass the bill, H.R. 5925, 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.

## OVERDOSE PREVENTION AND PATIENT SAFETY ACT

Mr. BURGESS. Mr. Speaker, pursuant to House Resolution 949, I call up the bill (H.R. 6082) to amend the Public Health Service Act to protect the confidentiality of substance use disorder patient records, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 949, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–75 is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 6082

*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 ''Overdose Prevention and Patient Safety Act''.*

***SEC. 2. CONFIDENTIALITY AND DISCLOSURE OF RECORDS RELATING TO SUBSTANCE USE DISORDER.***

*(a) CONFORMING CHANGES RELATING TO SUBSTANCE USE DISORDER.—Subsections (a) and (h) of section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) are each amended by striking ''substance abuse'' and inserting ''substance use disorder''.*

*(b) DISCLOSURES TO COVERED ENTITIES CONSISTENT WITH HIPAA.—Paragraph (2) of section 543(b) of the Public Health Service Act (42 U.S.C. 290dd–2(b)) is amended by adding at the end the following:*

*''(D) To a covered entity or to a program or activity described in subsection (a), for the purposes of treatment, payment, and health care operations, so long as such disclosure is made in accordance with HIPAA privacy regulation. Any redisclosure of information so disclosed may only be made in accordance with this section.''.*

*(c) DISCLOSURES OF DE-IDENTIFIED HEALTH INFORMATION TO PUBLIC HEALTH AUTHORITIES.—Paragraph (2) of section 543(b) of the Public Health Service Act (42 U.S.C. 290dd–2(b)), as amended by subsection (b), is further amended by adding at the end the following:*

*''(E) To a public health authority, so long as such content meets the standards established in section 164.514(b) of title 45, Code of Federal Regulations (or successor regulations) for creating de-identified information.''.*

*(d) DEFINITIONS.—Subsection (b) of section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) is amended by adding at the end the following:*

*''(3) DEFINITIONS.—For purposes of this subsection:*

*''(A) COVERED ENTITY.—The term 'covered entity' has the meaning given such term for purposes of HIPAA privacy regulation.*

*''(B) HEALTH CARE OPERATIONS.—The term 'health care operations' has the meaning given such term for purposes of HIPAA privacy regulation.*

''(C) HIPAA PRIVACY REGULATION.—The term 'HIPAA privacy regulation' has the meaning given such term under section 1180(b)(3) of the Social Security Act.

''(D) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' has the meaning given such term for purposes of HIPAA privacy regulation.

''(E) PAYMENT.—The term 'payment' has the meaning given such term for purposes of HIPAA privacy regulation.

''(F) PUBLIC HEALTH AUTHORITY.—The term 'public health authority' has the meaning given such term for purposes of HIPAA privacy regulation.

''(G) TREATMENT.—The term 'treatment' has the meaning given such term for purposes of HIPAA privacy regulation.''.

(e) USE OF RECORDS IN CRIMINAL, CIVIL, OR ADMINISTRATIVE INVESTIGATIONS, ACTIONS, OR PROCEEDINGS.—Subsection (c) of section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) is amended to read as follows:

''(c) USE OF RECORDS IN CRIMINAL, CIVIL, OR ADMINISTRATIVE CONTEXTS.—Except as otherwise authorized by a court order under subsection (b)(2)(C) or by the consent of the patient, a record referred to in subsection (a) may not—

''(1) be entered into evidence in any criminal prosecution or civil action before a Federal or State court;

''(2) form part of the record for decision or otherwise be taken into account in any proceeding before a Federal agency;

''(3) be used by any Federal, State, or local agency for a law enforcement purpose or to conduct any law enforcement investigation of a patient; or

''(4) be used in any application for a warrant.''.

(f) PENALTIES.—Subsection (f) of section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) is amended to read as follows:

''(f) PENALTIES.—The provisions of sections 1176 and 1177 of the Social Security Act shall apply to a violation of this section to the extent and in the same manner as such provisions apply to a violation of part C of title XI of such Act. In applying the previous sentence—

''(1) the reference to 'this subsection' in subsection (a)(2) of such section 1176 shall be treated as a reference to 'this subsection (including as applied pursuant to section 543(f) of the Public Health Service Act)'; and

''(2) in subsection (b) of such section 1176—

''(A) each reference to 'a penalty imposed under subsection (a)' shall be treated as a reference to 'a penalty imposed under subsection (a) (including as applied pursuant to section 543(f) of the Public Health Service Act)'; and

''(B) each reference to 'no damages obtained under subsection (d)' shall be treated as a reference to 'no damages obtained under subsection (d) (including as applied pursuant to section 543(f) of the Public Health Service Act)'.''.

(g) ANTIDISCRIMINATION.—Section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) is amended by adding at the end the following:

''(i) ANTIDISCRIMINATION.—

''(1) IN GENERAL.—No entity shall discriminate against an individual on the basis of information received by such entity pursuant to a disclosure made under subsection (b) in—

''(A) admission or treatment for health care;

''(B) hiring or terms of employment;

''(C) the sale or rental of housing; or

''(D) access to Federal, State, or local courts.

''(2) RECIPIENTS OF FEDERAL FUNDS.—No recipient of Federal funds shall discriminate against an individual on the basis of information received by such recipient pursuant to a disclosure made under subsection (b) in affording access to the services provided with such funds.''.

(h) NOTIFICATION IN CASE OF BREACH.—Section 543 of the Public Health Service Act (42 U.S.C. 290dd–2), as amended by subsection (g), is further amended by adding at the end the following:

''(j) NOTIFICATION IN CASE OF BREACH.—

''(1) APPLICATION OF HITECH NOTIFICATION OF BREACH PROVISIONS.—The provisions of section 13402 of the HITECH Act (42 U.S.C. 17932) shall apply to a program or activity described in subsection (a), in case of a breach of records described in subsection (a), to the same extent and in the same manner as such provisions apply to a covered entity in the case of a breach of unsecured protected health information.

''(2) DEFINITIONS.—In this subsection, the terms 'covered entity' and 'unsecured protected health information' have the meanings given to such terms for purposes of such section 13402.''.

(i) SENSE OF CONGRESS.—It is the sense of the Congress that any person treating a patient through a program or activity with respect to which the confidentiality requirements of section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) apply should access the applicable State-based prescription drug monitoring program as a precaution against substance use disorder.

(j) REGULATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate Federal agencies, shall make such revisions to regulations as may be necessary for implementing and enforcing the amendments made by this section, such that such amendments shall apply with respect to uses and disclosures of information occurring on or after the date that is 12 months after the date of enactment of this Act.

(2) EASILY UNDERSTANDABLE NOTICE OF PRIVACY PRACTICES.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with appropriate experts, shall update section 164.520 of title 45, Code of Federal Regulations, so that covered entities provide notice, written in plain language, of privacy practices regarding patient records referred to in section 543(a) of the Public Health Service Act (42 U.S.C. 290dd–2(a)), including—

(A) a statement of the patient's rights, including self-pay patients, with respect to protected health information and a brief description of how the individual may exercise these rights (as required by paragraph (b)(1)(iv) of such section 164.520); and

(B) a description of each purpose for which the covered entity is permitted or required to use or disclose protected health information without the patient's written authorization (as required by paragraph (b)(2) of such section 164.520).

(k) DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS FOR SUBSTANCE USE DISORDER PATIENT RECORDS.—

(1) INITIAL PROGRAMS AND MATERIALS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), in consultation with appropriate experts, shall identify the following model programs and materials (or if no such programs or materials exist, recognize private or public entities to develop and disseminate such programs and materials):

(A) Model programs and materials for training health care providers (including physicians, emergency medical personnel, psychiatrists, psychologists, counselors, therapists, nurse practitioners, physician assistants, behavioral health facilities and clinics, care managers, and hospitals, including individuals such as general counsels or regulatory compliance staff who are responsible for establishing provider privacy policies) concerning the permitted uses and disclosures, consistent with the standards and regulations governing the privacy and security of substance use disorder patient records promulgated by the Secretary under section 543 of the Public Health Service Act (42 U.S.C. 290dd–2), as amended by this section, for the confidentiality of patient records.

(B) Model programs and materials for training patients and their families regarding their rights to protect and obtain information under the standards and regulations described in subparagraph (A).

(2) REQUIREMENTS.—The model programs and materials described in subparagraphs (A) and (B) of paragraph (1) shall address circumstances under which disclosure of substance use disorder patient records is needed to—

(A) facilitate communication between substance use disorder treatment providers and other health care providers to promote and provide the best possible integrated care;

(B) avoid inappropriate prescribing that can lead to dangerous drug interactions, overdose, or relapse; and

(C) notify and involve families and caregivers when individuals experience an overdose.

(3) PERIODIC UPDATES.—The Secretary shall—

(A) periodically review and update the model programs and materials identified or developed under paragraph (1); and

(B) disseminate such updated programs and materials to the individuals described in paragraph (1)(A).

(4) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials under this subsection, the Secretary shall solicit the input of relevant stakeholders.

(l) RULES OF CONSTRUCTION.—Nothing in this Act or the amendments made by this Act shall be construed to limit—

(1) a patient's right, as described in section 164.522 of title 45, Code of Federal Regulations, or any successor regulation, to request a restriction on the use or disclosure of a record referred to in section 543(a) of the Public Health Service Act (42 U.S.C. 290dd–2(a)) for purposes of treatment, payment, or health care operations; or

(2) a covered entity's choice, as described in section 164.506 of title 45, Code of Federal Regulations, or any successor regulation, to obtain the consent of the individual to use or disclose a record referred to in such section 543(a) to carry out treatment, payment, or health care operation.

(m) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) patients have the right to request a restriction on the use or disclosure of a record referred to in section 543(a) of the Public Health Service Act (42 U.S.C. 290dd–2(a)) for treatment, payment, or health care operations; and

(2) covered entities should make every reasonable effort to the extent feasible to comply with a patient's request for a restriction regarding such use or disclosure.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and the ranking minority member of the Committee on Energy and Commerce.

The gentleman from Texas (Mr. BURGESS) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material on H.R. 6082.

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

There was no objection.

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

Mr. Speaker, over the course of the past several months, the Energy and Commerce's Subcommittee on Health held four legislative hearings on bills to address the opioid epidemic and reported 57 bills to the full committee. Of those 57 bills, only one received its own discrete hearing. That bill was H.R. 6082, the Overdose Prevention and Patient Safety Act, introduced by Representatives MULLIN and BLUMENAUER.

□ 1245

As a physician, I believe it is vital that doctors have all of the appropriate information to determine the proper course of treatment for a patient, ensuring patient safety and privacy, as required by Federal regulation known as HIPAA. The Overdose Prevention and Patient Safety Act maintains the original intent of the 1970s statute behind 42 CFR part 2 by protecting patients and improving care coordination.

In fact, the bill increases protections for those seeking treatment by more severely penalizing those who illegally share patient data than under the current statute. Current part 2 law does not protect individuals from discrimination based on their treatment records and, to this date, there have been no criminal actions undertaken to enforce part 2.

This bill has a wide range of support from national and State organizations. Since the bill was introduced, the Energy and Commerce Committee has heard from over 100 organizations in its support.

Arguably, the most notable support for this legislation comes from the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services. Dr. Elinore McCance-Katz, the Assistant Secretary for Mental Health and Substance Use, wrote to Mr. MULLIN in March, stating that SAMHSA ''is encouraged to see Congress examine the benefits of aligning part 2 with HIPAA. Patient privacy is, of course, critical but so too is patient access to safe, effective, and coordinated treatment.''

I agree with Dr. McCance-Katz that in order to ensure patient safety, physicians must have secure access to patient records, including substance use disorder information. When this information is not provided to healthcare professionals, they may end up prescribing medications that have dangerous drug interactions or may lead a patient who is in recovery to be inappropriately prescribed an opioid and fall back into addiction.

One particular complication driven by 42 CFR part 2 directly impacts the care for pregnant women and their infants. For women who are pregnant, part 2 does not allow redisclosure of substance use disorder medical documentation to the women's OB/GYN doctor, primary care physician, or health home without their written consent. This leads to fragmented care, which opens up the mother and her baby to potential harm.

Centerstone, one of the Nation's largest not-for-profit healthcare organizations, notes that ''mothers who continue to use during pregnancy and who do not wish to sign secondary releases to allow their care providers to treat them comprehensively put their unborn children at risk for addiction.''

Centerstone watches these women and their infants suffer right before their eyes, but, because of part 2, Centerstone cannot share the information to ensure that the mother and baby are getting proper care.

As an OB/GYN physician myself, I cannot imagine having this information withheld. Such a situation would leave me with the inability to treat the whole patient and ensure that the mother is healthy and her baby is not on a path for addiction.

In another situation, a patient was referred to a treatment center following an emergency room visit for an overdose. The patient was not able to give written consent to his providers due to acute intoxication. Due to a lack of written consent and 42 CFR part 2, the treatment facility could not communicate to the ER and learn about the patient's condition or confirm that the patient had, indeed, enrolled in a drug treatment center, further delaying critical care coordination.

There is clear evidence that part 2 is a massive roadblock to providing safe, quality, and coordinated care to individuals suffering from substance use disorder.

The issue of the stigma associated with substance use disorder has been a constant in all of the discussions that we have had, both in our offices and in our hearings. In April, we heard from numerous individuals who were parents of children who died from opioid overdoses. Some noted that their children were afraid to seek help from their families or from healthcare professionals because they were embarrassed or they felt stigmatized.

We should enable physicians to fully care for these patients suffering from substance use disorder as if they had any other disease. The Overdose Prevention and Patient Safety Act will do just that.

The first step in addressing a problem is admitting that it exists. I would like to pose a question to those who are arguing against this legislation:

If we continue to silo the substance use disorder treatment information of a select group of patients rather than integrating it into our medical records and comprehensive care models, how can we ensure that these patients are, in fact, receiving quality care? How can we really treat substance use disorder like all other complex health conditions?

H.R. 6082 ensures adequate patient data protection in accordance with Federal law, with HIPAA. There are provisions in the language that ensure that the data may only be used for purposes of treatment, payment, or healthcare operations. Substance use disorder data cannot be used in criminal, civil, or administrative investigations, actions, or proceedings without patient consent or a court order.

Additionally, the legislation explicitly prohibits discrimination against an individual on the basis of their patient needs. Currently, part 2 includes no antidiscrimination protections and no protections for individuals if there is a data breach or improper disclosure.

Think about that for a minute, Mr. Speaker. This was a 1970s-era law. There were not data breaches back in the 1970s. 42 CFR part 2 was never intended to protect a patient in the instance of a data breach.

Should any entity or individual share patient data under H.R. 6082, they, in fact, will be severely penalized.

There is a reason why SAMHSA and most of the healthcare stakeholder community is asking for this change. Clearly, there is an issue here that must be addressed. This opioid crisis is devastating our country. Passing the Overdose Prevention and Patient Safety Act will enable greater coordination among healthcare providers in providing quality, effective care for individuals across the country who are battling substance use disorder.

My thanks to Mr. MULLIN on the Energy and Commerce Committee and to Mr. BLUMENAUER for introducing this legislation that is of utmost importance.

I urge strong support for the bill, and I reserve the balance of my time.

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

Mr. Speaker, I rise in opposition to H.R. 6082, the Overdose Prevention and Patient Safety Act. This legislation would greatly harm our efforts to combat the opioid epidemic. If we really want to turn the tide on this crisis, we must find ways to get more people into treatment for opioid use disorder.

In 2016, there were about 21 million Americans aged 12 or older in need of substance use disorder treatment, but only 4 million of those 21 million actually received treatment. That means 17 million people are going without the treatment they need. Failure to get individuals with opioid use disorder into treatment increases risk of fatal and nonfatal overdoses as people continue to seek out illicit opioids as part of their addiction. The increasing presence of fentanyl in our drug supply only heightens this concern.

Strategies that increase the number of people getting into and remaining in treatment are particularly important because, as these treatment statistics show, major challenges exist to getting people with substance use disorders to enter treatment in the first place. And this House should not—and I stress ''should not''—take any action that puts at risk people seeking treatment for any substance use disorder, but particularly opioid use disorders.

Unfortunately, this bill risks doing just that: reducing the number of people willing to come forward and remain

in treatment because they worry about the negative consequences that seeking treatment can have on their lives. And this is a very real concern.

This bill weakens privacy protections that must be in place for some people to feel comfortable about starting treatment for their substance use disorder. Ensuring strong privacy protections is critical to maintaining an individual's trust in the healthcare system and a willingness to obtain needed health services, and these protections are especially important where very sensitive information is concerned.

The information that may be included in the treatment records of a substance use disorder patient are particularly sensitive because disclosure of substance use disorder information can create tangible vulnerabilities that are not the same as other medical conditions. For example, you are not incarcerated for having a heart attack; you cannot legally be fired for having cancer; and you are not denied visitation to your children due to sleep apnea.

According to SAMHSA, the negative consequences that can result from the disclosure of an individual's substance use disorder treatment record can include loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration. These are real risks that keep people from getting treatment in the first place.

While I understand that the rollback of the existing privacy protections to the HIPAA standard would limit permissible disclosures without patient consent to healthcare organizations, this ignores the reality: It may be illegal for information to be disclosed outside these healthcare organizations, but we know, Mr. Speaker, that information does get out. Breaches do happen.

Remember the recent large-scale Aetna breach that disclosed some of its members' HIV status?

But there are also small-scale breaches that don't make the news that can have devastating consequences for patients trying to recover and get treatment. For example, a recent ProPublica investigation detailed instances where a healthcare organization's employee peeked at the record of a patient 61 times and posted details on Facebook, while another improperly shared a patient's health information with the patient's parole officer. Breaches such as this are very concerning and could occur more often as a result of this legislation.

While I appreciate the sponsor's efforts to alleviate these concerns, I do not believe the potential harm that could be caused by eliminating the patient consent requirement under existing law for treatment, payment, and healthcare operations can be remedied through the measures included in this bill. The inclusion of these provisions cannot compensate for the risk of stigma, discrimination, and negative health and life outcomes for individuals with opioid use disorder that could result from the weakening of the existing privacy protections, and that is why every substance use disorder patient group has come out in opposition to this bill.

According to the Campaign to Protect Patient Privacy Rights, a coalition of more than 100 organizations: ''Using the weaker HIPAA privacy rule standard of allowing disclosure of substance use disorder information without patient consent for treatment, payment, and healthcare operations will contribute to the existing level of discrimination and harm to people living with substance use disorders.''

The Campaign goes on to say: ''This will only result in more people who need substance use disorder treatment being discouraged and afraid to seek the healthcare they need during the Nation's worst opioid crisis.''

This is a risk we simply should not take, and yet the majority is bringing this bill to the floor today, despite the very real concerns of these experts. These groups uniquely understand what is at stake from this legislation because many of their members live with or are in fear of the negative consequences that result from the disclosure of substance use disorder diagnosis and treatment information.

In fact, the negative consequences that will result from the disclosure of someone's substance use disorder would solely affect that individual and their family. They will bear the burden if we get this wrong. They could be at risk of potentially losing custody of their child and their freedom by the increased risk of improper disclosure of their medical record if this bill becomes law.

These risks may simply just keep them from seeking potentially lifesaving treatment. That is why substance use disorder treatment providers have also raised concerns.

The South Carolina Association of Opioid Dependence explained: ''Even with the growing awareness that substance use disorders are a disease, the unfortunate truth is that persons with substance use disorder are still actively discriminated against . . . such as a baby being taken away from a new mother because she is on methadone for an opioid use disorder, despite longstanding compliance with her treatment and abstinence from illegal drug use.''

Another provider, Raise the Bottom Addiction Treatment, one of two medical-assisted treatment facilities in Idaho, explained that ''our patients come from every walk of life, including professionals and executives within our community. Their anonymity and privacy is of utmost importance because their careers, families, and livelihood often depend on it.

''Knowing that people may seek treatment without fear of backlash and discrimination is often a deciding factor when considering entering treatment.

''To undo this protection will deeply affect one's ability and willingness to seek help. . . . Not only can the members of our community not afford to lose their right to confidentiality, but we as a nation cannot afford to move backwards in our fight to combat this opiate crisis.''

□ 1300

So again, Mr. Speaker, these are the words of experts on the frontline fighting this epidemic. People who suffer from substance use disorder should be able to decide with whom to share their treatment records from programs and for what purposes. Those rights are taken away from them under this legislation, and I believe that is wrong.

As we face a tragic national drug abuse problem, the scale of which our country has never seen, I believe maintaining the heightened privacy protections under existing law remains vital to ensuring all individuals with substance use disorder can seek treatment for their substance use disorder with confidence that their right to privacy will be protected. To do otherwise at this time is just too great a risk, and I strongly urge my colleagues to listen to the experts on the subject and to vote ''no'' on this legislation.

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

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Oklahoma (Mr. MULLIN), the principal sponsor of the bill and a valuable member of the Energy and Commerce Committee.

Mr. MULLIN. Mr. Speaker, I rise today to speak in support of my bill, H.R. 6082, the Overdose Prevention and Patient Safety Act.

My colleague Mr. BLUMENAUER and I introduced this bill to help physicians fight the opioid epidemic. The Overdose Prevention and Patient Safety Act allows the flow of information among healthcare providers and health planners for the purpose of treatment, payment, and healthcare operations.

Unfortunately, there is an outdated Federal Government mandate, 42 CFR part 2, which is creating a firewall between doctors and patients.

My bill, the Overdose Prevention and Patient Safety Act, will give doctors access to patients' addiction medical information that can integrate their care, prevent tragic overdoses, and improve patient safety.

SAMHSA has stated: ''The practice of requiring substance use disorder information to be any more private than information regarding other chronic illnesses, such as cancer or heart disease, may in itself be stigmatizing. Patients with substance use disorders seeking treatment for any condition have a right to healthcare providers who are fully equipped with the information needed to provide the highest quality care available.''

When a person violates part 2, it is referred to the Justice Department,

and there is only a $50 penalty. There have been zero cases—let me repeat that—there have been zero cases in which part 2 was enforced or any action taken by the Department of Justice or SAMHSA.

The penalties for noncompliance underneath HIPAA are based on the level of negligence and can range from $100 to $50,000 per violation, with a maximum of $1.5 million per year.

There have been 173,472 HIPAA violations since 2003, with 97 percent of those complaints resolved.

Patients, doctors, hospitals, and a broad spectrum of stakeholders agree we need to end this outdated Federal Government mandate helping prevent the private sector's innovation.

Mr. Speaker, I encourage my colleagues to support the Overdose Prevention and Patient Safety Act.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I appreciate Mr. PALLONE's courtesy in permitting me to speak on this bill. I respect his efforts, and I respect a number of his concerns. But I do think that the work that we have done with Mr. MULLIN, with the committee, and I appreciate the subcommittee's extra efforts to work through these elements, listen to people's objections, and to do it right.

There has been no argument that this provision has cost lives. The failure in emergency rooms, other circumstances, for people to not be able to get the full picture of a patient's condition ends up sometimes with tragic consequences. We have yet to hear any reason why we shouldn't coordinate.

Now, I appreciate concerns about patient privacy, but as Dr. BURGESS and my friend from Oklahoma point out, we are strengthening provisions under this bill for disclosure. People don't want to stigmatize those with substance abuse, we agree. But having a separate system that people have to go through just for substance abuse implies a stigma. People will think there is something wrong with these people. You don't do this for AIDS anymore. This harmonizes with all the other HIPAA provisions.

Candidly, forcing people to go through yet another step probably raises questions about the validity of disclosure, raising questions in the minds of those who go through that.

Mr. Speaker, we have made, I think, tremendous progress dealing with stigma, dealing with patient protection, what we have done for mental health, which has devastating consequences in some cases if people's records were revealed. Think what has happened with HIV/AIDS. There was a time when that would end up with people not just having a stigma but at risk of losing their jobs, being ostracized.

These are the same provisions in this bill that are there for HIV/AIDS or mental health, for everything under HIPAA.

I really do think that we take a step back, understanding that having separate authorizations complicates the coordination and integration of treatment. Oftentimes, behavioral health information doesn't arrive in an orderly fashion. It is another step of complication that could have tragic consequences.

In fact, the subcommittee's record demonstrates that. There have been examples where people have died because the medical providers did not have the full picture of the patient. This legislation will fix it.

Mr. BURGESS. Mr. Speaker, I yield 5 minutes to the gentleman from Oregon (Mr. WALDEN), the chairman of the full committee.

Mr. WALDEN. Mr. Speaker, I want to thank Dr. BURGESS, the chairman of the Subcommittee on Health, for his fine leadership on this issue, along with our colleagues, Mr. MULLIN and my friend from Oregon and colleague, Mr. BLUMENAUER, who put a lot of work into this. I commend my colleague from Oregon for his strong statement in support of this legislation.

Combating the opioid epidemic has been a top priority of all of us in this Congress and especially on the Energy and Commerce Committee, which I chair.

We have committed the last year and a half to examining the ways we can respond to save lives, to help people in our communities, and to end this deadly, deadly epidemic.

During that time, I have heard a lot of stories, both at the hearings here in the Nation's Capital and back home in Oregon, where I have held multiple roundtables and meetings in the communities about what we need to do to help the outcome of patients; our neighbors, our friends, in some cases family members, who are dealing with these addictions.

An extraordinary array of people, including patients, parents of those suffering with addiction, the Oregon Hospital Association, Oregon Governor Kate Brown, physicians, and substance use disorder treatment providers, have all told me and our committee that existing Federal confidentiality regulations and statute known as 42 CFR part 2, or simply part 2, are working against—working against—patients and making it harder to effectively treat addiction. There is hardly anyone in the healthcare sector that we have not heard from on this issue.

One story that really comes to mind is that of Brandon McKee. Brandon's brother, Dustin, testified before our Health Subcommittee when we reviewed a near identical version of this legislation back in May.

Tragically, Brandon had died of an opioid overdose at just 36 years of age. He left behind three young children.

Speaking about his passing, his brother Dustin told the subcommittee: ''Brandon's death was preventable. However, in part because of the antiquated provisions contained within 42 CFR part 2, the medical professionals that prescribed him opiate-based pain medications were not able to identify him as a high-risk individual.''

You see, Brandon was prescribed opioids after back surgery on two separate occasions despite his history of substance use disorder. Within a few months of his second surgery, Brandon fatally overdosed on heroin. That is why this bill is so important.

Health records for substance use disorder are the only—only—records that are siloed in this way, preventing physicians from seeing the complete picture of a patient they are treating. The doctors don't know.

All other protected health information for every other disease falls under HIPAA. The Overdose Prevention and Patient Safety Act will help align Federal privacy standards for substance use disorder treatment information more closely with HIPAA so that our doctors and our addiction specialists can provide the highest and safest level of treatment.

In short, this bill will improve coordination of care for patients suffering from substance use disorder and save lives by helping to prevent overdoses and dangerous drug interactions.

Now, I fully respect and understand the privacy concerns that some still have, and the sensitivities about the idea of making changes to a statute that has been in place since the 1970s, long before HIPAA. That is why Representatives MULLIN and BLUMENAUER worked in a bipartisan fashion to include strong unlawful disclosure penalties, discrimination protections, and breach notification requirements in this bill.

Doing so, H.R. 6082 will actually improve the ability to penalize those who illegally disclose a patient's information. This isn't about using this information for any other purpose than treating that patient safely.

To be clear, there is no legal way for a patient's substance use disorder treatment information to be used against them under this bill. This bill, instead, expands protections for individuals seeking addiction treatment above and beyond existing law, and it will help us turn the tide on the opioid scourge.

I want to thank Mr. MULLIN and Mr. BLUMENAUER once again for their work, and the other Members on the committee. This bipartisan bill will save lives. It is critically importantly to our efforts to combat the opioid crisis, and I urge my colleagues to support H.R. 6082.

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

Mr. Speaker, proponents of this legislation argue that taking away patients' privacy rights related to substance use disorder treatment records is okay because we would be applying the HIPAA standard that applies to other sensitive health conditions like HIV, but I strongly disagree.

Individuals with substance use disorder face risk because of their medical conditions that those with other medical conditions do not. According to SAMHSA, those negative consequences include loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrests, prosecution, and incarceration.

Unlike other medical conditions, including HIV, you can be incarcerated, legally fired, and denied visitation with your children due to your substance use disorder.

So let me paint this picture with a few examples.

A 20-year-old pregnant woman in Wisconsin voluntarily went to a hospital to seek treatment for addiction to the opiate OxyContin. Rather than providing treatment, the hospital called State authorities to report this woman. She was taken into custody and held for several weeks before a judge ordered her released.

Another example provided to the committee from a provider in Maryland explained:

Some time ago, we had a young lady in our methadone maintenance program who committed suicide. She had turned her life around. She was in college, working full time, owned her own car, was purchasing a house, and was no longer using illicit substances. She had to complete probation for her crimes that she had committed while she was actively using these drugs.

Her mother did not know she was in methadone treatment. She did not want her mother to know because her mother did not agree with methadone, and the judge found out she was in the methadone maintenance program and disclosed it in a court hearing with her mother present.

The judge and her mother insisted that she ''get off that stuff,'' and she complied only because of the pressure from both to do so.

She began abusing illicit substances and participating in illegal activity to obtain those substances. The guilt and shame of returning to what she described as a life of hell led her to write a suicide note and end her life.

□ 1315

Experiences like this, in addition to stories of individuals with substance use disorder who have lost jobs, housing, and child custody because of their substance use disorder, are reasons that some individuals with substance use disorder fear coming forward to enter treatment due to the negative consequences that result. It is why more than 100 groups, including AIDS United, joined the campaign to protect patient privacy rights. They have joined together to fight to protect the heightened privacy protections that exist under existing law.

Further, unlike the proponents of this legislation contend, the existing law is not an anomaly. States like Florida have laws requiring written patient consent for the sharing of a patient's substance use disorder and mental health treatment records, while others like New York, Kentucky, and Texas have such requirements for the sharing of HIV records. Other States have such requirements for reproductive health treatment records.

Further, the existing law is consistent with the confidentiality protections applied to substance use disorder treatment records. In fact, the law governing the confidentiality of VA medical records, 38 U.S.C. 7332, is consistent with and broader than part 2. Unlike that law, the VA cannot share a patient's substance use disorder, HIV, or sickle cell anemia treatment records with another provider without written patient consent.

So, Mr. Speaker, I want to stress that I do believe that we can learn an important lesson from our response to HIV, particularly during the height of the AIDS epidemic. A critical part of this Nation's response to the AIDS epidemic was increasing the privacy protections applied to HIV medical records. Such action was taken because people were afraid to enter treatment for HIV/AIDS because of the negative consequences that could result.

In the midst of the opioid epidemic, this bill would result in doing just the opposite: lowering the privacy protections applied to substance use disorder medical records despite the fact that, like during the AIDS epidemic, some individuals with substance use disorder remain afraid to enter treatment because of the negative consequences that result. And in many cases, they only do so out of the part 2 assurances that they can control to whom and for what purposes their treatment record is shared.

The increased stigma, discrimination, and criminalization faced by people with substance use disorder support the maintenance of the heightened privacy protections under existing law, in my opinion. And for some individuals, it is these privacy protections that make them feel safe to enter and remain in treatment for their substance use disorder. I am afraid that by passing this bill we could be creating a barrier that will keep people from getting the treatment they need, and that is a risk I am simply not willing to take.

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

Mr. BURGESS. Mr. Speaker, I yield myself 2 minutes for the purpose of response before I yield to Dr. BUCSHON.

Mr. Speaker, the tragic story that was just related to us really only reinforces the need to change the statute behind 42 CFR part 2. There are some important facts missing from the description of the situation that occurred.

It appears evident that at least one or both of the parties involved, the judge, and/or the methadone maintenance program, violated existing regulations under both part 2 and HIPAA.

Under part 2, patient records may only be disclosed without patient consent if the disclosure is authorized by an appropriate order of a court of competent jurisdiction. There must be a showing of good cause in which the court must weigh the public interest and need for disclosure against the injury to the patient, the physician-patient relationship, and treatment services. Further, the court must impose appropriate safeguards against unauthorized disclosure.

It is not clear from the description provided in the letter how the judge found out about the patient's participation in a methadone maintenance program. If the information to the judge was provided without an appropriate court order, then the methadone maintenance program likely violated the requirements under part 2 to safeguard the patient's records from such disclosure. If the information was provided as a result of a court order, then it is possible that the judge violated his or her ethical obligations to appropriately weigh the need for the information and safeguard the information once received.

Under HIPAA, there is still an obligation for the parties seeking information to confirm that reasonable efforts have been made to ensure that the individual has been given notice of the request for personal health information and the opportunity to object or that reasonable efforts have been made to secure a qualified protective order. Compliance with either of these requirements appears to have been lacking in the situation described in the letter.

All of this suggests that part 2 currently is insufficient to protect patients in these situations. The legislation before us today does not decrease the protections against the use of the records in criminal proceedings that already exist under part 2, but HIPAA makes the protections stronger.

I yield 3 minutes to the gentleman from Indiana (Mr. BUCSHON), a valuable member of our committee and our subcommittee that has heard the testimony on this legislation.

Mr. BUCSHON. Mr. Speaker, I rise today to speak in strong support of H.R. 6082, the Overdose Prevention and Patient Safety Act. This legislation will improve the ability of medical professionals to properly care for patients by allowing physicians access to a patient's full medical record, including information about substance use disorder treatment, while ensuring robust privacy protections.

As a physician, I know that patients don't always notify their doctors of all the medications they are taking, and not having a complete medical record or knowing a patient's background can result in potentially life-threatening complications related to medical treatment. I have seen this in my own practice, and my wife sees this almost daily in her anesthesia practice.

This is commonsense legislation which will ensure patients receive appropriate healthcare, while also ensuring the medical information remains private. Mr. Speaker, I urge my colleagues to support H.R. 6082.

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

Mr. Speaker, some of the proponents of this bill also mentioned the opiate use disorder situations in emergency rooms as a justification for the legislation, but I just want to say, Mr. Speaker, I think it is important to note that the existing law includes an exception to the patient consent requirement. A provider can access a patient's substance use disorder treatment records in the case of an emergency as determined by the provider without patient consent.

Additionally, nothing in the existing law prevents any provider from asking their patient about their substance use disorder history before prescribing any opioid, especially in the midst of the opioid epidemic. Every provider should ask patients about their opioid use disorder history, and, therefore, under the existing law and every other privacy law, the doctor can learn of a patient's opiate use disorder history by simply asking the patient that.

That remains, in my opinion, the optimum way of learning a patient's medical history, because currently our electronic health records aren't interoperable in many cases. Those underlying interoperability issues that prevent information sharing, including the part 2 information in cases where a patient has agreed to share their information with providers, aren't going to be solved by this bill.

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

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. SHIMKUS), a valuable member of the Energy and Commerce Committee.

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, it is good to be on the floor with my good friend and colleague, the ranking member, Congressman PALLONE. I know his heart is solid and I know he believes that we are challenging some privacy concerns, and I take that in the spirit intended.

As a Republican, I was an early supporter of one of our former colleague's—Sue Myrick's—Mental Health Parity Act. And the whole intent of that, for many of us, was to say mental health illness is an illness and should be accepted as an illness. But what we have done under the Federal code is to separate it. So I think the intent of what we are trying to do is not separate it and make it part of the health records.

We have heard the debate on both sides, but that is the basic premise from which I come. And we have heard the testimony of people for whom the information was not shared with the regular doctor versus the mental health, and then prescriptions occurring and then catastrophic events.

The intent of this legislation is to help patients and to help providers better take care of their patients. This is not about taking away privacy but taking care of people. It is about making sure people have the appropriate level of privacy for the services they are seeking.

We don't create extra privacy barriers so that people with heart disease, HIV, or diabetes can keep their doctors in the dark and withhold critical information relevant to the insurer benefits that they are using. This goes back to, as we have heard today, a 1970-era mandate.

Gary Mendell, the founder of Shatterproof, lost his son Brian, who was recovering from substance use disorder, after he tragically took his own life. Gary said the following about aligning part 2 with HIPAA:

The solution is not to keep this information out of electronic health records and not available. The solution is to end the stigma and to bring this disease and mental illness into the healthcare system, just like diabetes, cancer, or any other disease.

And I couldn't agree more with Gary. He also said:

If there's an issue related to unintended consequences, let's fix that.

I think in this piece of legislation, Congressman MULLIN and Congressman BLUMENAUER intended to do that.

Gary also said:

Let's not keep this out of the healthcare system, unlike diabetes, heart disease, and cancer, because then we just perpetuate the situation that is causing it in the first place.

I will continue. Individuals with opioid use disorder die, on average, a decade sooner than other Americans. This is largely because of the strikingly high incidence of poorly managed, co-occurring chronic diseases, including HIV/AIDS, cardiac conditions, lung disease, and cirrhosis.

Whatever we as a nation are doing to coordinate care for this highly vulnerable population is failing by any reasonable measure.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BURGESS. Mr. Speaker, I yield an additional 30 seconds to the gentleman from Illinois.

Mr. SHIMKUS. Mr. Speaker, an extraordinary array of organizations, hospitals, physicians, patient advocates, and substance use treatment providers have approached this committee to clearly state that existing Federal addiction privacy law is actively interfering with case management and care coordination efforts. Arguing against this legislation preserved a fatal and deadly status quo.

I support this piece of legislation, and I thank my colleague for the time.

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

Mr. Speaker, I mentioned earlier the various groups that are opposed to this legislation because of the privacy concerns, and I actually would like to read or go through some sections from this letter that was sent to Chairman WALDEN and me from over 100 groups, including the New Jersey Association of Mental Health and Addiction Agencies.

And they say, Mr. Speaker:

Dear Chairman Walden and Ranking Member Pallone:

We, the undersigned national, State, and local organizations strongly support maintaining the core protections of the Federal substance use disorder patient confidentiality law and its regulations, referred to collectively as part 2.

And they say:

We remain concerned that using a weaker HIPAA privacy rule standard of allowing disclosure of substance use disorder information without patient consent or other purposes will contribute to the existing level of discrimination and harm to people living with substance use disorders. This will only result in more people who need substance use disorder treatment being discouraged and afraid to seek the healthcare they need during the Nation's worst opioid crisis.

We strongly support maintaining part 2's current core protections for substance use disorder information instead of those weaker HIPAA privacy standards for the following reasons.

And there are five.

One, the heightened privacy protections in part 2 are as critical today as they were when they were enacted more than 40 years ago and must be preserved.

Two, in the midst of the worst opioid epidemic in our Nation's history, we must do everything possible to increase, not decrease, the number of people who seek treatment.

□ 1330

Three, substance use disorder is unique among medical conditions because of its criminal and civil consequences and the rampant discrimination people face.

Four, with so much at stake, patients in substance use disorder treatment should retain the right to consent when and to whom their records are disclosed, as currently found in part 2.

Five, effective integration of substance use disorder treatment with the rest of the healthcare system is critically important, and information exchange in accordance with confidentiality law and current technology is now possible. To facilitate that process, SAMHSA recently amended the part 2 regulations to further promote the integration of confidential substance use disorder information into general health records.

They finally conclude, Mr. Speaker, by saying:

We respectfully request that the House Energy and Commerce Committee maintain the current confidentiality protections of part 2 to support individuals entering and staying in substance use disorder treatment and recovery services.

Mr. Speaker, I include in the RECORD this letter from these patients.

CAMPAIGN TO PROTECT PATIENT PRIVACY RIGHTS,
*June 18, 2018.*

Re Opposition to H.R. 6082—''Overdose Prevention and Patient Safety Act''.

Representative GREG WALDEN,
*Chairman of the U.S. House of Representatives Energy and Commerce Committee, Washington, DC.*

Representative FRANK PALLONE, Jr.,
*Ranking Member of the U.S. House of Representatives Energy and Commerce Committee, Washington, DC.*

DEAR CHAIRMAN WALDEN AND RANKING MEMBER PALLONE: We, the undersigned national, state, and local organizations strongly support maintaining the core protections of the federal substance use disorder patient confidentiality law (''42 U.S.C. 290dd–2'') and its regulations ''42 CFR Part 2,'' (referred to

collectively as ''Part 2'') to effectively protect the confidentiality of patients' records. The Substance Abuse and Mental Health Service Administration (''SAMHSA'') recently amended Part 2's patient privacy regulations in 2017 and 2018, which accomplishes the bill's proposed objective of providing coordinated care between substance use disorder (''SUD'') and other health care information.

We remain concerned that using a weaker HIPAA Privacy Rule standard of allowing disclosures of SUD information without patient consent for treatment, payment, health care operations, or other purposes other than those currently allowed by Part 2—will contribute to the existing level of discrimination and harm to people living with substance use disorders. This will only result in more people who need substance use disorder treatment, being discouraged and afraid to seek the health care they need during the nation's worst opioid crisis.

We strongly support maintaining Part 2's current core protections for SUD information, instead of those of a weaker HIPAA Privacy standard as described in H.R. 6082 for the following reasons:

1. The heightened privacy protections in Part 2 are as critical today as they were when they were they were enacted more than 40 years ago, and must be preserved.

2. In the midst of the worst opioid epidemic in our nation's history, we must do everything possible to increase—not decrease—the number of people who seek treatment.

3. SUD is unique among medical conditions because of its criminal and civil consequences and the rampant discrimination people face.

4. With so much at stake, patients in SUD treatment should retain the right to consent when and to whom their records are disclosed, as currently found in Part 2.

5. Effective integration of SUD treatment with the rest of the health care system is critically important, and information exchange in accordance with confidentiality law and current technology is now possible. To facilitate that process, SAMHSA recently amended the Part 2 regulations to further promote the integration of confidential SUD information into general health records.

We respectfully request that the House Energy and Commerce Committee maintain the current confidentiality protections of Part 2 to support individuals entering and staying in SUD treatment and recovery services.

Sincerely,

Campaign to Protect Privacy Rights: A New PATH; Addiction Haven; Addictions Resource Center, Waukesha, WI (ARC, Inc.); Advocates for Recovery Colorado; AIDS United; Alano Club of Portland; Alcohol & Addictions Resource Center, South Bend, IN; American Association for the Treatment of Opioid Dependence (AATOD); American Group Psychotherapy Association; Apricity; Arthur Schut Consulting LLC; Association of Persons Affected by Addiction; Atlantic Prevention Resources; California Consortium of Addiction Programs & Professionals (CCAPP); Capital Area Project Vox—Lansing (MI)'s Voice of Recovery; Center for Recovery and Wellness Resources; CFC Loud N Clear Foundation; Chicago Recovering Communities Coalition; Colorado Behavioral Healthcare Council; Communities for Recovery.

Community Catalyst; Connecticut Community for Addiction Recovery (CCAR); Council on Addiction Recovery Services (CAReS)-Orlean, NY; DarJune Recovery Support Services & Café; Davis Direction Foundation—The Zone; Daystar Center; Delphi Behavioral Health Group—Maryland House Detox; Detroit Recovery Project; The DOOR—DeKalb Open Opportunity for Recovery; Drug and Alcohol Service Providers Organization of Pennsylvania; El Paso Alliance; Faces & Voices of Recovery; Faces and Voices of Recovery (FAVOR)—Grand Strand-SC; Faces and Voices of Recovery (FAVOR)—Greenville, SC; Faces and Voices of Recovery (FAVOR)—Low Country: Charleston, SC; Faces and Voices of Recovery (FAVOR)—Mississippi Recovery Advocacy Project; Faces and Voices of Recovery (FAVOR)—Pee Dee, SC; Faces and Voices of Recovery (FAVOR)—Tri-County: Rock Hill, SC; Facing Addiction; Fellowship Foundation Recovery Community Organization.

Foundation for Recovery; Friends of Recovery—New York; Georgia Council on Substance Abuse; Greater Macomb Project Vox; Harm Reduction Coalition; Home of New Vision; HOPE for New Hampshire Recovery; Jackson Area Recovery Community—Jackson, MI; Latah Recovery Center; Legal Action Center; Lifehouse Recovery Connection; Long Island Recovery Association (LIRA); Lotus Peer Recovery; Maine Alliance for Addiction Recovery; Massachusetts Organization for Addiction Recovery; Message Carriers of Pennsylvania; Mid-Michigan Recovery Services (NCADD Mid-Michigan Affiliate); Minnesota Recovery Connection; Missouri Recovery Network.

National Advocates for Pregnant Women; National Alliance for Medication Assisted Recovery (NAMA Recovery); National Association for Children of Addiction (NACoA); National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD); National Association for Rural Mental Health (NARMH); National Center on Domestic Violence, Trauma & Mental Health; National Council on Alcoholism and Drug Dependence, Inc. (NCADD); National Council on Alcoholism and Drug Dependence—Central Mississippi Area, Inc.; National Council on Alcoholism and Drug Dependence—Maryland; National Council on Alcoholism and Drug Dependence—Phoenix; National Council on Alcoholism and Drug Dependence—San Fernando Valley; Navigating Recovery of the Lakes Region; New Jersey Association of Mental Health and Addiction Agencies; Northern Ohio Recovery Association; Oklahoma Citizen Advocates for Recovery and Transformation Association (OCARTA); Overcoming Addiction Radio, Inc.; Parent/Professional Advocacy League; Peer Coach Academy Colorado; Pennsylvania Recovery Organizations—Alliance (PRO–A).

People Advocating Recovery (PAR); Pennsylvania Recovery Organization—Achieving Community Together (PRO–ACT); Portland Recovery Community Center; Public Justice Center; REAL—Michigan (Recovery, Education, Advocacy & Leadership); Recover Project/Western MA Training; Recover Wyoming; RecoveryATX; Recovery Alliance of Austin; Recovery Allies of West Michigan; Recovery Cafe; Recovery Communities of North Carolina; Recovery Community of Durham; Recovery Consultants of Atlanta; Recovery Epicenter Foundation, Inc.; Recovery Force of Atlantic County; Recovery is Happening; Recovery Resource Council; Recovery Organization of Support Specialist.

Revive Recovery, Inc.; Rhode Island Cares About Recovery (RICARES); Rochester Community Recovery Center; ROCovery Fitness; Safe Harbor Recovery Center; SMART Recovery (Self-Management and Recovery Training); S.O.S. Recovery Community Organization; SpiritWorks Foundation; Springs Recovery Connection; Tennessee Association of Alcohol, Drug & other Addiction Services (TAADAS); The Bridge Foundation; The Courage Center; The McShin Foundation; The Ohana Center for Recovery; The Serenity House of Flint; The Phoenix; The RASE Project; The Recovery Channel; Tia Hart Community Recovery Program.

Together Our Recovery Center Heals (T.O.R.C.H.), Inc.; Treatment Trends, Inc.; Trilogy Recovery Community; U MARC (United Mental Health and Addictions Recovery Coalition); Utah Support Advocates for Recovery Awareness (USARA); Vermont Recovery Network; Voices of Hope for Cecil County, MD; Voices of Hope Lexington; Voices of Recovery San Mateo County, CA; WAI–IAM, Inc. and RISE Recovery Community; Wisconsin Voices for Recovery; Young People in Recovery.

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

Mr. BURGESS. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I would like to point out that there are over 100 groups in support of the Partnership to Amend 42 CFR part 2. A letter from that partnership says, in part:

We are pleased that the bill aligns part 2 with HIPAA's consent requirements for the purposes of treatment, payment and operations, which will allow for the appropriate sharing of substance use disorder records, among covered entities, to ensure persons with opioid use disorder and other substance use disorders receive the integrated care that they need. Additionally, as we do not want patients with substance use disorders to be made vulnerable as a result of seeking treatment for addiction, this legislation strengthens protections and limits the number of institutions that have access to their records.

I am not going to read all of the names on the list, but some of the notable ones are the National Alliance on Mental Illness, Mental Health America, Hazelden Betty Ford Foundation, National Governors Association, Healthcare Leadership Council, American Hospital Association, American Society of Addiction Medicine, Centerstone, New Jersey Hospitals, and National Association of Addiction Treatment Providers.

Mr. Speaker, I include in the RECORD the entire list of all of the groups in favor of the Partnership to Amend 42 CFR.

PARTNERSHIP TO AMEND 42 CFR PART 2—A COALITION OF OVER 40 HEALTH CARE STAKEHOLDERS COMMITTED TO ALIGNING 42 CFR PART 2 (PART 2) WITH HIPAA TO ALLOW APPROPRIATE ACCESS TO PATIENT INFORMATION THAT IS ESSENTIAL FOR PROVIDING WHOLE-PERSON CARE

JUNE 15, 2018.

Hon. MARKWAYNE MULLIN,
*House of Representatives, Washington, DC.*
Hon. EARL BLUMENAUER,
*House of Representatives, Washington, DC.*

DEAR REPRESENTATIVES MULLIN AND BLUMENAUER: The undersigned members of the Partnership to Amend 42 CFR Part 2 (Partnership) and additional stakeholder organizations applaud your leadership on the issue of substance use disorder privacy records. We strongly support the Overdose Prevention and Patient Safety (OPPS) Act, H.R. 6082, which will align 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of health care treatment, payment, and operations (TPO). The Partnership is pleased that the OPPS Act was voted out of the Committee on Energy and Commerce with a bipartisan vote.

The Partnership is a coalition of more than 40 organizations representing stakeholders across the health care spectrum committed to aligning Part 2 with HIPAA to allow appropriate access to patient information that is essential for providing whole-person care.

We are pleased that the bill aligns Part 2 with HIPAA's consent requirements for the purposes of TPO, which will allow for the appropriate sharing of substance use disorder records, among covered entities, to ensure persons with opioid use disorder and other substance use disorders receive the integrated care they need. Additionally, as we do not want patients with substance use disorders to be made vulnerable as a result of seeking treatment for addiction, this legislation strengthens protections and limits the number of institutions that have access to patient records.

Thank you both for your leadership on this issue and we look forward to working with you on helping to address the opioid crisis by passing this important bipartisan legislation on the floor of the U.S. House of Representatives.

Sincerely,

PARTNERSHIP TO AMEND 42 CFR PART 2 MEMBERS

Academy of Managed Care Pharmacy; American Association on Health and Disability; American Health Information Management Association; American Hospital Association; American Psychiatric Association; American Society of Addiction Medicine; American Society of Anesthesiologists; America's Essential Hospitals; America's Health Insurance Plans; AMGA; Association for Ambulatory Behavioral Healthcare; Association for Behavioral Health and Wellness; Association for Community Affiliated Plans; BlueCross BlueShield Association; Catholic Health Association of the U.S.; Centerstone; Confidentiality Coalition; Employee Assistance Professionals Association; Global Alliance for Behavioral Health and Social Justice; Hazelden Betty Ford Foundation.

Health IT Now; Healthcare Leadership Council; The Joint Commission; InfoMC; Medicaid Health Plans of America; Mental Health America; National Alliance on Mental Illness; National Association for Behavioral Healthcare; National Association of ACOs; National Association of Counties (NACo); National Association of State Mental Health Program Directors (NASMHPD); Netsmart; OCHIN; Otsuka; Pharmaceutical Care Management Association; Premier Healthcare Alliance.

ADDITIONAL STAKEHOLDER ORGANIZATIONS

ACO Health Partners; Aetna; AMITA Health; Anthem, Inc.; Ascension Health; Avera Health; Banner Health; Baptist Healthcare System; Beacon Health Options; Bon Secours Health System, Inc.; CareSource; Catholic Health Initiatives; Centene Corporation; Change Healthcare; Cigna; College of Healthcare Information Management Executives (CHIME).

Excellus BlueCross BlueShield; Franciscan Sisters of Christian Charity Sponsored Ministries, Inc.; Greater New York Hospital Association; Henry Ford Health System; Howe Home Designers; Johns Hopkins Medicine; Kern Health Systems; Leidos; Lycoming County; Magellan Health; Marshfield Clinic Health System; Mental Health America of Indiana; Mosaic Life Care; NAMI; NAMI DC; NAMI Delaware.

NAMI Greene County Tennessee; NAMI Helena; NAMI of Howard County, MD; NAMI Jefferson County, Washington; NAMI Kaufman County; NAMI Kershaw County; NAMI Lewistown; NAMI Lexington; NAMI of the Pee Dee (South Carolina); NAMI Piedmont Tri-County; NAMI Sarasota County; NAMI South Suburbs of Chicago; NAMI Sussex, Inc.; NAMI Temple Area; NAMI Utah; NAMI Valley of the Sun.

National Alliance on Mental Illness (NAMI) Texas; National Association of Addiction Treatment Providers; New Directions Behavioral Health; OPEN MINDS; Optum; PerformCare; Providence St. Joseph Health; SCAN Health Plan; SSM Health; Texas Health Resources; The Center for Health Affairs/Northeast Ohio Hospital Opioid Consortium; The MetroHealth System; Trinity Health; University of Tennessee Medical Center; Valley Health System; Vizient; Wayne Meriwether.

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

Mr. PALLONE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I just want to say in conclusion today, that amidst the worst opioid epidemic our country has ever faced, I think it is really important that we not take any action that could result in any individual with an opiate use disorder not seeking or remaining in treatment for this life-threatening condition.

I understand the opinions on both sides, but I do think that if we don't protect the existing privacy and keep the current law with regard to privacy that we will see many individuals not seeking treatment or remaining in treatment. That is why I strongly oppose this bill, and I urge my colleagues to vote ''no.''

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

Mr. BURGESS. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, by continuing to segregate substance use disorder records means that we are willing to allow some patients to receive care that is potentially lower quality at a higher cost.

Treating patient substance use disorder in isolation from their medical and mental health conditions—which predominated care in the 1970s—is not the standard for good practice today. There is now overwhelming evidence that patients' substance use disorders cannot be treated in isolation from other healthcare conditions. In the 1970s when part 2 was written, this was not widely accepted, and treatment for addiction was largely separate from treatment for other illnesses.

Mr. Speaker, further, I would say that the problem here is we need to treat addiction just like any other medical illness and improve our outreach to patients who meet the criteria for treatment. Maintaining a decades old, ineffective confidentiality law simply is not going to do that.

I urge my colleagues to support the bill. It is a good bill supported by Mr. MULLIN and Mr. BLUMENAUER.

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

The SPEAKER pro tempore (Mr. BOST). All time for debate has expired.

Pursuant to House Resolution 949, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. PALLONE. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. PALLONE. I am opposed to H.R. 6082.

Mr. BURGESS. Mr. Speaker, I reserve a point of order against the motion.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Pallone moves to recommit the bill H.R. 6082 to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike page 1, line 4, through page 8, line 20.

Strike page 11, line 8, through page 12, line 9.

Page 8, line 21, through page 11, line 7, promote subsection (k) to become a section which reads as follows:

**SEC. 2. DEVELOPMENT AND DISSEMINATION OF MODEL TRAINING PROGRAMS FOR SUBSTANCE USE DISORDER PATIENT RECORDS.**

(a) INITIAL PROGRAMS AND MATERIALS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with appropriate experts, shall identify the following model programs and materials (or if no such programs or materials exist, recognize private or public entities to develop and disseminate such programs and materials):

(1) Model programs and materials for training health care providers (including physicians, emergency medical personnel, psychiatrists, psychologists, counselors, therapists, nurse practitioners, physician assistants, behavioral health facilities and clinics, care managers, and hospitals, including individuals such as general counsels or regulatory compliance staff who are responsible for establishing provider privacy policies) concerning the permitted uses and disclosures, consistent with the standards and regulations governing the privacy and security of substance use disorder patient records promulgated by the Secretary under section 543 of the Public Health Service Act (42 U.S.C. 290dd–2) for the confidentiality of patient records.

(2) Model programs and materials for training patients and their families regarding their rights to protect and obtain information under the standards and regulations described in paragraph (1).

(b) REQUIREMENTS.—The model programs and materials described in paragraphs (1) and (2) of subsection (a) shall address circumstances under which disclosure of substance use disorder patient records is needed to—

(1) facilitate communication between substance use disorder treatment providers and other health care providers to promote and provide the best possible integrated care;

(2) avoid inappropriate prescribing that can lead to dangerous drug interactions, overdose, or relapse; and

(3) notify and involve families and caregivers when individuals experience an overdose.

(c) PERIODIC UPDATES.—The Secretary shall—

(1) periodically review and update the model program and materials identified or developed under subsection (a); and

(2) disseminate such updated programs and materials to the individuals described in subsection (a)(1).

(d) INPUT OF CERTAIN ENTITIES.—In identifying, reviewing, or updating the model programs and materials under this section, the Secretary shall solicit the input of relevant stakeholders.

At the end, insert the following new section:

**SEC. 3. REPORT ON PATIENT EXPERIENCE WITH PART 2.**

(a) REPORT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct or support a study that examines information sharing behaviors of individuals who obtain substance use disorder treatment through a Part 2 program.

(b) TOPICS.—The study pursuant to subsection (a) shall examine the extent to which patients at Part 2 programs agree to share their information, including the following:

(1) Patient understanding regarding their rights to protect and obtain information under Part 2.

(2) Concerns or feelings patients have about sharing their Part 2 treatment records with other health care providers and organizations.

(3) Whether or not patients agree to share their Part 2 medical records.

(4) The extent of providers with which patients agree to share their Part 2 treatment records.

(5) If patients have shared their Part 2 treatment information—

(A) at what point in the treatment relationship with the Part 2 program did the patients choose to do so; and

(B) what prompted the patients to share the information.

(6) What considerations were taken into account by the patient when deciding whether or not and with whom to share their Part 2 treatment information.

(7) How did having the choice to decide to what extent and with whom to share Part 2 treatment records affect patients' decision to uptake or remain in treatment.

(8) Would not having a choice to decide the extent to which to share their treatment records from Part 2 programs affect a patient's decision to participate or stay in treatment.

(c) SCOPE.—The study under subsection (a) shall—

(1) include a nationally representative sample of individuals obtaining treatment at Part 2 programs; and

(2) consider patients of Part 2 programs being treated for various substance use disorders, including opioid use disorder and alcohol use disorder.

(d) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit a report to the Congress on the results of the study under subsection (a).

(e) DEFINITIONS.—In this section:

(1) The term ''Part 2 program'' means a program described in section 543 of the Public Health Service Act (42 U.S.C. 290dd–2).

(2) The term ''Part 2'' means the program under section 543 of the Public Health Service Act (42 U.S.C. 290dd–2).

Mr. PALLONE (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading of the motion.

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

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey is recognized for 5 minutes in support of his motion.

Mr. PALLONE. Mr. Speaker, this is the final amendment to the bill which will not kill the bill or send it back to committee. If adopted, the bill will immediately proceed to final passage, as amended.

Mr. Speaker, this amendment would maintain the privacy rights provided to individuals with substance use disorder. Those patients would retain their right to determine with whom and for what purpose to share their substance use disorder treatment records from part 2 programs.

Rather than strip away patients' privacy rights, my amendment would incorporate section 509 from the bipartisan Alexander-Murray bill, S. 2680, the Opioid Crisis Response Act of 2018, that was reported out of the Senate HELP Committee on a bipartisan basis, and that was incorporated in the underlying legislation.

That provision requires the Secretary to support the development and dissemination of model training programs for substance use disorder treatment records under part 2. It would help ensure that more patients, families, and providers understand how information can be protected and shared under part 2.

My amendment would also help us to better understand the privacy needs of individuals with substance use disorder as well as how to balance those needs with the information needs of our health system to provide the highest quality care.

Specifically, my amendment would require the Secretary to conduct or support a study to better understand the patient experience with part 2 through the examination of information-sharing behaviors of individuals who obtain substance use disorder treatment at part 2 programs.

This study will provide critical insight into the central question under debate today: What is the appropriate level of privacy protections that should be applied to substance use disorder treatment records?

While there are a lot of opinions and persuasive evidence to support both sides of this debate, there is a lack of research on this issue generally or as it specifically relates to part 2. Such information will help us better understand the level of control individuals with substance use disorders need over their medical records to ensure their privacy concerns are not a barrier for such individuals accessing potentially lifesaving treatment.

It would also help us better understand what is the appropriate balance between the needs of these individuals regarding the privacy of their substance use disorder treatment information with the needs of a coordinated healthcare system to best serve its patients.

We know that today, under current law, some patients who receive substance use disorder treatment from part 2 programs choose not to share their treatment records with any provider outside of their substance use disorder treatment provider. On the other hand, there are others who choose to share with only a few of their nonsubstance use disorder treatment providers.

So I just believe it is critical we understand the reasons why such individuals have made these decisions as well as how the right to make such a decision affected their willingness to seek or remain in treatment.

This amendment is consistent with the recent recommendations from the Medicaid and CHIP Payment and Access Commission. As part of their June 2018 report to Congress, the commission stated that at this time the commission does not recommend alignment of part 2 and HIPAA. Instead, the commission recommends additional subregulatory guidance, education, and training on part 2.

As I have made clear, Mr. Speaker, I have concerns that the underlying bill would hurt our efforts to respond to the opioid epidemic and could increase the odds that fewer individuals with opiate use disorder enter and remain in treatment, a risk I believe too great to take during the worst drug abuse epidemic our country has ever faced.

However, I realize there is another side of this argument as advanced by the proponents of this bill, and we should not be concerned that this bill will affect the uptick of treatment, and, in fact, we should believe that this will only improve treatment.

Rather than undertake the 50–State experiment to see which side is right, we should support the thorough study of this issue before taking any action to weaken the privacy protections provided by part 2. In that way, we can determine the actual effect on taking away from individuals with substance use disorder the ability to decide how their treatment information is shared. That way we would have no doubt on both the intended and unintended consequences of eliminating the patient consent requirement for treatment, payment, and healthcare operation purposes as proposed by the underlying bill.

I think the stakes are too high to get this wrong. I urge my colleagues to support this amendment to increase the awareness of patients, families, and providers about how their treatment records are protected and can be shared under part 2 as well as to increase our understanding of the privacy needs of individuals with substance use disorders.

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

Mr. BURGESS. Mr. Speaker, I withdraw my point of order.

The SPEAKER pro tempore. The reservation of the point of order is withdrawn.

Mr. BURGESS. Mr. Speaker, I claim the time in opposition to the motion.

The SPEAKER pro tempore. The gentleman from Texas is recognized for 5 minutes.

Mr. BURGESS. Mr. Speaker, I urge a ''no'' vote on the motion to recommit as it will destroy the intent of the bill.

Eliminating the sharing of records for the purposes of treatment, payment, and healthcare operations completely negates the entire purpose of this initiative.

Aligning 42 CFR part 2 with HIPAA for purposes of treatment, payment, and healthcare operations is the entire purpose of the legislation.

Opponents of this bill have offered no evidence or findings to back up their claim that HIPAA is inadequate to protect sensitive data contained in substance use disorder treatment records.

HIPAA is currently functioning well in protecting sensitive patient information in a number of areas.

Real integration of behavioral health and primary care simply cannot happen until we align 42 CFR part 2 with HIPAA.

The opposition of H.R. 6082 is not based on protecting privacy. It is based on very specific distrust of the healthcare community to properly provide care to people with substance use disorder—the very people whom we are asking to help us with this.

Yet, the ranking member is strongly in favor of numerous bills that seek to expand access to evidence-based medication-assisted treatment, telehealth and integration with mainstream medicine—the very things that demand alignment with HIPAA. So the thinking, Mr. Speaker, to be kind, is incongruous.

Prohibiting the sharing of addiction medical records for treatment, payment, and healthcare operations makes it impossible to prescribe the latest substance use treatment medications safely.

Like most pharmaceuticals, buprenorphine and methadone have drug interactions and interact with other medicines. Adverse events from drug interactions can lead to emergency hospital visits, serious injuries, or death.

We must amend part 2 so we can safely prescribe medication-assisted treatment for patients. Put simply, standard clinical practices like medication reconciliation are not feasible under the current Federal law. For that reason, I urge my colleagues to vote ''no'' on the motion to recommit. Vote ''yes'' on the underlying motion.

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

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. PALLONE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

## INDIVIDUALS IN MEDICAID DESERVE CARE THAT IS APPROPRIATE AND RESPONSIBLE IN ITS EXECUTION ACT

### GENERAL LEAVE

Mrs. MIMI WALTERS of California. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on the bill, H.R. 5797.

The SPEAKER pro tempore (Mr. SHIMKUS). Is there objection to the request of the gentlewoman from California?

There was no objection.

The SPEAKER pro tempore. Pursuant to House Resolution 949 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the state of the Union for the consideration of the bill, H.R. 5797.

The Chair appoints the gentleman from Illinois (Mr. BOST) to preside over the Committee of the Whole.

□ 1345

### IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the state of the Union for the consideration of the bill (H.R. 5797) to amend title XIX of the Social Security Act to allow States to provide under Medicaid services for certain individuals with opioid use disorders in institutions for mental diseases, with Mr. BOST in the chair.

The Clerk read the title of the bill.

The CHAIR. Pursuant to the rule, the bill is considered read the first time.

The gentlewoman from California (Mrs. MIMI WALTERS) and the gentleman from New Jersey (Mr. PALLONE) each will control 30 minutes.

The Chair recognizes the gentlewoman from California.

Mrs. MIMI WALTERS of California. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the opioid epidemic is ravaging this Nation. Families have been torn apart; lives have been destroyed; and communities are endangered.

This crisis does not discriminate. Americans from all walks of life in all 50 States are being held hostage by the scourge of opioids.

Tragically, the opioid epidemic claims the lives of 115 Americans on average each day. In my home of Orange County, California, 361 people died from opioid overdoses in 2015. That accounts for a 50 percent increase in overdose deaths since 2006.

According to the OC Health Care Agency's 2017 ''Opioid Overdose and Death in Orange County'' report, the rate of opioid-related emergency room visits increased by more than 140 percent since 2005. Between 2011 and 2015, Orange County emergency rooms treated nearly 7,500 opioid overdose and abuse cases.

We can put an end to these tragic statistics by providing full access to various treatment options to those seeking help with their addictions. While many of these patients may benefit from outpatient help, others need highly specialized inpatient treatment to ensure they are receiving the most clinically appropriate care.

The IMD CARE Act will increase access to care for certain Medicaid beneficiaries with opioid use disorder who need the most intensive care possible: inpatient care.

Current law prohibits the Federal Government from providing Federal Medicaid matching funds to States to provide mental disease care to Medicaid-eligible patients aged 21 to 64 in facilities defined as institutes of mental diseases, commonly known as IMDs. This IMD exclusion means that Federal dollars may not be provided for the care of Medicaid-eligible patients in this age group for substance use disorder treatments at hospitals, nursing facilities, or other institutions with more than 16 beds.

It is time to repeal the IMD exclusion and remove this outdated barrier to inpatient treatment. The IMD CARE Act would allow States to repeal for 5 years the IMD exclusion for adult Medicaid beneficiaries who have an opioid use disorder, which includes heroin and fentanyl.

These beneficiaries would receive treatment in an IMD for up to 30 days over a 12-month period, during which time the beneficiary would be regularly assessed to ensure their treatment and health needs require inpatient care. The bill would also require the IMD to develop an outpatient plan for the individual's ongoing treatment upon discharge.

Throughout the Energy and Commerce Committee's work on the opioid crisis, the IMD exclusion is consistently identified as a significant barrier to care for Medicaid patients. Not every patient needs treatment in an IMD, but those who do are often among the most vulnerable. What once was a well-intended exclusion on Federal Medicaid spending has since prevented individuals from seeking treatment.

In the light of the opioid epidemic, I believe my legislation strikes the right balance. I know some have suggested States continue to seek CMS waivers to allow Medicaid to pay for IMD care. Waivers can be a good option for some States, but not all States want a waiver. In fact, less than half of the States have applied for a waiver. Additionally, a waiver can take a substantial amount of time to develop, review, and approve.

We are losing too many friends and family members to force States to navigate a lengthy and uncertain waiver process. The IMD CARE Act allows