House Energy And Commerce Committee, Health Subcom.., sked FINAL

May 9, 2018 3:03PM ET

TRANSCRIPT

May 08, 2018

COMMITTEE HEARING

REP. MICHAEL C. BURGESS

WASHINGTON, DC

HOUSE ENERGY AND COMMERCE COMMITTEE, HEALTH SUBCOMMITTEE HEARING ON IMPROVING SUBSTANCE USE DISORDER TREATMENT

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HOUSE ENERGY AND COMMERCE COMMITTEE, HEALTH SUBCOMMITTEE HEARING ON IMPROVING SUBSTANCE USE DISORDER TREATMENT

MAY 8, 2018

SPEAKERS:
REP. MICHAEL C. BURGESS, R-TEXAS, CHAIRMAN

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REP. E.L. "BUDDY" CARTER, R-GA.

REP. BOB LATTA, R-OHIO

REP. GREG WALDEN, R-ORE., EX OFFICIO

REP. GENE GREEN, D-TEXAS, RANKING MEMBER

REP. ELIOT L. ENGEL, D-N.Y.

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REP. BEN RAY LUJAN, D-N.M.

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REP. KURT SCHRADER, D-ORE.

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REP. TONY CARDENAS, D-CALIF.

REP. DIANA DEGETTE, D-COLO.

REP. ANNA G. ESHOO, D-CALIF.

REP. FRANK PALLONE JR., D-N.J., EX OFFICIO

WITNESSES:

REP. EARL BLUMENAUER, D-ORE.

H. WESTLEY CLARK, DEAN'S EXECUTIVE PROFESSOR IN THE PUBLIC HEALTH PROGRAM AT SANTA CLARA UNIVERSITY

GERALD DELOSS, OFFICER IN GREENSFELDER, HEMKER, AND GALE, P.C.

JEREMIAH GARDNER, MANAGER, PUBLIC AFFAIRS AND ADVOCACY, HAZELDEN BETTY FORD FOUNDATION

DUSTIN MCKEE, DIRECTOR OF POLICY IN THE NATIONAL ALLIANCE ON MENTAL ILLNESS OF OHIO

AND PATTY METCALF, EXECUTIVE DIRECTOR OF FACES AND VOICES OF RECOVERY, TESTIFY

BURGESS: Subcommittee on Health will now come to order. The chair recognizes himself for five minutes for the purposes of an opening statement. Over the past several months, this subcommittee has held hearings to evaluate bills to address the opioid epidemic. We have also favorably reported 57 bills to the full Energy and Commerce Committee.

Today we are here to discuss a bill that would make timely reforms to a privacy law that affects patient access to health care and creates in some minds barriers to treatment, the Overdose Prevention and Patient Safety Act. This hearing is an important opportunity for us to gain a better understanding of federal privacy laws and how they function in the health care system. As a physician I believe that it is vital that when we are making clinical decisions, we need all the appropriate information to make the correct determination in the treatment of the patient.

Those suffering from a substance use disorder should receive the same level of treatment and care as other individuals. Patients affected with substance use disorder deserve to be treated by physicians who are armed with all the necessary information to provide the best of care. I certainly do understand and respect the privacy protection is paramount and should be held to the highest regard.

The Overdose Revention 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, Mr. Mullin's bill increases protections for those seeking treatment by more severely penalizing those who breach that patient data standard. The issue of the stigma associated with substance use disorder has been a constant in all the discussions we have had both in our offices and in hearings.

We have dedicated months of our time to putting together legislation to help break the stigma and help individuals with this complex disease gain access to health care and support services critical to getting them on the road to recovery. First step in addressing this problem is admitting that it exists, if we continue to silo the substance use disorder treatment information from a select group of patients rather than integrating it into

medical records and comprehensive care models, it's hard to see how we can ensure that these patients are receiving quality care.

Physicians unknowing of the patient's substance use disorder may prescribe medications that have significant drug interactions or worse, they may prescribe controlled substances and make the patient substance use disorder significantly worse.

As it currently stands, 42 CFR Part 2 is actively prohibiting physicians from ensuring proper treatment and patient safety while perpetuating stigma. In our second opioid hearing held this March, we brought this bill up for consideration, and openly debated the privacy concerns with experts and expert witnesses amongst health -- and the Health Care Subcommittee members.

Additionally, panelists at our recent roundtable discussion with families who've been affected by the opioid epidemic echoed the need for reforming current law. As we all know, providing high quality health care is a team effort, physicians do lead that team but it is necessary that physicians have the necessary information to adequately coordinate care. We must align payment operations and treatment to allow coordination of both behavioral and physical health services for individuals with substance use disorder.

I recently heard from a hospital in my district that mentioned that there is some likelihood that Part 2 as it currently stands could be a disincentive for health care systems seeking to open additional addiction treatment centers due to the problems that the law creates, particularly, the sequestration of patients information from their hospital. There is a reason why the Substance Abuse Mental Health Service Administration and most of the health stakeholder community is asking for this change.

Clearly, there is an issue here that must be addressed, this crisis, this opiate crisis is devastating our country. Our action is important to the families and communities and to our constituents who are impacted by this epidemic. I want to thank all of our witnesses who are here today and look forward to their testimony and I yield the balance of my time to the gentlelady from Tennessee.

BLACKBURN: Thank you, Mr. Chairman. And I thank you for having this hearing and for listening to us as we have brought the concerns forward with Part 2. This is something that has become a barrier to many people that are in treatment to get the full access to comprehensive care that they need to be able to fully recover.

And I've spent a good bit of time the past few years doing roundtables, and visiting treatment centers, and talking with families that are covered -- and I come at this as a mother, and a grandmother, and a friend. And having individuals close to me who have those in their family and their circle that have suffered from addiction. So, thank you for this. Thank you for the attention to this issue, I look forward to the hearing. I yield back.

BURGESS: The gentlelady yields back. The chair yields back, the chair recognizes the ranking member of the subcommittee, Mr. Green of Texas. Five minutes for your opening statement please.

GREEN: Thank you, Chairman for holding today's hearing on substance use disorder treatment, and 42 CFR Part 2. Ranking member Pallone and I requested

a hearing on 42 CFR Part 2 last month, and I appreciate the majority's willingness to hold a hearing on this important issue. Title 42 of the Code of Federal Regulations Part 2 are the implementing regulations of the two laws Congress passed in the early 1970s, to protect individuals who seek treatment for substance abuse. According to the Substance Abuse and Mental Health Administration, SAMHSA, the purpose of 42 CFR Part 2 is to ensure that a patient receiving a treatment for substance use disorder in Part 2 programs is not made more vulnerable by reason and the availability of their patient record than an individual with substance abuse disorder who does not treat, seek treatment.

I agree with SAMHSA, Americans suffering from substance abuse should not become more vulnerable for doing the right thing in seeking treatment. 42 CFR Part 2 provides individuals receiving substance use disorder treatment with the privacy they need to guard against the negative consequences and unauthorized release of their drug or alcohol patient information, such as a loss of child custody, parental rights, a loss of a job, denial of health care, possible exclusion from public housing, possible criminal justice consequences, including arrest and prosecution. SAMHSA in recent years had revised Part 2 in order to improve coordination among providers providing treatment to individuals suffering from substance abuse.

The revisions expand the ability of providers to share information about a patient with a substance use disorder, as well as allow new consent options for disclosure, but continue to maintain Part 2's core protections. In 2017, treating -- provider relationships were allowed under certain circumstances, such as, providing information to entities that agree to provide diagnosis, treatment, evaluation, and consultation with the patient. As we work to balance the privacy needs of individuals seeking substance abuse treatment, we also need to ensure that providers are able to access needed information in order to properly provide them with the treatment they need. And I want to make sure that in an effort to improve coordination of care, we do not sacrifice the rights of individuals seeking needed treatment for their addiction.

We have spent the past few months working on addressing the opioid crisis, and have learned from medical professionals that only a small fraction of Americans suffering from substance abuse seek treatment in part out of fear that their medical records may be disclosed. Current law allows for disclosure of information under Part 2 with regard to internal communications, medical emergencies, special court orders, in the event of a crime on the premises or against personnel on the premises and entities covered under Part 2, qualified service organization and business associate agreements. Before our committee moves forward with the Overdose Prevention and Patient Safety Act, HR 3545, we need to make sure that rights and privacy of patients seeking treatment are protected.

I'm open to considering changes to Part 2 if these changes need to be made to meet the current standard protection to protect Americans seeking substance abuse treatment. Mr. Chairman, I yield back to balance of my time.

BURGESS: Chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Oregon, chairman of the full committee, Mr. Walden.

WALDEN: Thank you very much, Mr. Chairman. And, again, thank you for your leadership on this, and so many other health care issues. Today marks

our fourth health legislative hearing on solutions to address the opioid crisis, an epidemic that knows no geographic, political, or socioeconomic bounds. Throughout this process, part of this committee's approach has been to shift attitudes toward substance use disorder and treatment. As I've stated before, substance use disorder is a medical illness and we must treat it that way. Removing the stigma of addiction is one of the most important things we as members of Congress can do to respond to the national emergency, and it will dramatically change how we prevent and treat this complex issue.

During our work to develop policies to stem the tide of addiction and abuse, an extraordinary array of hospitals, physicians, patient advocates, and substance use disorder treatment providers have approached this committee to clearly state that existing federal confidentiality regulations, known as 42 CFR Part 2 or Part 2, are interfering with case management and care coordination to effectively treat substance use disorder. The statute behind Part 2 was enacted more than 20 years ago, 20 years before the Health Insurance Portability Act or HIPAA, and 40 years prior to the use of electronic health care records. The intent behind Part 2 was to protect patients seeking treatment from negative repercussions such as incarceration or loss of employment, laudable goals.

And yet Part 2 does not even apply to all substance abuse disorder patients, meaning some providers have full access to a patient's medical records and others don't. For the millions of patients suffering from substance use disorder who are treated by a provider not subject to part to their records are protected by HIPAA. Now this begs the following question, is HIPAA protective enough for those seeking substance use disorder treatment or not? If it is not, what can we do to better protect patient privacy and better coordinate substance use disorder treatment? Because as currently written, the statute behind Part 2 handcuffs providers and it hurts patients. Representatives Mullin and Representative Blumenauer have tackled this complex issue and written the Overdose Prevention in Patient Safety Act, which I believe strikes the right balance of maintaining and strengthening patient protections while allowing for the limited sharing of substance use disorder treatment records between health care providers, plans, and clearing houses.

The legislation also includes strong penalties and discrimination prohibitions in statute to protect people seeking and receiving substance use disorder treatment. I've heard from providers in Oregon, from hospitals to health care centers, to addiction specialists who believe these changes are critical to their improving treatment of substance use disorder. And if I may, Mr. Chairman, I have a letter for the record from the Oregon Hospital Association commending our efforts I'd like inserted without objection.

BURGESS: Without objection, so ordered.

WALDEN: So, I understand this issue is a sensitive one, there've been a lot of discussions, there's been a lot of confusion, understandably so about what this bill does or doesn't do, which is why we're having this extra hearing. Privacy law is complex, which is why we're having additional testimony in addition to what we heard in March. So, we're here to learn more about this issue, to listen to stakeholders on both sides of the argument, it's important we have a thoughtful discussion and get to the bottom of this.

The ranking member has made clear that he will evaluate bills based on two principles. One, whether the proposal improves access to treatment for

opioid use disorders. And two, whether the proposal helps to prevent people from getting addicted to opioids in the first place.

I would argue that the Overdose Prevention and Patient Safety Act does both, treating patients' substance use disorder in isolation from their medical conditions which predominated care in the 1970s is not, is not is not the standard of good medical practice today. This legislation will arm physicians with all the necessary information to provide the best care, ultimately improving access to treatment and preventing the unnecessary prescribing of substances that may cause patient harm. With that, Mr. Chairman, I'd turn the remainder of my time to Mr. Mullin of Oklahoma, the leader on this issue for this committee.

MULLIN: Thank you, Mr. Chairman, and thank you Chairman Burgess for allowing us to have this hearing today and for all the witnesses, you know, Congressman Blumenauer and myself, we don't typically agree on a whole lot. But, when we start talking about this, we do agree a hundred percent on this issue.

This is about allowing the physicians to be able to see the complete record and be able to treat the patient as a whole, not just part. This is about destigmatizing what addictions, and it really means, it allows us to bring us back into the 21st century. When Part 2 was first put up there, the medical field looked completely different than it does now. So, without Part 2 alignment, we're going to continue to stigmatize patients with substance use disorder. I urge all my colleagues today to take a look at how we can bring a substance use disorder treatment and the rules and laws that govern them into the 21st century.

It's simple. We want to take care of the patients, that pay -- the doctors want to take care of the patients. We need to move forward, this is something that's hit all of us personally. With that, Mr. Chairman, I yield back.

BURGESS: Chair thanks the gentleman. The chair observes that there are a series of votes on the floor. So, we are going to adjourn while, or recess, while we attend to those votes on the floor, we will reconvene immediately after the last votes and hear from the ranking member of the subcommittee, Mr. Pallone for his opening statement. The Committee stands in recess.

Call the subcommittee back to order, when the committee recessed for votes, we were in the process of hearing opening statements from members, and is now in order to yield to the ranking member of the subcommittee, Mr. Pallone of New Jersey. Five minutes for opening statement.

PALLONE: Thank you, Mr. Chairman. Today's hearing provides a critical opportunity for committee members to better understand 42 CFR Part 2, and the legislative proposal to roll back the heightened protections it provides. As I noted at the subcommittee markup, we all agree that action must be taken to combat the opiate epidemic ravaging our country, but taking the wrong action because we're not spending the appropriate amount of time to understand the consequences of the proposal could have serious consequences of making things worse. And that's why I requested a separate hearing that just focused on Part 2 and any legislative proposal that would make changes to it, and as you know, not only that this issue controversial, but it is complicated.

So, I thank the chairman for having this hearing, because I think it will help members hear firsthand why the substance use disorder patient advocacy community is united -- is united in their opposition to rolling back the protections of Part 2. This is the committee that will bear the ultimate burden of this action, and therefore, we should listen to their thoughts before making any changes that could potentially cause harm. And we'll also hear more about why the substance use disorder provide a community is split on this issue.

Mr. Chairman, you know we're in the worst -- in the midst of the worst opiate epidemic in our country's history, while I appreciate the bill sponsor's intention to help build a better health care system for the patient community, I do have concerns with the proposal before us.

Confronting the opioid crisis requires identifying strategies that promote more people entering and remaining in treatment for opiate use disorder, this is critically important because major challenges exist to getting people with substance use disorders to enter treatment. In fact, SAMHSA National Survey on Drug Use and Health found that only about four million people out of approximately 21 million Americans in need of substance use disorder treatment received it in 2016, and that's only 19 percent.

And I believe that any action that would potentially prevent people from seeking treatment for any substance use disorder, and in particular opiate use disorder must be avoided. Unfortunately, the proposal before us I think risks doing just that, reducing the number of people willing to come forward and remain in treatment. Part 2 generally requires patient consent to share their substance use disorder medical records.

That's because individuals might not seek or remain in treatment if they're worried about the real negative consequences that seeking treatment can have on their lives. It can mean a loss of job, a home, or a child, but also could mean discrimination by doctors and insurers or worse, arrest, prosecution, and incarceration.

Disclosure of substance use disorder information has tangible consequences that are not the same as other medical conditions. You can't legally be fired for having cancer, you're not denied visitation to your child due to severe acne, and you're not incarcerated for having a heart attack. But ensuring strong privacy protections is critical to maintain people's trust in health care system and willingness to obtain these health services. And these protections are especially important where very sensitive information is concerned.

So, I think we're at a critical moment, at this moment I believe we should heed the advice of the congressional conferees that negotiated the confidentially stats, confidentiality statute that created Part 2, and I'm quoting, The said "the conferees wish to stress the conviction that the strictest adherence to confidentiality of substance use disorder patient records is absolutely essential to the success of all drug abuse prevention programs.

Every patient and former patient must be assured that his or her right to privacy were protected, without that assurance here or public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem needs to be overcome."

And then, once again, we face a tragic national drug abuse problem, the scale of which our country's never seen, and I believe maintaining the heightened protections of Part 2 remain vital to ensuring all individuals with substance use disorder can seek treatment for their substance use disorder with confidence that the right to privacy will be protected, and to do otherwise at this time I just think is too great a risk. I yield the rest of my time to the gentlewoman from California, Ms. Matsui.

MATSUI: Thank you, ranking member Pallone and thank you, Mr. Chairman, for holding to hearing today. This is a very important complex issue relating to the opioid epidemic. I feel strongly that we should take action in the space, patients that are currently receiving treatment may not be getting the best care if their provider does not have all the information necessary. However, many challenges remained, only some of which might be solved by this bill, providers still don't always have electronic health records, and even when they do, information is not always shared across providers. We cannot fully coordinate care if substance abuse is not a part of your medical history.

However, we are walking a fine line, as much as we need to reduce stigma, and move toward integrated care, we still face technological, medical, and social barriers. Most of all, we do not want to unintentionally harm patients who may still be discriminated against for their addiction. I look forward to the discussion today, and I thank the witnesses for their testimony. Thank you, and I yield back.

BURGESS: And the gentlewoman yields back. And we -- the chair thanks the gentleman. This concludes the member opening statements, and the chair would like to remind members pursuant to committee rules, all members' opening statements are made part of the record.

Testifying for our first panel is Congressman Earl Blumenauer. Thank you, Mr. Blumenauer for being with us today, and taking your time to testify before the subcommittee. We look forward to what you have to share with us, just as a housekeeping detail, as is general custom with a member testifying, we will not do questions, but we will go directly to our second panel of witnesses. So, Congressman Blumenauer, you're now recognized five minutes to summarize your opening statement.

BLUMENAUER: Thank you, Mr. Chairman, for your courtesy and I appreciate the opportunity to share some observations with you, to be able to discuss how better to provide high quality coordinated care for patients with substance use disorders. And I heard my two colleagues here, and I agree, but we are looking here, I would put it slightly different, where we have an antiquated law that prevents lifesaving medical care for patients in recovery for substance abuse disorders, originally designed to protect the privacy of individuals in addiction treatment, this decades-old barrier now creates an impediment to the implementation of integrated care. Drug Abuse Prevention, Treatment and Rehabilitation Act of 1972 currently governs how doctors and health care professionals share alcohol or substance use disorder records.

Under this law, which predates HIPAA of 1996, patient medical records from addiction treatment facilities are segregated from the patient's medical records. And this can create a life-threatening fire wall that prevents medical doctors from knowing their patients' full medical history, which could include treatment for substance abuse disorders.

The rules that govern this firewall, known as 42 CFR Part 2 or simply Part 2, had -- are more restrictive than HIPAA. It supersedes HIPAA, and can only be breached in an emergency or with express written consent of the patient. This consent can often be impossible or difficult to maintain, and in those instances, the care itself cannot be fully integrated. Failure to modernize Part 2 has weakened our nation's ability to respond to the ongoing opioid crisis that is contributing to a record number of drug overdose deaths in 1970 -- in nine -- in 2017 and are continuing.

Our nation's health care delivery system has changed and innovated over the last 45 years and as providers shift towards new coordinated models of care, they must rely on shared medical information to improve patient health. Regulations from Part 2 restrict the provider's ability to access critical substance treatment information, which can result in poor, and in some cases, tragic outcomes. And I believe the subcommittee has heard some really jarring testimony to this effect. Doctors can't treat a whole patient with half a medical record. And patients have a right to the best medical care available. Along with Representative Mullin, I'm -- we've been pleased to author this bipartisan overdose prevention act to prevent tragedies such as the committee has heard.

Our legislation would treat medical records generated at a substance use treatment facility that relate to treatment payment or health care operations in exactly the same manner as all other medical records, removing the stigma that has for so long segregated those records from the rest of the health care system. At the current time, persons with substance use disorders are the only subset of the health care patients whose records are treated differently, and as a result, may not receive the coordinated care they need.

Now, there's stigma associated with mental health and HIV AIDS, but both mental health and HIV AIDS fall under the protections of the HIPAA privacy law. Care is improving for both of those populations, thanks to increased access to public health data, and open lines of communication that reduce unnecessary discrimination.

For Americans who are in recovery, our legislation maintains and strengthens Part 2 protections to prevent disclosure of information. For example, it's currently illegal to share and individual substance treatment record for an employer, law enforcement or landlord, that wouldn't change under this legislation. Indeed, we would strengthen the penalties for unauthorized disclosure to make it more secure.

As the health care system moves forward with more robust integrated care models, every member of a patient's treatment team needs to understand the patient's medical full medical history, including substance use disorder. Current Part 2 regulations stand as a hindrance to the whole person care, and I think they must be changed to ensure all patients regardless of diagnosis have access to safe, effective, high quality treatment and care.

I deeply appreciate the opportunity to share some observations with you and look forward to your just discussions in this area to be able to give people the big picture. Thank you very much.

BURGESS: Mr. Blumenauer, thank you for providing your testimony to the subcommittee today, it's a very valuable part of our insight into solving this problem.

WALDEN: Mr. Chairman? Before my colleague from Oregon departs the table, I just point out that in 1972, he was winning his first election to the State House at the age of either 23 or 24 depending about when this was written into law. So, not that it's been a long time since 1972, but he has very distinguished career ever since. In the city council, he and my father served to get -- he and my father, my father and he served together in the state legislature. Yeah, he does go back that far, and then here in the Congress. So, we appreciate him being here and sharing this.

BURGESS: And his father was the real legislator.

WALDEN: Yeah. He said, "Oh." Is this where I move to table the bill?

BURGESS: The chairman yield? Yes.

LONG: Mr. Chairman, I was also elected in 72 -- are you telling me we're old?

WALDEN: I did not, I would never -- no. I'm saying the law that was started in 1972 was old.

BURGESS: Chair thanks the historical perspective that all have provided today. Mr. Blumenauer, again, thank you for sharing with us. And we'll transition into our second panel, and as we do that, I want to thank all of our witnesses for being here today and joining us at the -- at the witness table, each witness is going to have the opportunity to give an opening statement followed by questions from members.

We have our name placards at the ready. I can't exactly see, you know what? Here we go. Just placing the names and today we are going to hear from Mr. Dustin McKee, director of policy, the National Alliance of Mental Illness from Ohio. Ms. Patty McCarthy Metcalf, executive director, Faces and Voices of Recovery. Mr. Jeremiah Gardner, manager of public affairs and advocacy, Hazelden Betty Ford Foundation. Dr. Wesley Clark, the dean's executive professor, public health programs, Santa Clara University. And Mr. Gerald DeLoss, officer Greensfelder Hemker and Gale, public corporation, we appreciate each of you being here today.

And Mr. McKee, you're now recognized for five minutes for an opening statement, please?

MCKEE: Thank you, Mr. Chairman. Chairman Burgess, Vice Chair Guthrie, ranking member Green, and members of the Energy and Commerce Subcommittee on Health, thanks for this opportunity to testify before you today on HR 3545, the Overdose Prevention and Safety Act. As you all well know, our nation is in the midst of a public health crisis. Between 2014 and 2016 in my home state of Ohio, 10,383 people died from an opiate-related overdose. One of those people that died during that time was my big brother, Brandon J. McKee. He was 36. He left behind three sons, four, eleven, and sixteen. Mr. Chairman, Brandon's death was preventable.

However, the antiquated provisions of 42 CFR Part 2 prevented his medical professionals that were prescribing in high doses of opiate-based pain medications with multiple refills from knowing that they were treating a high risk patient, with an ongoing history of substance abuse treatment and relapse.

But before I start describing the events leading to his death, I want to tell you a little bit about Brandon. Brandon struggled for most of his life with addiction disorder, but in spite of it he found success early. My big brother was the best salesman you'll ever meet. I mean, this guy could sell a double bacon cheeseburger to vegan. He was a talented salesman that made six figures by the time he was twenty years old, selling cars in Mansfield, Ohio, as a sales manager.

But despite two courses of residential treatment, and periodic outpatient treatment for substance use disorder, his substance use led to several job losses, multiple DUIs, lots of family strife, and an eventual divorce. After that divorce, he moved into my mom's basement, she was kind enough to let him be there, try and get sober.

One night, he decided to go out, and he got into a terrible car crash that crushed a few vertebrae in his spine. He was transferred up to Cleveland Metro Hospital. The orthopedist had no way of knowing he was an addict. So, after the surgery he was prescribed high doses of opiates based pain medication with multiple refills, four months later, interestingly enough, he broke his back again while riding his bike and getting into a wreck.

Again, he went to that same surgeon, and again he was prescribed high doses of opiate based painkillers with multiple refills. He didn't sign a 42 CFR waiver. He was an addict. He was about ready to get the Holy Grail. Those drugs made him feel perfect. We didn't even know that he was on narcotics until -- well, I was the last one to speak with him, three days before his death, he had burned all his bridges because of the secrets and lies associated with his addiction disorder.

He called me that day and admitted that it was more than just the alcohol, and that, he was taking pills, and I said he was -- I was proud of him for telling me about it. Ironically, his phone battery was drained that day and his phone cut out before the conversation was over. His last words to me, "So, I'm going to go to that NA meeting tonight, I promise, brother."

Three days later he died of a heroin overdose, he was found alone in his apartment curled up on the floor in the fetal position, it was May 10th, 2014. Mr. Chairman, Brandon's story demonstrates that 42 CFR Part 2 is a significant barrier to integrating care for behavioral health, medical surgical care, and aftercare. It's also a major patient safety issue. We at the National Alliance on Mental Illness know that silo treatment for mental illness and addiction is ineffective, and leads to negative outcomes, this is common sense,

I'd further emphasize that 42 CFR -- sorry, HR 3545 takes a very narrow targeted approach that simply aligns 42 CFR Part 2 with HIPAA for the purpose of sharing information only for treatment, payment and health care operations. There's no risk that the records will be shared with outside parties, like landlords, employers, law enforcement, or exposing folks to civil litigation.

These are common sense policy changes. You can make these changes. The lives of your constituents may just depend on it. Thank you for this opportunity to testify before you today. I'd be happy to answer any questions.

BURGESS: Mr. McKee, thank you for your testimony. Ms. Metcalf, you're recognized for five minutes, please.

METCALF: Good afternoon, and first I'd like to thank the committee for hosting this important hearing, and for inviting me to testify. My written and oral testimony or the result of my experience as a person and substance use disorder recovery, as well as my professional experience as a direct -- executive director of Faces and Voices of Recovery.

I am a woman in long term recovery from alcohol and drug addiction. For me, that means I haven't used alcohol or drugs in over 28 years. And that recovery has allowed me to give back to my community, earn college degrees, own a home, raise a family, pay taxes, establish a career, and become a leading advocate for the recovery community.

As an organized voice protecting the rights of individuals with substance use disorders, Faces and Voices of Recovery is adamantly opposed to dismantling of our critically important 42 CRR Part 2 confidentiality protections. We do not want our highly sensitive personal information shared for the purposes of treatment, payment, health care operations, or for any other purpose beyond the current rule without our express written consent.

We agree with the Congress who enacted Part 2 in the 1970s, that weakening policy regulation -- privacy regulations will discourage individuals who need treatment from seeking it. The dismantling of Part 2 is the antithesis of the principle of patient centered integrated care and is largely being pursued by coalitions and entities who hold their own business interests in -- ahead of the rights of the interests of our community.

These protections are as critical now as they were 40 years ago, and must be maintained to ensure that individuals and families will seek help. We believe that the interaction between the treatment provider and the client when discussing specific consents and disclosures strengthens the therapeutic relationship and builds trust. Patients feel secure enough to know where their personal health information is going and for what purpose. Most often, the treatment provider encourages their clients to provide a written consent, to share information with their primary care physician, but if the client is reluctant to do so, for whatever reason, they have an opportunity to weigh the benefits and discuss the options.

We wouldn't be here today discussing Part 2 if it weren't for the fact that we're in the midst of an opioid epidemic. But I want to remind you that the federal confidentiality record -- regulations are intended to protect the privacy for all individuals with all substance use conditions, not just those with substance with opioid use disorders. There are an estimated 16 million people like me, in the United States, that have am alcohol use disorder. And research has repeatedly shown that people with alcohol use disorders experience stigmatization by the public as well as from health professionals more severely than people with mental disorders.

This perceived stigma is shown to reduce the probability of using health care services, and thereby, contributes to a decreased likelihood of seeking treatment. Research also indicates that worries about privacy keep people from seeking treatment.

Making the changes to minimize our privacy protections will have long-lasting effects for a wide range of individuals and family members. The

potential for negative consequences of stigma and discrimination with regard to employment and education is real for millions of Americans, even after years of sustained recovery from alcohol and drug addiction.

And unlike most other medical illnesses, substance use disorders often have criminal and civil legal consequences and patients are vulnerable to arrest, prosecution, and incarceration. Patients may be hesitant to reveal they have been discriminated against, because they would have to disclose the use of illegal drugs as well as the activities that are associated with the use of illegal drugs.

The vast majority of persons who will have this happen to them will lack the resources to determine who used their information in an improper way. Even if they did know this, in most cases they would not take action for the very fact of trying to assert their rights would acknowledge drug use and addiction in a way that would open them up to prosecution and discrimination. Part 2 provides safeguards for patients against potentially disastrous results of unauthorized disclosure.

In conclusion, beyond the significant harm that eliminating Part 2 would do to our communities, it's entirely unnecessary. There is far too much at stake here for those of us depending on these protections in order that we may heal and realize our full potential as productive citizens of this great nation.

Many of us have made it clear that we would not have gone to substance use disorder treatment or accepted services if we thought our information would be shared with other entities without our permission or knowledge. We would not have put our careers reputations, our families at risk of stigma and discrimination if we were not assured that our information about our substance use disorder was safe and would only be shared with our consent. As a person in long term recovery, a parent, and on behalf of the recovery community, I look forward to working with members of the committee to protect patient privacy. And thank you for the opportunity to testify and address such an important issue to our community.

BURGESS: Thank you, Ms. Metcalf. Mr. Gardner, you're recognized for five minutes please?

GARDNER: Mr. Chairman, thank you for inviting me, I'm grateful to you and subcommittee members for your leadership in addressing opioids and addiction and for this opportunity to testify in support of HR 3545. My name is Jeremiah Gardner, and I'm a person in long term recovery from substance use disorder. I'm also a recovery advocate with a master's degree in addiction studies and a counseling license. In addition, I work as a communications professional for the Hazelden Betty Ford Foundation, a nonprofit that has been advocating for patients and helping them overcome addiction for decades.

I believe all of us here today can agree about the need for more coordinated and integrated care, less discrimination against those with substance use disorder, and appropriate patient privacy. We all want to help patients, not harm them HR 3545 is not a question of privacy versus no privacy, or coordination versus no coordination, or discrimination versus no discrimination, providers versus patients.

The very specific question as the chairman noted is, does HIPAA provide sufficient enough privacy protection to warrant removing the Part 2 barriers that sometimes get in the way of more efficient coordinated care? And as you weigh that choice, I'd like to tell you about my mom who is another illustration of why this topic is so important. At age 59, my mother misused fentanyl patches, Vicodin and anxiety medications, and died just a couple of rooms away from her husband and 13-year-old grandson. She had started taking prescribed opioids 20-some years earlier for pain.

Eventually, she was on 400 milligrams of morphine a day, which over time, led to other ailments, deteriorating mental health, and additional medications. Not to mention more doctors, she had lots of them, and lots of medications. But before her long journey with opioids began, she was treated for alcohol problems at a Part 2 facility. It was a significant fact in her health history that, as far as I can tell escaped the attention of her later doctors and failed to inform her healthcare moving forward.

Two decades later at the end, my mom suffered from a complex combination of opioid use disorder, chronic pain, acute pain due to knee surgery, depression, anxiety, arthritis, type 2 diabetes and other physical conditions.

She also had an assortment of social stresses and because she relied so much on pills for so long, a deficit of healthy coping mechanisms, her pain was indeed profound, manifesting itself like addiction does physically, mentally, emotionally, socially, and spiritually.

What my mom needed but never got was a good year or more of integrated, coordinated care and checkups surrounded by support. She needed her multiple care providers to have the full picture of her health and to work together.

Instead, they kept prescribing deadly amounts and combinations of drugs to somebody with a substance use disorder. My mom got subpar care. Could she have done more to actively coordinate care herself? Yes. But as a professional in the field and someone with lived experience, I can tell you that that's a tall order for someone with a severe substance use disorder.

Maybe she was too embarrassed or ashamed to acknowledge her condition because of the public stigma. Maybe she didn't understand she was at greater risk or maybe she did and was not inclined to volunteer information that might prevent her from getting pills for her pain or her anxiety. She eventually came to know opioids as a relentless monkey on her back, but she also saw them as a solution. And that drive to continue using despite problems reflects the very nature of addiction.

My mom needed help recognizing that her constellation of issues tied together and that substance use disorder was, in many ways, at the center of it. My point in sharing is simply that the health of people like my mom can be very complex, coordinated care is critical and too often absent, and timely relevant information sharing is important.

This bill isn't just about IT or workflows or convenience or efficiency or stigma or cost. It's about knocking down any barriers we can to help ensure optimal care. It's about taking the next step toward parity and bringing the full weight of healthcare to bear against this public health problem. Most of all, it's about people, real people with families like my mom.

There is some fear this bill will discourage help seeking. I certainly don't speak for all patients or family members, but I can tell you privacy laws were not a factor in my own help seeking or my mom's contemplations. And the topic frankly is rarely broached by the thousands who call the Hazelden Betty Ford Foundation for help each year.

Most want to know, "Can you help," and, "How can I pay for this?" I really believe this bill addresses those priorities that patients and their families care about most. I also believe HIPAA is a sufficient and enforceable privacy standard, that discrimination can and must be prosecuted vigorously and that this is an essential piece of the federal opioid response and the paradigm shift that began with the 2008 parity law. Thank you for the opportunity to share. I look forward to answering your questions.

BURGESS: Thank you, Mr. Gardner. Dr. Clark, you're recognized for five minutes, please.

CLARK: Thank you, Mr. Chairman, Mr. Green, and members who are assembled. Thank you for the opportunity to present to you today. I'm here as a physician, addiction medicine specialist and as a college professor. I'm here to advocate for maintaining the integrity of 42 USC 290dd-2 and for keeping those federal regulations that protect individuals with substance use disorders.

Do not discourage them from seeking treatment by stripping away their current right to consent to the release of their personal substance use disorder histories. There are two contemporary phenomenon that are relevant here. One, the Facebook-Cambridge Analytica issue and two the NIH All of US longitudinal research project.

In the case of the Facebook-Cambridge Analytica issue, it was clear that the general discourse about the misuse of information that privacy and confidentiality were important to people and the disclosure of their private information without their consent was a violation. That the information was subsequently used for predictive analytics for the purpose of influencing those whose information had been compromised show the potential for abuse.

This is not a case of data security but a case of breach of confidentiality and apparent invasion of privacy. Alternatively, the NIH study will include all data available in the participant's electronic health records including demographics, visits, diagnosis procedures, medications, laboratory visits.

Pertinent information can include data about mental health, substance use or HIV status. What is interesting about the NIH All of US study and relevant to this hearing is that participants will be asked to consent to release information from their electronic health records. The All of Us study invokes the idea of the comprehensive health record heralded by some EHR vendors who seek a new generation of electronic information of our people, information that includes all sorts of medical and non-medical information.

Thus the medical record becomes a comprehensive dossier on the individual. The actual benefit to a patient of integrating all that is known about an individual using the health record as the portal has yet to be determined.

Privacy, confidentiality, and consent are important to Americans. If the two vignettes that I've used to introduce my testimony can be understood in the context as the current discussion, then you as members of Congress will understand the importance of maintaining the protections of 42 USC 290dd-2 and 42 CFR Part 2 to a population that is more vulnerable than those on Facebook or those who agree to participate in the All of US study.

While the issue opioid misuse is of major importance, we should keep in mind that 42 CFR Part 2 does not just apply to opioids. The National Survey on Drug Use and Health reveals that 65 million Americans admit to binge drinking in the past month and 24 million Americans admit to being past month users of marijuana.

The critical question today is how do we get the 28.6 million Americans who are current illegal drug users and the 65 million Americans who are binge drinkers to discuss their substance use with the medical community. We won't do it by compromising their privacy. It is also argued that substance use is like the flu, diabetes, hypertension, or HIV and therefore, should be treated like those conditions with regard to disclosure.

The reality is that most substances of misuse are illegal and that disclosure of such information can give rise to harm to the individual affected. These harms include loss of employment, loss of housing, loss of child custody, the loss benefits, stigma and discrimination, the loss of privacy, shame, and the loss of autonomy.

The cases often made the healthcare delivery systems need to know about the substance use history of a patient. You all hear why providers can't simply ask patients themselves about their substance use histories.

You hear it's confusing for clinicians to know about 42 CFR Part 2 and to -- and how to apply rule. Yet the same clinicians and healthcare systems spend quite a bit of time learning about and executing reimbursement rules, administrative rules, quality standard rules. And all the rules that are necessary to get paid for the services delivered to the very people whose agency and dignity are now deemed too inconvenient to respect.

They also hear that people lie about their substance use, implying that they cannot be trusted. However, since behavioral care is the dominant form of substance use treatment, trust is the cornerstone with behavioral treatments. We should be promoting a patient provider cooperative relationship instead of encouraging an adversarial one.

The healthcare operations exception found in HIPAA is a loophole in confidentiality that is so large, you can drive a Mack truck through. Neither provider nor regulators will be able to protect those substance use disorders. The only choice left to those who are vulnerable is not to seek treatment.

Remember, 90 percent of those who currently need treatment do not seek treatment. We should be focused on reducing the ratio of those who need treatment versus those seek treatment from 9 to 1 to 1 to 9. Therefore, I ask you, please do not weaken 42 USC 290dd-2 and as a result, I ask you to look closely on HR 3545. It is not the panacea that it's being marketed as being. Thank you.

BURGESS: Dr. Clark, thank you for your testimony. Mr. DeLoss, you're recognized for five minutes, please.

DELOSS: Thank you. My name is Gerald DeLoss. I'm an attorney with Greensfelder, Hemker, & Gale in Chicago, Illinois and I practice in behavioral health law as well as health information privacy and confidentiality.

I represent several behavioral healthcare providers that are governed by 42 CFR Part 2 as well as others that are impacted by those provisions and overly restrictive provisions including the county of -- Lake County in Illinois, Nicasa , North Central Behavioral Health Systems, Stepping Stones Treatment Center and (inaudible).

Each of these are large and small providers that have had to come to bear and deal with these provisions and these restrictions. I'm here today on behalf of Netsmart Technology -- Technologies, the technology partner with the behavioral healthcare space and I'm here today to discuss the protections that are provided under HIPAA as well as under 42 CFR Part 2 and the legislation that we're discussing, as well as those protections that would be, not only, retained but enhanced by HR3545.

At the outset, I wanted to describe those limitations that would remain in place because of HR3545 as amended. As mentioned earlier, the only change that the bill would provide in terms of disclosures without consent would be with respect to treatment, payment, and healthcare operations.

We're not talking about disclosures for legal proceedings. We're not talking about disclosures to law enforcement. We're not talking about disclosures to employers, landlords, marketers, et cetera. We're talking about those limited purposes that are the primary types of opportunities and activities that all sorts of healthcare providers engage in.

In addition, and more specifically to address some of the concerns that were raised about operations and the extent and scope of exchanges of information for healthcare operations under HIPAA, the disclosures allowed under the bill would only be allowed to other covered entities. Covered entities is a HIPAA defined term. It includes only healthcare providers, health plans, and healthcare clearing houses.

Those entities that assist in the reimbursement process. Only those three entities would be allowed to receive Part 2 information under the bill. It would not be fair to say that this information could be shared with third parties. It would not be fair to say that it could even be shared with business associates strictly reading the terms of the bill.

So we would not open up the exchange of information to third parties that have no business. These are parties that need this information in order to carry out payment, treatment, and healthcare operations. The bill itself provides substantial protections in terms of the disclosures for civil, criminal, and administrative proceedings.

The bill actually enhances those protections that 42 CFR Part 2 previously had in place. So they're increased and heightened types of protections that are available. I did in my written comment set forth a lengthy review of the protections that are available under HIPAA, those in terms of the protections, in terms of legal proceedings, employers, also the

impact of the Americans with Disabilities Act if any of this information should happen to get into the wrong hands.

SUD is a disability under the ADA and is protected as such as set forth in my written comments. Landlords and housing agencies would also be governed by HIPAA as well as the ADA. The law enforcement and legal proceedings exceptions under HIPAA are very narrow and very stringently enforced primarily requiring a court order or patient consent in order for the information to be shared for those purposes.

One of the areas that I did want to address is the inability under the current Part 2 regulations to allow for a patient to make a choice in terms of sharing their information for treatment payment or healthcare operations as defined under this law as well as HIPAA. In addition, I think it's important to note that if a Part 2 program does not want to share information, this bill and HIPAA, more importantly, would not mandate a disclosure without consent.

The SUD treatment program has the opportunity to impose higher or more stringent protections against disclosure not those simply set forth under HIPAA. So there is a choice not only for patients but also for programs or others that might be concerned about disclosure. To summarize the impact of the bill, a disclosure for treatment payment or healthcare operations can only be made to a covered entity.

That recipient, the covered entity, a healthcare provider, a health plan, or a healthcare clearinghouse would then be bound by these regulations or this law not to disclose that information to anyone other than another covered entity. Down the line.

So in conclusion, I wanted to correct some of the misunderstandings with respect to HIPAA, misunderstandings with respect to the scope and impact of this law. And point out that HIPAA itself over the history of its enforcement has resulted in millions of dollars in fines and penalties, a comprehensive enforcement mechanism where 42 CFR Part 2 has not. Thank you for your time.

BURGESS: Thank you, Mr. DeLoss. And I want to thank all of our witnesses for testifying before us today. And we're going to move into the question portion of the hearing. I'm going to begin that portion by yielding my time to the gentleman from Oklahoma. Mr. Mullin, five minutes for your questions.

MULLIN: Thank you. Thank you, Mr. Chairman. And thank you for all of our witnesses that are here today and since I only have five minutes, I'm going to get right into it. Dr. Clark, how many -- are all subject -- substance disorder provider subject to 42 CFR Part 2? No, the answer is are they all subject to it?

CLARK: (inaudible) federally assisted...

MULLIN: The answer to that is no and they're not all federal assistance because the VA doesn't fall underneath Part 2.

CLARK: Not all...

MULLIN: VA doesn't fall underneath it and they're federal...

CLARK: (inaudible) has its own 38 CFR...

MULLIN: The question was, do all -- do all of them fall underneath 42 CFR?

CLARK: No.

MULLIN: So is there evidence that patients that fall underneath it, has that been abused?

CLARK: Well, you invoked the VA, I used to work for the VA, I spent 14 years...

MULLIN: No, sir, I said is there evidence -- is there evidence that people that do not fall underneath 42 CFR Part 2, is there evidence that those that their medical records are being abused and are being discriminated against?

CLARK: I couldn't say that there is.

MULLIN: Because it's no. Is Part 2 -- how many times has it been tried? Violators, people that violated Part 2, how many times has it been tried?

CLARK: It's not a heavily litigated area.

MULLIN: Heavily -- it's never been. It's never (inaudible)

CLARK: It has been litigated, sir.

MULLIN: No, it is -- it is exactly zero. And I have the information right here. And I know that you can give your opinion but we're dealing with facts here.

CLARK: Okay. I'm a lawyer also, sir. And so 1970...

MULLIN: No, no, hang on. It's my time.

CLARK: Okay.

MULLIN: You said a lot in your five minutes. I'm just pointing out holes in it. Now, underneath HIPAA, how many times has it been tried? 173,426 times since 2003 because Part 2 is unenforceable. They can't comply with it. It's only 50-dollar penalty. You start talking about discrimination, in your testimony, you said that the harms to which a person who admits to substance use may suffer includes loss of employee, the loss of housing, the loss of child custody, loss of benefits, stigma, discrimination, the loss of privacy, and the loss of (inaudible).

How would that actually work? How would this -- how would you do this legally underneath a system that's there? Is that -- it's an assumption that you're making because there's no legal way to actually do that? There's laws already that protects the individual from that. Is that not true?

CLARK: No, that's not true...

MULLIN: Okay. Isn't -- well, you're an attorney, so explain that to me then.

CLARK: Okay. If I'm an active substance user, the ADA does not protect. The Americans with Disabilities Act does not protect an active substance user...

MULLIN: Well, there's (inaudible) that protect people from being discriminated against because as a person that also has several property companies, I can't use that information to deny someone from housing. As an employer, I can't use that to deny someone for employment because it would be discriminating. So you're making an assumption here that's actually not accurate.

Now, you also said in your testimony that you're comparing my bill to the Cambridge Analytical-Facebook issue. How is adding anti-discrimination language and extra protection for patient information comparable to the Facebook data scrubbing?

CLARK: The issue is data scrubbing just as you said. The healthcare...

MULLIN: You're not talking about data scrubbing here. There's (inaudible)

CLARK: We are talking about data scrubbing...

MULLIN: Who's scrubbing it?

CLARK: When you're talking about electronic health records, you're talking about predictive analytics and you're talking about data scrubbing.

MULLIN: Yes, but we already show that the only people this covers essentially Medicare and Medicaid and when we get in to the situation that private payers and VA that they're not being discriminated against, why is this such a big issue now? Because you're making a lot of assumptions. And, sir, I know that you're able to make the assumptions but we're also dealing with people's lives.

CLARK: (inaudible)

MULLIN: There isn't anybody in here that hasn't been touched by -- this has touched me three different times and I take it very personal. And when people come here and they want to give their opinion and it's not based on fact, it really bothers me.

CLARK: (inaudible)

MULLIN: I'm sure you're a very smart individual. Sir, I'm sure you're a very smart individual but you're coming in here and you're just giving your opinion.

CLARK: Well, you wanted to know about -- for instance, unemployment, the ADA does not apply to active substance users. That is a fact. That's not an opinion. So I can't help you with that. In fact, there are rules historically for housing. HUD used to have and still does have rules that allow you to discriminate against people who are active substance users.

MULLIN: What are those rules? What are those rules? And besides, by the way, you just mentioned another federal agency and this is about federal protection for those on Medicare and Medicaid. We're talking about the

private sector because that's what you're making comparable -- comparisons to.

And, sir, I am -- I'm very serious about trying to protect people's lives here. And I know you are, too. But we got to make sure that we're dealing on the same page. And while I respect your ability to give your opinion, I completely disrespect your testimony because it's based on opinion, not facts. With that, I yield back.

BURGESS: Chair thanks the gentleman. Gentleman yields back. Chair recognizes the gentleman, ranking member of the subcommittee five minutes for questions, please.

GREEN: Thank you, Mr. Chairman. I want to thank our witnesses for being here because this is something that is really important because chemical addiction is so rampant that we're changing law that provides more protection for someone chemically instead of just the mental or anything else.

And, Dr. Clark, you've read the language in the bill. Is there any way that we could -- as a lawyer you could just suggest other language than what's in the bill that would have some protection there that we still do because a number of us have concern about this legislation, but I also know under HIPAA this is much more stronger than anything HIPAA has, the bill does.

Is there anything you would suggest that would feel more comfortable to both you but also to Ms. Metcalf? Because I understand we all have relatives who really don't want to -- or may tell us what their issues are? And they have some right to privacy no matter what they have.

CLARK: Well, as -- the first thing as a physician, if your patient doesn't trust you, they won't disclose information to you. And that's what gets lost in this. We know that people with mild to moderate conditions that lead to severe conditions don't talk about their substance use.

So if you want to save lives, you do it upstream. You don't wait until the problem is so severe that it's actually quite transparent to everybody in the room. And that's what actually happens.

People hide their substance use. And there is no record of it. All the stories that you hear, how horrible they are and how tragic they are, the stories are that the people do not feel comfortable disclosing what's going on.

So 90 percent of the people who meet criteria for an SUD don't discuss that with the health care delivery system. Now, the question is, is there any way to address this? The healthcare operations component of HIPAA as I said in my five minutes is so broad that it gives rise to -- when you start explaining that these people, if you can explain it to them clearly, they'll understand that they really have no privacy.

And so, they'll keep their mouth shut. And by the time that you're aware that their problems are so severe that they need intervention, it will become transparent. We will hear -- your committee has dealt with physicians who have misused prescribing.

We now know we have enough data of using prescription drug monitoring programs and other strategies that we can track what's happening with patients. So, it won't be those people from whom prescriptions are written because now we can track those. We can enhance electronic health records. There are models being proposed. The gentleman to my left, Mr. DeLoss talked about working with the EHR community. I also worked, when I was with SAMHSA worked with the EHR community.

We had developed bridges to allow for patient consent. But the EHR community was not interested because there was not enough money in it for them. They had an opportunity early in this whole discussion when they HITECH Act was passed, they just were not interested.

I met with the major providers, they were not interested. This was just small potatoes as far as they are concerned. Let's get rid of healthcare operations and you got a different bill that at least will allow people to address this.

GREEN: Well, thank you --

Ms. Metcalf, I understand from where you're coming from, but we still have this issue that Mr. McKee said that even as a family member he wasn't getting information from his brother. And that happens whereas I don't know if HIPAA could be a change.

The only thing I could say as a lawyer is that a family member gets a guardianship, so you take over that oversight. And guardianships are tougher because it's harder to get, but as a family if you -- that's the only legal thing.

Mr. DeLoss, do you have any other options that a family member could use?

DELOSS: In order to share the information, correct. The current bill would not allow the direct sharing, it would allow for the sharing only to a covered entity. As far as an alternative to share that information in that precise situation, there could be an anonymized disclosure, Part 2 programs in order to avoid some of the implications of Part 2 that are overly restrictive and engage in a process to warn others.

There is no duty to warn exception under Part 2. So if there is an issue where someone should threaten to kill someone, they cannot inform police or anyone else under Part 2. So what Part 2 programs have done is to anonymize the disclosure. Disclose that in such a way that does not indicate where it came from or who it is about specifically with respect to their SUD diagnosis. So these are workarounds that SUD programs governed by Part 2 must undertake in order to avoid these overly restrictive requirements.

GREEN: Thank you, Mr. Chairman. I know I'm out of time.

BURGESS: The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Oregon, the chairman of the full committee, Mr. Walden for five minutes...

WALDEN: Thank you, Mr. Chairman. And thanks to our panelist for being here. As we work on this very difficult issue, I've heard from my hospitals in Oregon who are very supportive of what we're trying to do here.

They say that this regulation makes it very difficult or prevents the sharing of patient information necessary to deliver effective and coordinated care. This conflict forces hospitals and health systems now to go to the extraordinary lengths to deliver needed care.

In our panel with the survivors, many of whom lost children, this was an issue they raised. The lack of ability to know what's going on in their kids' lives. We've heard it from others about substance use disorder treatment.

I know these are separate issues. But, Mr. Gardner, patients with substance use disorder who are currently using illegal drugs, I understand to be the case are not protected by civil rights laws such as ADA that protect those with disabilities from employment, housing, and other types of discrimination. The legislation before us includes anti-discrimination language, does it not?

GARDNER: That's my understanding.

WALDEN: And regarding protections for patients seeking substance use disorder treatment, does this language strengthen or does it weaken the statute behind 42 CFR Part 2? And can you turn on your mike. I'm not sure it's...

GARDNER: Yes.

WALDEN: Okay. Here we go.

GARDNER: Thank you for the question, chairman. My understanding is that, although I'm not a lawyer is that it would strengthen protections for the use of such information in criminal proceedings which I think is important.

WALDEN: Well, that's my understanding. And like you, I'm not burdened by a law degree. I just try to do public policy. No offense to my -- those who have passed the bar or stopped in there.

Mr. DeLoss, can you identify the legal mechanisms if any in this legislation for substance use disorder treatment records to get into the hands of landlords, law enforcement and civil and court judges without patient consent or a court order.

DELOSS: No, there is no possible way to do so under this bill. This bill would prohibit those types of disclosures. The disclosures would only be allowed for purposes of treatment payment operations.

Does not include any of those third-parties. Those third-parties are not -- do not fall under the definition of a HIPAA covered entity, so those third-parties would not receive that information, only certain healthcare providers. Not all healthcare providers are governed by HIPAA, so they would not -- not all healthcare providers would receive the Part 2 information under this bill. They would be restricted. Health plans and healthcare clearing houses.

So in addition to those restrictions against the third-parties receiving the information, as you've mentioned there are heightened antidiscrimination provisions that would...

WALDEN: Heightened.

DELOSS: Absolutely.

WALDEN: Stronger, more than exist today.

DELOSS: Much more stringent, much more protective than current Part 2 protections with respect to antidiscrimination., in housing, in employment, protections against use of any of this information in any kind of proceeding -- civil, criminal, or administrative. All of this is far greater in terms of its protections than what Part 2 currently provides.

WALDEN: So if it can't be used to discriminate against you in your employment, your housing, and in criminal cases, what is the only thing it can be used for?

DELOSS: Well, it would primarily be used for treatment. As we've heard, coordinating care is the biggest issue that these SUD programs are facing, is trying to integrate that care with HIEs, Health Information Exchanges, accountable care organizations, any kind of integrated healthcare environment under the Medicaid program.

All of this requires coordination. And with respect to the ability to share that information, the issues that have arisen are so complex in terms of trying to comply with Part 2 that these independent entities, these ACOs, these HIEs, these are not vendors.

These are entities that are created to coordinate care. They have refused to allow Part 2 information to be included. I have worked with several HIEs or healthcare networks that have refused to include this information exactly because of the Part 2 restrictions and despite many efforts to create workarounds or ways to address these issues will not include that information.

WALDEN: So I was at a federally qualified healthcare facility in my district, Klamath Falls, Oregon last week. And we talked about this very obstacle to quality healthcare. And that's all they care about is the patient and quality healthcare.

And they said, please, please, please. I said 42 CFR Part 2 and they said, "Yes. You have no idea what an obstacle that is to patient safety, and treatment." And so that's why we're here. We want to get it right. We appreciate all of the panelists today, sharing their opinions. This is important stuff. It's not easy.

And, Mr. Chairman, thank you for holding this hearing. I think it's been very, very helpful.

BURGESS: We thank the chairman. The chair now yields five minutes for questions to the ranking member of the full committee, Mr. Pallone of New Jersey.

PALLONE: Thank you, Mr. Chairman.

I want to thank all the witnesses for joining us. And Dr. Clark, I'm interested in learning more about the uptake of substance use disorder treatment in the U.S. I'm going to start with you. In your testimony, you

note that of the 28.6 million people who misuse illicit drugs and the 65 million people who have been drinkers in the past month only, 3.8 million people received treatment in the past year.

Could you explain some of the reasons people don't receive treatment for substance use disorder? And quickly because I have more questions to ask.

CLARK: Sure. A number of reasons, the first reason is the ability to pay. The second reason is that people don't want to stop. Third reason and fourth reason, people do have concern about privacy and stigma.

It is an issue that drives people's motives. And as I pointed out in my five minutes in response is that we need to get people early and before we wind up having to deal with them later in their substance use.

PALLONE: All right. So for you and also Ms. Metcalf, could you explain why maintaining Part 2 protections is important to individuals seeking treatment for substance use disorders, including opioid use disorder? Briefly again.

You could start, Dr. Clark and then we'll go to Ms. Metcalf.

METCALF: Yes. Thank you, 42 CFR is important to people seeking treatment because they're assured when they come to treatment, they have that conversation about who will receive their information.

And they have a choice to sign it. And it's a simple conversation. And so, it's important to actually build -- empower those individuals to be part of their care. And it enables -- it allows them to make that choice that their physician or other individual -- people involved with their medical care can -- have the information that they're in treatment.

If they choose not, there are many, many, many reasons why they might choose not to, for fear in small rural communities where they just choose not to share that they have gone to treatment for their alcoholism, then in counseling. Lots of reasons why they may choose to not share that with those small town family physician, that's their physician.

PALLONE: All right. Let move on. Under the proposed legislation, patients would lose the right to determine the extent to which their patient record is shared for treatment payment and healthcare operations or receive the added requirements related to the use of their Part D record in criminal, civil, and administrative proceedings as well as discrimination by lawful holders of Part 2 information.

Again, either Ms. Metcalf or Dr. Clark. Could you explain why the extra protections included in this proposal do not cure your concerns about eliminating Part 2's patient consent requirements?

I guess he is asking for you to speak, Ms. Metcalf.

METCALF: The added protections, I think we're still seeing -- one of our constituents, a member of Faces & Voices of Recovery has shared her story about unlawful sharing of her medical records, unlawful redisclosure. The impact on her life lifelong is that an inability to start her small business as a result of the -- unable to purchase group health plan for prospective employees based on her health history of substance use disorders.

Despite being her primary breadwinner, unable to buy life insurance policy to protect her family based on her health history of substance use disorders and unable to obtain disability insurance due to the same.

So the bill does not protect these individuals from those who the health insurer will share that information with, which includes extensions of their -- the companies that are related to life insurance, disability insurance and so on.

PALLONE: All right. Now, let me ask on more question, Dr. Clark. Due to the concerns you've expressed with eliminating Part 2's patient consent requirements, what actions can Congress take to allow patients to further benefit from the health system's coordinated care arrangements and still maintain Part 2 protections? I'll issue that with you directly.

CLARK: One of the things that we would encourage the Congress to do or decide is to facilitate the acquisition of electronic health records by the substance use delivery system, which incidentally is not primarily populated in hospitals or in doctor's offices. It's primarily populated in small recovery type-oriented behavioral health treatment systems. So, by the time you reach the doctor's office, your problems actually are much more severe.

So, you could do that. And one issue that's missing from this is the issue of child custody. There is no discussion about that in the bill. So, while it says you can't use it by the plaintiff, it doesn't say you can't use it by the defendant.

So, these are kinds of things that need to be deconstructed from the bill so that it can enhance the issue of protection because that's what your will is. But I applaud the efforts to address these issues, so I don't want to suggest that bill because of its weaknesses is -- it's got a bad intent. I think it's a good well-intended bill but I think it's inadequate for the purpose, that we need to look at these things more carefully. And I really applaud the Congress's interest in trying to correct some of these problems.

PALLONE: Thank you.

Thank you, Mr. Chairman.

BURGESS: The chair thanks the gentleman. The gentleman yields back. The chair will just observe for the record that I did vote against the HITECH Act. Now, I'd like to recognize the gentleman from Texas, Mr. Barton for five minutes for questions.

BARTON: Thank you, Mr. Chairman. And I want to appreciate you and Chairman Walden, honoring your word at the markup where this bill was not marked up. And you promised to hold this hearing.

It's good to follow regular order and try to get more information. I come at this a little bit differently than most of the Republicans on this committee. I'm the co-chairman of the Privacy Caucus here in the House and have been for the last 10 or 15 years.

I want to read a very brief part of the majority memo for this hearing. It's on the second page of the memo. This is a direct quote. "Part 2 regulations provide stronger protections for substance use disorder treatment

records than do most other federal and state health privacy laws, including the standards for privacy of individually identifiable health information privacy rule (ph) under the Health Insurance Portability and Accountability Act of 1996, HIPAA (ph)."

Repeat, Part regulations provide stronger protection -- stronger protection than do most other federal and state health privacy laws. That's the crux of the issue Nobody disputes these tragic individual stories, the gentleman from Ohio.

The gentleman that I think is representing Betty Ford, whose mother had a problem. Nobody disputes that. But Part 2 protects and provides stronger protections for individuals. Most federal laws don't.

Now, a lot of the so-called privacy protections that we have now in federal law are jokes. They're information disclosure laws that when a breach happens the group that's allowed the breach has to notify you that you're dad has been comprised.

They don't protect privacy. They just require the group that let their privacy be abused, the disclosure that has been abused. And in some cases, especially banking it's not that it's been breached. They just have the right to use the information however they want as long as they tell you.

So here we have a law that actually does provide privacy protection. And in the name of better healthcare, we're trying to breach it. I'm opposed to that. Now, I'm not opposed to some change in Part 2. I understand. But I am opposed to just unilaterally overriding the individual's right to privacy by requiring written consent. I want to ask the gentleman from Ohio, Mr. McKee. Was your brother, to your knowledge, ever asked to waive his right to privacy under Part 2?

MCKEE: Not that I'm aware of.

BARTON: Okay. What about you, Mr. Gardner? Was your mother ever directly asked to waive her Part 2 rights?

GARDNER: I cannot answer for sure.

BARTON: Okay. It may be they were never asked. It may be they were asked and they refused to. We just don't know.

MCKEE: Congressman Barton?

BARTON: Yes.

MCKEE: With all due respect, how will the physician have known to ask?

BARTON: What's that?

MCKEE: How would the physician -- how would the surgeon have known to ask?

BARTON: Well, if I were treating and I'm not a doctor, but if I were treating your brother, I know when I go to my dentist, when I go in for any kind of procedure, I've had gallbladder surgery. I had a heart attack, I have

to fill out a form, three or four pages long that's asked if I've ever been treated for any of the following occasions.

And I believe that if I were a prescribing physician, giving fairly strong pain medication, I would probably either informally verbally or formally ask that question. I just know. In fact, every time I go to my doctor, I have to fill out the same form again.

And I said, "Well, I just filled it out last year." "Well, I'm sorry, you've got to do it again." So, there are cases and my time is about to expire, there are cases where maybe the patient is not mentally able to make a decision.

But my guess is a vast majority of the time they are competent and they choose not to disclose for their own purpose. Now, I don't know that. That's just a supposition. Anyway, I had two more questions I will submit for the record, Mr. Chairman, since my time has expired.

And thank you all -- the witnesses for being here.

BURGESS: The chair thanks the gentleman. The chair recognizes the gentleman from Maryland, Mr. Sarbanes for five minutes for your questions please.

SARBANES: Thank you, Mr. Chairman. Thanks to the panel. I can't see. All the way on the end, yes.

DELOSS: Mr. DeLoss.

SARBANES: Sorry. I lost track of the witness list. You, think were describing in the new proposed draft of the bill that's been mentioned here today that there is some antidiscrimination language in there. And I guess that would make it illegal for any entity to use records to discriminate for healthcare hiring, for employment, sale or rental housing, access to courts, recipient funds, et cetera.

And that gives you some confidence, increased confidence that facilitated sharing of information as suggested by the proposed bill would mitigate the occasion for discrimination, therefore potentially be less stigmatizing. So, it goes to addressing that issue, is that right? Is that the idea?

DELOSS: That is correct.

SARBANES: Yes.

DELOSS: Yes.

SARBANES: And I get that. What I worry about is that -- that's well and good. But it's kind of like the cow's out of the barn. In other words, once the data is out there or the information is shared, it may be that somebody misusing it is subject to some kind of penalty or prosecution or what have you.

But as we know in life, a lot of times, that kind of discrimination can go unpunished and at that point the information is out there, so a better protection is to keep the information safe or in close hands before it even

gets out there and you have to test the proposition of whether people are handling it properly.

So, I think while I get, I see what people are pointing to that and suggesting will actually give us comfort. I'm not sure it gives the comfort you're suggesting to a patient who is going to say, well, that's fine if someone could get in trouble if they misuse my information. But the chances that it could get misused are still pretty high. And they might not get penalized for it. There may not be a deterrent effect as a result. So the better path for me is to just not share the information or that puts me in an exposed position.

So, I just wanted to make that point because I think it's a fair one. And I wanted to turn to you, Ms. Metcalf and ask you...

DELOSS: Sir, could I quickly respond.

SARBANES: Yes, you could.

DELOSS: Thank you. The issue that I see in response to those concerns, which I think are valid is that the current Part 2 regulations, even though there is a consent process, because they are so overly stringent and technical, it doesn't allow the patient to make that choice because the recipients such as HIEs or ACOs or these integrated care environments that are part of the new healthcare model would not accept that information.

So even if the patient made the choice to share the information, it couldn't be accepted because those entities would refuse it. In addition, the recipients would have to segment that data if they did receive it, so it would not be re-disclosed. Again, something that certain electronic health records do not have the current capability to do. And in addition, with respect to the bill itself, in addition to the antidiscrimination provisions you mentioned, there is a limited set of recipients that could receive this information.

So it's not going out to third-parties. It's not going out to billing agencies. It's not going out to marketers. It's not going out to businesses associates.

SARBANES: Well, let me jump in because I'm now down to 14 seconds. I want to ask you this question, Ms. Metcalf.

DELOSS: Thank you.

SARBANES: My understanding is that even keeping the key components of the Part 2 regulations in place through education, through finding ways of streamlining some of the technical obstacles that people are concerned about, that we could improve the situation for coordinated care without compromising the concerns people have about the privacy of the data.

So that's why I continue to have some misgivings about the proposed legislation here that we're talking about. With that I'll yield back. Thank you.

BURGESS: The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Kentucky, Mr. Guthrie, five minutes for your questions, please.

GUTHRIE: Thank you very much, Mr. Chairman. Thanks for having this meeting. And the first few questions for Mr. DeLoss. I'm going to try to ask some on behalf of my good friend from Texas, Mr. Barton.

But first, Mr. DeLoss, it's my understanding that Part 2 only applies to federally supported providers who identify themselves specifically providing SUD treatment and referrals. Are there health providers, say office space positions prescribing (inaudible) or for-profit providers that do not fall in this category and do not have to comply with Part 2.

DELOSS: That is correct. There are certain providers that do not have to comply with Part 2 because either they don't, are not federally assisted or do not hold themselves out as specializing in this area.

GUTHRIE: So what about the Department of Veterans Affairs? And does it make sense that some patients with substance abuse disorders will have this information in their medical records and some will not?

DELOSS: With respect to the Department of Veterans Affairs that would be an exclusion from the coverage of Part 2. Part 2 does not apply to those records.

GUTHRIE: Does it make sense that someone has this information and others would not?

DELOSS: No. It is an incomplete record, absolutely.

GUTHRIE: So, while Part 2 is supposed to have stronger protections, Mr. DeLoss, can discuss the enforcement authority for Part 2 infractions in comparison to the enforcement authority for HIPAA violations?

DELOSS: Yes. Part 2 is a criminal statute, so the enforcement in addition to the Substance Abuse and Mental Health Services Administration, SAMHSA, there would be a criminal enforcement through the Department of Justice.

To my knowledge -- and I know, Dr. Clark, had a different opinion. To my knowledge there has never been a substantive enforcement action taken for a violation of a Part 2 provision and its history.

With respect to HIPAA, you have the Office for Civil Rights, Department of Health and Human Services that would engage in a process of audits, reviews, complaint-driven responses, investigations.

You have the breach notification provisions, which are now part of Part 2 under the bill. I did not mention that earlier. All of that results in a very comprehensive enforcement scheme and I believe the most recent information I have is that over $75 million in fines and penalties have been levied against those that have violated HIPAA or not complied completely with respect to the protections that that law requires.

GUTHRIE: Okay. And I'm going to ask the question I have from my friend from Texas, he didn't get to, so I'm going to read it. Substance use disorder treatment records have -- and this is for Mr. DeLoss -- has already been subject -- has been subject data -- have already been subject to data breaches.

For example, on August 2016, an addiction treatment provider in Baltimore was hacked and the patient addiction treatment information was put for sale on the dark web. In 2017, a data breach at Bronx Lebanon Hospital Center in New York caused the release of at least 7,000 people's records which included addiction histories. So that said, under Part 2, are there currently breach notification requirements?

DELOSS: Correct. The HIPAA breach notification requirements would require notification not only to the individual patients, probably in the cases you mentioned to the media as well as the Department of Health and Human Services.

GUTHRIE: Okay. Under Part 2, what are the penalties for an unauthorized disclosure?

DELOSS: Well, they can range from $100 for a small negligible type of violation up to $1.5 million.

GUTHRIE: Okay. So how would the legislation before us help patients whose addiction treatment data has been compromised?

DELOSS: Well, there would be a requirement, an affirmative duty to report any type of breach or violation under the breach notification provisions. Part 2 does not currently require any kind of notification of a violation by a program or by a provider.

So, there would be that new affirmative obligation to disclose that. Not only to the individual patient but also to the department as well. So that would obviously bring up the ability or heighten the ability to enforce the law because it would impose an affirmative obligation to do so.

GUTHRIE: Okay. Thank you. And I have about a minute. So, Mr. Gardner, I have -- the Assistant Secretary for Mental Health and Substance Use, Elinore McCance-Katz wrote recently in a letter that -- and I'll read what's -- a paragraph from her letter. "The practice of requiring substance use disorder information to be more private than information regarding other chronic illnesses such as cancer or heart disease making 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 of care."

I have 30 seconds, Mr. Gardner, do you agree with that statement?

GARDNER: It's a big subject for 30 seconds. But I do believe that over the course of time a paradigm of separation and secrecy as opposed to integration and openness does indeed create a culture that, where stigma lives.

GUTHRIE: Well, thank you, and my time has expired. And I yield back.

BURGESS: The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from California, Ms. Matsui for five minutes of your questions, please.

MATSUI: Thank you, Mr. Chairman. I want to thank all the witnesses for being here today.

Mr. DeLoss' testimony highlights that under this bill, a Part 2 provider could still require additional consent if it wanted to. There may be a way for this bill to reflect that option more directly.

I recognize that Mr. McKee's brother's story is all too common scenario in which the patient may have not chosen to consent even if sharing information will be in their best interest. However, I think the big question we must ask ourselves is whether we want to completely take away that right to consent.

I think the middle ground here is retaining some ability for the patient to consent to whether or not the information is shared. Under current Part 2 law, the patient has the right to consent either every time their information is shared or under new SAMHSA rules more broadly if they choose.

Under the current bill we're considering, the patient's information will be shared automatically with covered entities for the purposes of treatment, payment, and healthcare operations when they choose to be treated.

What if upon seeking treatment, the patient retained the right to consent and could choose between privacy protections under 42 CFR or under HIPAA? Dr. Clark, I'll start with you, but I'd like to hear from the other witnesses as well.

CLARK: As I mentioned, I applaud the efforts of this committee to address some of these critical issues because they are of great concern to our nation's public health and to the citizens of this country.

You raised an important point that essentially already exists, has already been acknowledged. You can strengthen 42 CFR Part 2 by strengthening the penalty without abandoning the confidentiality to make a personal decision.

There are conflict of laws issues that are raised by the current bill that will have to be negotiated because indeed, it attempts to aggregate things like the ADA, the DOT, and Department of Justice kinds of rules.

So, then there is the issue of competency of individuals, if you will remove an individual's competency in this situation automatically then what about for cancer, what about for other conditions.

So the right to choose what happens to your own person is ant important right. And what we are talking about is creating a slippery slope where we nullify that right for this condition, then we have to nullify that right for another condition. So, I think we need to keep that in mind.

Addressing the conflict of laws. Addressing the issue of penalties and making sure that we understand the covered entities.

MATSUI: Okay. Is there any other comment to this at all?

DELOSS: I can respond briefly.

MATSUI: Yes.

DELOSS: In terms of requiring the consent, I believe that one of the issues would in what situation would consent be required, even with the changes that were made in the regulations in 2017 and 2018. There are still issues exchanging that information directly with other healthcare providers because of the limitations that are imposed in and because of the complexity of those regulations. And I think that probably really sums up the critical issue which is because of those complexities that health systems, medical groups, hospitals and others cannot comply, the HIEs, the ACOs, et cetera, this information is not being included in those exchanges of information for purposes of care coordination.

So a consent by itself does sound good but if you add the layers of complexity that are in place currently under the law, as well as others that have been proposed by the opponents to this bill then it makes it extremely difficult if not possible to share that information. Thank you.

MATSUI: All right.

Now I realized that both HIPAA and Part 2 protect against information be shared with landlords and employers but I am concerned that the definition of covered entity under HIPAA may still be too broad such that it increases the likelihood of a breach.

Mr. DeLoss, under this bill could information only be shared between treating providers or could it be shared between to covered entities that are not necessarily treating a specific patient.

DELOSS: The information could be shared for treatment, payment or healthcare operations only between two covered entities, a Part 2 program and a covered entity and then a covered entity with another covered entity downstream, and definitely correct.

MATSUI: I've heard differing opinions on whether HR 3545 it allows for disclosures to business associates, are business associates not covered under payment treatment and operations under HIPAA?

DELOSS: It is my interpretation of HR 3545 that the bill would not allow disclosure to business associates because they are not quote, unquote, "covered entities." Correct.

MATSUI: Okay.

Mr. Chairman, I yield back. Thank you.

GREEN: Does the gentlelady yield her time to me?

MATSUI: I yield to you.

GREEN: I thank my colleague.

Mr. Chairman, you and I have talked about this. I'd like to ask Mr. DeLoss to testify that the bill would not allow information to be shared with business associates. However, a Republican memo states, quote, "The discussion (inaudible) permit said records to be shared between covered entities, the healthcare providers, payers and business associates."

I'd like to see if Mr. DeLoss as to the intent to just include entities or is it also the intent to include business associates?

BURGESS: Before that, we go into that it's not Mr. DeLoss' -- it's not required of him to justify what is in the majority memo. I mean he is responsible for his testimony, we're responsible for ours, and you're welcome to address that if you would like but you're not required to.

DELOSS: Again, it's my interpretation, I'm not familiar with the memo and it's my interpretation because it allows for disclosures from Part 2 programs to covered entities, or by covered entities, to covered entities that business associates would not be included, that's my interpretation.

GREEN: I just wanted to get the...

BURGESS: Will the gentleman yield back?

The chairman recognizes from Tennessee Ms. Blackburn for five minutes of your questions, please.

BLACKBURN: Thank you, Mr. Chairman.

And I thank you all for your patience in being here today and talking with us about this issue. As you know we had quite an extensive hearing prior to your hearing today with the drug distributors and looking at the opioid issue and their participation in it. So this is an issue that we take very seriously.

And as Chairman Walden said one of the things we have heard from families, from recovering, those that are recovering from addiction, that suffered from addiction is wanting to have visibility into those records so that they could be there to help their family member or their loved one.

And we were -- Ms. Matsui was just touching on the consent forms. And I want to go back to that issue but take a little bit different tack with this because I was talking with an attorney yesterday and we were talking about someone they were trying to get into drug court and a treatment program. And this person had looked at this attorney and said, "You can take me to drug court, they can send me to detox but I'm not going to stop using."

And he talked about the heartbreak and I think many of us and you all -- Ms. Metcalf, your situation, Mr. McKee with your brother, Mr. Gardner, with your mom, those are the heartbreaking, heart-wrenching situations that those as a mom and as a friend to people who have dealt with this it just tears you apart. And we realize that.

Ms. Metcalf, I want you to just say what would it have meant to you if there was somebody else that had that visibility and, you know, we hear from doctors about compliance or that people not telling -- maybe telling the truth but not the whole truth when they come in and have a discussion about their health, what would it have meant to you to have somebody with the visibility that could say you need to sign this consent form, you need to be truthful and honest about this. Just give me 30 seconds on that?

METCALF: Absolutely, thank you and it meant an awful lot to me. I had a physician and my mother when I was 17 years old worked together to coordinate

my care and I signed a consent form because my counselor said that this would be a good thing to work together as a team.

I was prescribed Antabuse at the age of 17 because I was drinking excessively and had been to treatment twice. And so, they coordinated together. It made a lot of sense to me to work together and I consented and signed that form as a 17-year-old. I would do it again because I was educated in that, I was given the opportunity to make a choice.

BLACKBURN: Now as you work with those that are recovering how do you counsel them.

And Mr. Gardner, I want you to come and right behind her on that answer. How do you counsel people on signing a consent form?

And Ms. Metcalf, you first and then Mr. Gardner.

METCALF: I worked as an intake worker in a residential treatment program and had those conversations many, many times. It was a very validating experience to have to say this is what this form is, 42-CFR Part 2 . If you would like to share your information with your physician you can sign it now or as you are here in treatment with us we will revisit this because you may want to coordinate the care.

I believe that having others make a choice for us or even having this conversation is stigmatizing in a way that says that we don't have the ability or that we're less than, that we don't -- that we're not capable of making those choices and we are. There are millions of people that are making those choices every day and consenting to sharing information with their healthcare provider.

BLACKBURN: Would you say that consenting to share that information and get that help saved your life?

METCALF: I don't know that. The prescription that I was given didn't save my life, it didn't work for me. I didn't go on -- I went on as an adult...

BLACKBURN: Okay.

Mr. Gardner?

GARDNER: Thank you for the question. I do think those are compassionate conversations. I will say that I don't think patients generally have an expectation, come in with some expectation or knowledge of Part 2, some difference between the HIPAA and the Part 2.

They have some general expectation of privacy for sure. And I will say that when we come back for repeated consents in the real world that is sort of annoying, frustrating sometimes and can actually raise alarms. Like what I wasn't I thinking about that I need to be thinking about now?

BLACKBURN: Okay.

I yield back.

BURGESS: Thanks to the gentlelady.

The chair now recognizes the gentlelady from California for five minutes for questions please?

ESHOO: Thank you, Mr. Chairman.

And thank you to all of the witnesses. I've had the advantage of being able to not only listen to your testimony but also to listen to all of the questions from members on both sides. And there are enormous complexities in this. I don't really think there's a tidy answer to this and I say that because I keep thinking of my first cousin who suffered all of his life from mental health issues from the time that he was in his early 20s until he passed away maybe about six months ago.

And he didn't really fit into what we're talking about here today in many ways because if you said to him give consent he really would not have known what he was talking about. He wasn't in a position to do that.

So I want to thank Dr. Clark. He's a part of a great university in my region, Santa Clara University. It's a Jesuit college with a graduate school and it's highly regarded for many of its graduates, one of them a member of Congress, a son of the House Leon Panetta.

So thank you for being with us.

What I would like to know is from amongst yourselves what would -- Mr. Gardner, what would you and Mr. McKee say to Ms. Metcalf, Ms. Metcalf, what would you say to them? You believe that Part 2 is necessary and you told your story and it's an important one. They told their stories. They are an important one. What is lacking in HIPAA?

Where is the danger going to come from if we change this? Maybe the three of you in a minute tell me why your case you believe is the strongest?

METCALF: I will go and I wanted to say that, you know, we hear these stories and it's very impactful. I think that when a patient or when a person with a substance use disorder wants to share their information with a family member they will.

I don't know that signing a -- that HIPAA is going to allow them to or is going to help that. I think that the family member doesn't have access to that...

ESHOO: You see the thing in what you are saying to me is and maybe my own experience is discolored by the fact that my cousin really was not capable, I mean, if he said so he sounded and he looked very clearly but he really didn't know what he was talking about a good part of the time.

So is that what we are relying on?

METCALF: I think we have a very misunderstood image of what alcohol and drug addiction is. There are millions of us, 23 million in recovery. There are individuals who go on to live and overcome addiction. We don't, we are not...

ESHOO: And this applies only to alcohol and drug abuse, what we are talking about today, it only applies to those two addictions? It only applies to those two addictions?

MCKEE: You know I would say that by enshrining this distinction between medical and surgical care and substance use disorder conditions that in the federal code we are simply adding to the stigma in a structural way.

You know, there are other health conditions that are highly stigmatized like sexually transmitted infections, HIV-AIDS. Why are we separating out substance use disorder information?

You know, I work for NAMI, there's a lot of folks that we represent that are seriously mentally ill.

ESHOO: That's an extraordinary organization. I've worked with them for years. They really are outstanding.

MCKEE: Thank you very much, Congresswoman. We appreciate that very much and there's a lot of folks with serious mental illness like your brother -- your cousin who simply don't understand this, this process. And yet their treatment providers of either mental health provision or medical surgical care are still blocked from seeing these things. I mean it's almost as if we're...

ESHOO: Can we give Mr. Gardner just a moment? I appreciate what you say.

GARDNER: Yes, thank you. I think in the specialized addiction treatment field we've recognized for a long time that the way to -- one of the big opportunities to improve the way addiction is addressed in America is to get all of healthcare involved and not have it be just us in the specialty treatment field.

And so, every opportunity that I think we can get to bring healthcare into the fold and get more eyes and professionals on this disease for the people that suffer from it I think the better. And this seems like an opportunity to do that.

Privacy is important it's what I would say. There's no doubt about it. I just think the strategy that we had in the '70s of trying to avoid discrimination is no longer the right strategy. We should be confronting discrimination and I think in HIPAA and newly -- the new language around Part 2 that we can enforce discrimination and still bring healthcare into the fold.

ESHOO: Thank you very much.

Thank you, Mr. Chairman.

BURGESS: The chair thanks the gentlelady.

The chair recognizes the gentleman from New Jersey Mr. Lance, five minutes for your questions please?

LANCE: Thank you very much, Mr. Chairman, and good afternoon to the panel.

I will be introducing a bill that will target new resources for substance use disorder. Health Homes as I understand it they currently exist in four states, Maine, Maryland, Rhode Island and Vermont.

Under the model of care in Vermont for example the state has markedly expanded access to medication assisted therapy, reduced the use of alcohol, opiates and other illicit drugs, increased the use of hospital emergency departments, reduced illegal activities and run-ins with law enforcement and substantially improved family life, housing, stability, and emotional health.

But however according to a January, 2015 bulletin put out by CMS entitled "Designing Medicaid Health Homes For Individuals With Opiate Dependency Consideration For States," one barrier to effective treatment and care coordination identified by Vermont and other participating states was 42-CFR Part 2 and I quote, "Collectively the three states cited federal confidentiality requirements as a barrier to effective integration of care and sharing of vital information between the health, home and other medical professionals." Close quote.

And, Mr. Chairman, I ask that the CMS study be submitted to the record.

BURGESS: Without objections, so ordered.

LANCE: Thank you, Mr. Chairman.

I know that you don't know the particulars of my (inaudible) but it seems like a way forward and that would be to align Part 2 with HIPAA. And I think that people on the ground tend to agree with this.

Mr. DeLoss, would aligning Part 2 with HIPAA eliminate the barrier to effective integration of care in sharing vital information between the health, home and other medical professionals and what sort of improved outcomes for patients could we expect to see if these were the case?

DELOSS: Well, again, without seeing the bill but based upon your description it would appear to me that aligning HIPAA with Part 2 would allow for the free flow of information between those entities, as well as substance abuse and substance use disorder Part 2 programs. So that would coordinate the care to allow that information to be shared for the betterment of the quality of care, as well as ensuring that there is no, any type of drug that could interact negatively with anything that the individual is currently taking in the form of MAT or what they may, as mentioned earlier as far as their addiction itself.

LANCE: Thank you.

Is there anyone else on the panel who would like to comment? Yes, yes, Doctor?

CLARK: I'd like to remind people that most substances don't have medications available to treat them. And that we are talking about essentially blaming individual autonomy and rights for the failure of the HITECH Act, the failure of practitioners to be adequately trained to address the issue of addiction, so we are blaming the very people that we're trying to help for the weaknesses of the delivery system.

You just had a hearing this morning. You had people throwing large amounts of drugs into the delivery system without question, making money hand-over-fist and no one questions that now. But we recognize, oh, yes, that we should have recognized that large numbers of pills going into a community might be a problem.

We've heard of physicians just writing prescriptions without recognizing that this is an issue. I've treated patients a long time ago and we always ask do you want your family involved, you need your family involved because this is a family disease, it's not just your own individual disease. So what we're talking about is not dealing with the system, we are talking about blaming the victim.

And I encourage you to look at Part J of this bill 3545 which says, "To develop and disseminate model training programs for substance use disorder patient records ," to get people, to make sure that we have enough pilots to prove the point rather than to speculate the point because once the horse had left the barn you can close all the doors you want but you don't have the horse.

LANCE: Thank you.

Others on the panel?

I commend to your attention the bill that I will be introducing and I certainly would like you to examine it for your expertise. This is an issue that knows no bounds here in Congress. It's an issue on which we hope to work in a bipartisan capacity and also in a bicameral fashion because obviously we want to improve the system together.

Thank you very much and I yield back the balance of my time.

BURGESS: The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentlelady from Florida for five minutes for your questions please?

CASTOR: Thank you, Mr. Chairman and Mr. Green for organizing this hearing today and I'd like to thank all of the witnesses for being here and especially for those of you who have shared very personal stories, thank you very much.

Ms. Metcalf, I'd like to get a better understanding of the importance of Part 2's patient consent requirement, what role does getting patient's consent to disclose their substance use disorder treatment information to providers and other entities play in their treatment? And why is this patient consent requirement important for individuals with substance use disorders?

METCALF: I'd like to respond to that. What we find with people in active addiction is that they are very little healthcare services for preventive care. They are not getting treated for the conditions that are underlying. They're not doing things that are healthy and seeing dentists, or you know there are so many things that can be done to help that person.

Once they engage in treatment that conversation about their health and wellness, taking care of those things to help them live better, longer lives it happens because the counselor talks to them about the value of getting

that, sharing that information with their physician. And we've seen, you know, incredible life improvements of people in recovery when they are able to do that. That is a process that takes place, that initially people are not generally...

CASTOR: Do you have data on that or there are studies you can point to?

METCALF: We have, I have studies of people in long-term recovery that the Life in Recovery survey that indicates that what recovery does for people it helps them engage in those medical services where they weren't before and that the services that they were reusing before where the higher cost emergency departments services or treatment services versus the preventive care where they could be going to their physician.

CASTOR: What should providers do if substance use disorder patients refuse to give their consent to disclose their patient information to other health providers?

METCALF: They should continue to have that conversation with them and when they're ready and they see the value of that they will do that in most cases.

CASTOR: Because the relationship between the patient and provider is critical especially with folks with substance use disorders, the cornerstone of the relationship of course is trust which includes trust that the information that you give to your provider will be used appropriately, and that you know how it will be used.

According to one recent study two-thirds of adults in America are concerned about a breach in the security and privacy of their personal health information. In addition the study showed that over 12 percent of patients withheld information over privacy concerns. The more concerned you were about privacy the more likely you were to withhold information. And I am hearing that this is called your privacy protection behaviors. There's got to be a simpler term for that.

But Dr. Clark for people with substance use disorders, you know, all of you know that that relationship is important between the patient and the provider. Would you say that people with substance use disorders are particularly sensitive to concerns about how their data would be used? Is it...?

CLARK: That's my clinical experience but as Ms. Metcalf pointed out the job of the professional in the treatment arena is to encourage individuals to recognize the importance of comprehensive interventions. And that way they can sample the kinds of reactions that they get.

I've heard people in other settings who are on recovery point out that they in fact were dropped by practitioners for what appears to be essentially manufactured reasons. You can't determine whether you've been discriminated against, you just know that these practitioners are unavailable.

The problem with the HIE notion is that you may have hundreds of thousands of entities who have access to that information and they get to decide whether they want to see you or not...

CASTOR: But Mr. DeLoss I thought made some good points and I know you are sitting right next to him and heard that this is very narrow and could be helpful when we are talking about the covered entities. You heard what he said and how narrow it is and why doesn't...

CLARK: Okay. I disagree with his definition of how narrow it is. Remember this is your bill, not his bill so his interpretation won't control, your interpretation will control, you are making this. He doesn't get to talk about legislative history, he gets to litigate it...

CASTOR: But we're building the record, we are building the record here...

CLARK: So some of the statements he's made in terms of like third-party notification, 42-CFR Part 2 does permit third-party notification. You do have to go through extra steps but it does permit third party notification. So he was wrong about that. So he's probably wrong about whether the covered entity is a construct is as limited as he thinks it is. So we have to think about that collectively rather than just sort of extemporaneously make a declaration.

CASTOR: I wish I had time to allow him, Mr. DeLoss to respond but maybe another member could ask about that.

BURGESS: I think we should allow Mr. DeLoss to respond.

CASTOR: Okay.

DELOSS: Thank you.

42-CFR Part 2 , to respond directly to Dr. Clark's statement does not have a duty to warrant exception.

CLARK: It does have a duty to warrant exception, it does.

DELOSS: No.

CLARK: It does have it. It permits third-party notification. You should read it a little more closely, sir.

I know...

BURGESS: The gentleman from Texas is correct. The witnesses don't get to debate here...

CLARK: It's not a debate here.

BURGESS: And (inaudible) in order, to recognize Mr. Long of Missouri for five minutes for your questions please?

LONG: Thank you, Mr. Chairman.

And Mr. McKee, one recent study found that physician continued to prescribe opioids for 91 percent of patients who suffered a non-fatal overdose, with 63 percent of those patients continuing to receive high doses, 17 percent of these patients overdosed again within two years. How would this

legislation before us help to stop overdoses and prevent these deaths from recurring?

MCKEE: Thank you, Congressman.

Assuming both of my hands are covered entities it lets the left hand know what the right hand is doing.

LONG: Pretty good explanation I would say. Do you think that allowing health providers to see patients complete medical record when making treatment decisions would help to prevent such tragedies as in the case of your brother?

MCKEE: I think that it's very likely that it improves their odds of surviving.

LONG: Your brother you said 36 years old at the time he deceased, three children, divorced, living in your mother's basement. You had fought this, he had fought this addiction, your family had fought this addiction for years and years, and years. What can we do as congressmen, what can we do here in Washington D.C. to prevent another 36-year-old brother deceasing such as yours?

MCKEE: Thank you, Congressman.

HR 3545 is a great step. We also have to improve access to prevention treatment services and ensure that folks are covered, ensure that essential health benefits are maintained such as those requiring substance use disorders to be covered. And we also have to ensure that we really truly have behavioral health parody in this nation.

LONG: We have done of course had several panels and discussions on this topic here in the Energy and Commerce Committee. And a few weeks ago we had I believe seven family members that had all, or seven folks that had all lost family, usually younger college-age students and things.

There's one fellow that worked here in Washington D.C. and I was describing at a function one night about how my two daughters, one was 29, I'd better get this right and one will be 32 I think in a few more days, but they had had three friends of theirs that have deceased from opioids.

And when we had the panel in here with the seven parents that had lost children, and one lady that was addicted herself and had been since a young, young age, is there anything that -- it had to be extremely frustrating dealing with your brother over the years trying to help him. We had as I started to say one fellow that worked here that had a son, and as I was describing at this dinner, about his son just gotten out of treatment for the third time, at Christmas time and they opened packages, and the boy disappeared.

And he told his wife, he said, well, you know, we need to check in on him, they hadn't heard from him and they went upstairs and they found him collapsed as he described in a fetal position on the floor of the bathroom. In this case they were able to revive him and got him to the hospital. The next morning they walked in and he told his daddy, he said, "Daddy, I knew that I went out of treatment, I couldn't do the amount of heroin that I've done before,"

But he said, "My gosh, dad," he said, "I just had such a tiny bit on a spoon. I could barely melt it."

Is there anything you can enlighten us with that would help these families that are where you were before they've lost these loved ones?

MCKEE: That's a great point. When Brandon called me he talked about how he had been off of opioids for about a week and a half and he had gotten dope sick. And then he relapsed. He didn't know about medication assisted treatment or there is enough stigma around medicated assisted treatment that he didn't access it. He was an all or nothing kind of guy.

And I think that when you align things like these, with 42-CFR with HIPAA you're simply showing that this is a disease. These are chronic brain diseases and the public needs to understand that they are no different than HIV AIDS, diabetes, cancer. The more we have these discussions the more we break that stigma just like with mental illness.

LONG: Thank you for sharing your story here today and I thank all of you for being here. And the fellow that I was talking about, his son, his son had since, receiving the injection that you get, I think it's once a month maybe that -- and it's expensive, it's a $1,000 a month, but you know, for people that can afford it that's fine, those who can't -- but anyway, thank you.

Mr. Chairman, I yield back.

BURGESS: The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Indiana Dr. Bucshon for five minutes for your questions?

BUCSHON: Thank you very much, Mr. Chairman.

I was a cardiovascular and thoracic surgeon for many years prior to coming to Congress. And I just wanted to describe a few personal experiences. My wife is an anesthesiologist with the -- what can happen when you have an incomplete medical record.

You know, I have -- I will just describe one patient who was a lady in her probably in her mid-70s who I did an aortic valve replacement on. She was a nice lady. In her medical history there was nothing about alcohol abuse. However, the second night after surgery she went into DTs, jumped over her bed rail, landed on her head. And when I subsequently went and talked to the family they said, well, actually, you know, she drinks quite a bit.

And I'm like why didn't you tell us that upfront. It wasn't in her record. We had no idea she had been in -- she had been in, you know, in Alcoholics Anonymous in the past, relapsed. This is a real problem.

You know, I had patients -- and it's not just alcohol or narcotics, I had patients that take dietary supplements for vascular health. Well, let me just give you a little clue, when you have open-heart surgery and you are taking medication for vascular health you bleed like crazy and you can't, you won't stop. I had no idea.

I've had three or four patients with that. They didn't tell us. We asked specifically, do you take dietary supplements? They didn't tell us.

And then my wife is an anesthesiologist who has happened -- I don't have a specific case, but has routinely had problems anesthetizing patients with narcotic and benzodiazepine-related anesthetic agents and subsequently has found out from the family even though the patient denied it that they chronically used opioids and or benzodiazepines.

Patients don't tell you these things and it's a really big problem. We need to know. Physicians, real physicians out there in practice need to know because it has real repercussions.

My patient who jumped over the rail and hit her head subsequently after about two weeks in the hospital survived her DTs and her aortic valve replacement and her minor concussion. But they may not.

So, Doctor Clark, your written testimony you say the case is often made and healthcare delivery systems need to know about the substance, you see the history of a patient, you don't hear why -- you don't hear why providers simply can't ask patients themselves about their substance use history. Do you really believe that patients are going to -- are going to tell you about these things?

I mean every patient is going to tell you when you ask them? The mike?

CLARK: Every patient is not going to tell you everything about everything. On the other hand if in fact you take the time or you have a staff person who can take the time to establish the rational relationship between what it is that intervention is going to do I think you will get more truth telling than you are aware.

I've found that asking people things in a carefully designed non-judgmental way gets a better response than simply reading it in the chart and deciding that you may or may not...

BUCSHON: Clear enough. So the thing is that you are a psychiatrist?

CLARK: Yes I am.

BUCSHON: People come to you because you need to ask, you know, because they have been sent to you to ask questions about mental illness and substance abuse things. Of course I appreciate your experience but I can tell you when you're not a psychiatrist and you're just a practitioner or a heart surgeon and an anesthesiologist in my personal experience patients do not tell you the full picture.

And it's not a criticism of them. Many people don't know the impact, the potential impact, medical impact of not telling you. You know, for example, why would a dietary supplement be a problem if you are going to have heart surgery? Well they don't realize the fact that it really does, anti-coagulate. You bleed, right, and you have to be transfused, I've had this happen.

So I appreciate your experience but I would argue that the patients don't tell you and there's real repercussions.

I mean the other question is I have is can you disclose to people's employers or law enforcement people's HIV or mental health status without their consent?

CLARK: Generally not but it also depends on the context of the situation.

BUCSHON: Right, Okay, I get that, and there is some context, right, if they are threatening someone or something like that, there's exceptions, right?

Why would you -- why would you think if there is a history of substance abuse or alcohol abuse in a patient's medical record already covered by HIPAA why would you think that there would be a high risk of that being disclosed?

CLARK: Well, actually HIPAA's protection is weaker when it comes to such disclosures. I think 3545 makes an attempt to address that. If it does allow administrative police inquiries, so you don't really...

BUCSHON: Yes, but Mr. DeLoss says you have to have a court, is it...

CLARK: No, you don't need a court order.

BUCSHON: What's the requirement?

DELOSS: You have to have a court order...

BUCSHON: But the patient has to authorize it?

CLARK: Correct.

BUCSHON: Okay. So, you know, what I am saying here is that -- look, I appreciate your experience on this issue. But what this legislation is trying to do is honestly I think create parody for patients so that medical providers can provide adequate healthcare and, you know, the reality is this that -- and, Mr. Chairman, just a couple more seconds.

Is that without complete information and my personal experience as a healthcare provider, in a medical record there are potentially serious ramifications of not understanding a patient's complete medical history.

I yield back.

BURGESS: The chair thanks the gentleman. The gentleman yields back.

And the Chair now recognizes the other representative from Indiana the gentlelady from Indiana for five minutes for your questions please?

BROOKS: Thank you, Mr. Chairman, and thank you all for being here and for sharing.

It's my understanding that individuals with opioid use disorder die on average 20 years sooner than other Americans. And it's largely because of a strikingly high incidence of poor managed co-occurring chronic diseases, whether or not that might be HIV-AIDS or cardiac conditions, lung disease, cirrhosis.

And in our home state of Indiana sadly we've seen an incredibly growing number of Hepatitis C cases linked to the injection drug use occurring in tandem with the opioid crisis. And so, I'm interested in each of your perspective, wouldn't you agree that care coordination which we've heard a little bit about is -- and which I think Dr. Bucshon was just talking about is absolutely vital to ensuring better outcomes for those patients with chronic conditions. And in many ways wouldn't you consider substance use disorder a chronic condition as well?

Sir?

MCKEE: Congresswoman, thank you for that.

Care coordination is at the heart of better health outcomes. It's allowed us in Ohio to make significant advances in moving away from volume and towards value. If we don't have care coordination -- you know, part of the reason the mental health system is so broken and especially for the chronically and mentally ill is that because we don't have enough care coordination. We are working on that in Ohio. This is simply another step in that direction.

BROOKS: And don't we know that those with serious mental illness also often don't have their chronic conditions taken cared of. They are co-occurring conditions. They have worse other health outcomes.

MCKEE: Congresswoman that is absolutely correct and I'd love for you to join as a member of NAMI in Indiana.

BROOKS: Okay, thank you.

Yes, Ms. Metcalf? Can you hit your mike please? Thank you.

METCALF: Absolutely we agree that care coordination is critical. We 100 percent support that and not at the expense of taking away our right to choose who our information goes to.

BROOKS: Except that we visit often and I just visited when I was back home in Indiana last week ER physicians at Eskenazi Health and when people are coming in overdosing they -- and we have hospitals saving lives each and every day but those individuals have no ability to share any information about what their conditions is. And so, why would we want to tie the hands particularly of those in our ERs that are being inundated with people overdosing, why would we not want them to have access, to know what is happening in that individual's life?

Mr. Gardner?

GARDNER: I was just going to say that addiction treatment is changing pretty drastically in recent years. We are really making an attempt to keep people engaged in care longer. It's no longer you come to a building and you are there for 28 days and you go home...

BROOKS: Sure, outpatient, everything.

GARDNER: You may go from residential to outpatient. You may go back to your home community and we're facilitating that ongoing care more and more. Partly that's been driven by the fact that more and more medication-assisted

treatment is taking place, including at our facilities. But you need to link people with prescribers in their home communities and ongoing therapy for this to work. So care coordination like never before has become important in addiction treatment.

BROOKS: Dr. Clark and I want time for Mr. DeLoss?

CLARK: Care coordination requires patient cooperation, patient compliance. It's not just the prescriber's role...

BROOKS: Excuse me but what if the patient has OD'd?

CLARK: Well oddly enough the emergency room doctor is not controlled by 42-CFR Part 2.

BROOKS: Okay.

CLARK: And we could enhance that. So we also are dealing with heroine...

BROOKS: But how would the ER physician get access to that individual's substance addiction history?

CLARK: Well this bill won't change that. What we are trying to do is encourage people as Mr. Gardner said if we can intervene early enough we don't deal with this. One of the things with medication-assisted treatment is that the average length of stay is only six months. And so, what we are trying to do is trying to foster that longer period of time so that we can facilitate recovery and that's what a saver is about, trying to get people to recognize that they could retain, they remain vulnerable and just as was previously mentioned just a small amount of Fentanyl, a small amount...

BROOKS: Thank you, sir, I'd like to hear from the last panelist.

Mr. DeLoss, would this bill help ensure that an ER physician could get access to a substance abuse record?

DELOSS: Absolutely and an ER physician is a covered entity and would receive the information under the TPO exception that is in this bill. So that the ER physician would receive all of the information available relevant to the SUD treatment relevant to the overdose and be able to treat that condition and overdoes more effectively.

If I could continue I'd also like to expand on there's been a lot of discussion with respect to other providers in the community trying to coordinate care and provide treatment services or their own medical surgical services. I'd like to speak on behalf of the SUD programs. They want the information from those other providers as well. They want to partner with the physicians, they want to partner with the hospitals but they can't because of Part 2 because it's too complex, it's overly stringent.

That information not only cannot be disclosed by the program but the program can't go out and ask for that information because that information would identify the patient as suffering from an SUD , so they are not able to coordinate the care as well.

There's a number of other issues and I will stop there unless there are other questions.

BROOKS: Well and I think on behalf of patients in Indiana the SUD programs do need to coordinate particularly with the infectious disease conditions that we are seeing an incredible rise in Indiana.

Thank you. I yield back.

BURGESS: The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Virginia Mr. Griffith, the Vice-Chairman of the Oversight Investigations Subcommittee for five minutes for your questions please.

GRIFFITH: Thank you very much, Mr. Chairman. And I appreciate it. This is one of those difficult issues and I appreciate you, Mr. Chairman, holding this hearing because I'm trying to figure out exactly what I should do and how I should go on this. And I was decided coming in here.

I leaned towards voting for the bill because we've had problems for some time. I also had concerns on the privacy side. So let me go over some of those issues that we have, you know, as early as last year we had Brian Moran the secretary of Homeland Security and Public Safety from Virginia and he said we got to do something. And it would help us to combat the opioid epidemic and save lives if we could have improved data sharing" and he specifically mentioned Part 2.

And I do think, and Mr. McKee, if I could ask a couple of questions of your situation and I know it's painful and I appreciate you being here today to discuss it, your brother was doing well when he had the accident. Is that correct? Is that my understanding?

MCKEE: He had had periods of sobriety and periods of relapse and I'm not sure how many relapses and how close together they were.

GRIFFITH: Okay, fair enough, because he didn't tell you everything. And then, he has this accident and as a part of the accident, they had to do surgery. Was that surgery something that they did immediately upon him having the accident?

MCKEE: It was not immediate. He was stabilized in Western Community Hospital and then he was driven to Cleveland Metro Hospital.

GRIFFITH: Okay. So, here's the question I have and you may not know the answer. When he stabilized, did they give him opioids for the pain that he was experiencing at that time?

MCKEE: Absolutely.

GRIFFITH: And he was not fully conscious, was he?

MCKEE: No. He was making some jokes about the appearance of the nurse when I came to see him.

GRIFFITH: Okay. So, here's what's interesting and I have this theory, documentary archaeology even sometimes going to documents and figure out that people didn't realize what the future would hold. This bill was passed in the

early '70s in which you find in the bill is you got a section on medical emergencies.

Under the procedures required by Paragraph C of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bonafide medical emergency in which the patient's prior informed consent cannot be obtained. Your brother couldn't give an informed consent, forget his abuse problems, he's just been in an accident. They're probably giving him opioids and you suspect that in '92, before he ever get sent over for the surgery before he ever gets the prescription. And because of the way the law is written or at least as it's been interpreted for the last 40 years, nobody knows that he has a substance abuse problem.

So, they've already given him substances before he ever has a chance to waive. So, I recognize that. Do you see that problem as well, don't you? Yes or no.

MCKEE: Yes, Congressman.

GRIFFITH: Okay, because I'm just trying to get to the other side. Now, here's the other side of this. I've got this hypothetical form in my head where the person whose previously had a substance abuse problem goes to apply for a job and that job happens to be a covered entity who has access to all this information and maybe they're not supposed to use it that way, but they have access to all this information.

And let's just assume that this person happens to be a medical professional, say, a nurse for the sake of argument and they're going to go to work for, say, an insurance company, working for the insurance company who is going to provide the health insurance because that's what they do. What's the likelihood notwithstanding the fact that we're never going to see the fingerprints?

Ms. Metcalf, what's the likelihood that nurse is never going to get that job, that he's going to be excluded because as they're doing the work up on the paperwork and so forth, they discover he's got a prior substance abuse problem and they'll never say why, but all of a sudden, "We found out we don't have an opening." What do you think those odds are?

METCALF: It's a very tight job market out there. Of course, they're going to go with someone that does not have a history of substance abuse disorder. That's the history of discrimination.

GRIFFITH: And my colleague says why would they do that. Of course, they would. Maybe they wouldn't. I don't know, but this is the concern that people who has with substance abuse problems in their past and they're on recovery. They're doing well. They worry about these things.

So, Dr. Clark, as my lawyer doctor on this team, here's what we need help on, there are some of us who want to find a balance because without something as an alternative, I'm voting for the bill. That's what I've assessed today because there's more good than evil and even though I worry about the privacy concerns and agree with Mr. Barton and others, I don't have an alternative. Now, we got to fix HIPAA at some point, too.

That's a whole another discussion, Mr. Chairman. But, right now, I've got a lot of people, nobody anticipated in the early '70s that we would have

drugs so powerful that you would be addicted, 6 percent we heard earlier somewhere in the studies I've been doing the last year or so -- 6 percent on the first use of certain opioids are addicted; 13 percent if you extend that out over a period of time. We're dealing with a whole lot more dangerous drugs than we knew about when this bill was passed.

So, I'm going to vote for this unless I have an alternative. I don't have any time left, but if you can get me any answers, any advice on how we might be able to make this bill better or an alternative, I would greatly appreciate it. And thank you for you all listening and for your input today and it's been very educational for a guy who was undecided walking in here.

I yield back.

BURGESS: The chair thanks the gentleman.

I do want to point out to Dr. Bucshon those dietary supplements. They're all natural. So, it's Okay. It's okay, right? They're all natural.

I'm going to ask the indulgence of Mr. Mullin. I know he's anxious to yield to me for my questions. But, we could go to Mr. Carter and hear from him?

Mr. Carter, you're recognized for five minutes please.

CARTER: Thank you, Mr. Chairman.

And thank all of you for being here and thank you especially for your personal stories. They have been very inspirational.

And Mr. McKee, I'll start with you. I really do appreciate your stories and especially appreciate your work with NAMI, what a great group. I worked with them when I was in the state legislature and I continue to work with them here and they truly do some great work and I appreciate that.

I wanted to ask you from your perspective after all you've been through, integrated care could change a patient's trajectory. Do you believe that?

MCKEE: Absolutely.

CARTER: And obviously, you've given an example where you thought in your particular situation where it could have, I'm a pharmacist professionally and I've practiced pharmacy for over 30 years and I have been wringing my mind and trying to think how I can incorporate my experiences into this.

And having tools in our toolbox is very important and I'm just thinking along the lines that if I had the opportunity to know that someone had a history of substance use disorder that that would help me in my practice. It would help me help my patients and that's what pharmacists want to do. They want to serve their patients and help them.

And I'm just thinking, I'm just trying to figure out what would be the downside of this. I mean, I've had the opportunity to be in a number of different conferences and to speak on substance abuse. In fact, one of those conferences was down in Atlanta, the prescription drug abuse and heroin conference that Representative Hal Rogers sponsors every year and I've an opportunity. One of the things we talked about at that conference is the

stigma and that is a big problem we have to get over particularly when we're talking about the opioid addiction.

I suspect and one of the things we talked about at that conference in particular was that we say there's 115 people dying every day because of opioid abuse or opioid addiction. It's probably a lot higher than that. You look in obituaries in papers and you'll see it was a sudden illness or it was even suicide. And there are families and individuals who would rather say that it was a sudden illness or suicide that to say it was substance use disorder.

And just if I could go to Mr. Gardner and just ask you, I know you mentioned earlier about all these forms you had to fill out and in the sense that it just stigmatized you made you feel -- can you just elaborate on that and what your feelings were with that?

GARDNER: Well, when I went to treatment myself 12 years ago, before I went -- and I'm just one person. So, again, I'm not speaking for all patients, but I called my boss. I called three or four people that I figured needed to know before I went. I wasn't sure how I could keep that secret in the first place to be quite honest with you.

And I had no assumption necessarily. Of course, I had some embarrassment or shame or frustration mainly about why I couldn't get this under control myself, but I didn't have an assumption that I needed to keep getting healthy or better or getting help a secret. I really truly genuinely believed that that notion was introduced to me in some way by the consent process.

CARTER: Right.

GARDNER: But not just the consent process, I don't want to oversimplify it. Stigma is a much bigger, broader thing and I just think this overall paradigm of secrecy and separation, separating this particular illness from the rest of healthcare over time is stigmatizing. I mean I think the healthcare -- can I say one more?

CARTER: Sure.

GARDNER: The healthcare industry is one of the places where this has been neglected the most in the past. And so, I think things are changing for the better. Healthcare is at the table now. I mean you know here in the halls of Congress how much attitudes have changed drastically in the last five years, 10 years in healthcare.

So, for example, I think if we want to have, as I do, substance use curriculum in medical schools as a part of becoming a doctor...

CARTER: Absolutely.

GARDNER: ...which I think is paramount, I think we need to open these highways to integration and get help...

CARTER: So, in other words, it's time to pull the drapes to that. It's time to open it up and I'm not just talking about patients. It's time for us as society to recognize and then we talked about NAMI. It's time for us to recognize that these are truly diseases here, that this is not something

someone chooses in a lot of cases. This is something that needs medical treatment.

I have not during this testimony today found one reason why I don't support this legislation. I have just simply not. I want to thank the author of this bill for bringing this forward. It's time for us to get through the '70s and get into 2018. So, thank you for bringing this forward and thank all of you again for being here and for your testimony and your work.

And I yield back, Mr. Chairman.

BURGESS: The chair thanks the gentleman. The gentleman yields back.

The chair is prepared to recognize Mr. Mullin if Mr. Mullin will yield to the chair.

MULLIN: I would yield my time gladly to Mr. Chairman.

BURGESS: Thank you for that.

And as far as the '70s are concerned, Dr. Clark, you and I are probably about the same vintage in our medical school training, 42 CFR, product of the '70s. I actually did take during my time in medical school. I was actually partitioned out to a methadone clinic which was state-of-the-art in 1974 for substance abuse treatment.

Unfortunately, it's still state-of-the-art and I don't know that it's improved a great deal which is the thing that concerns me about our continuation down the path with 42 CFR in 1972 law. It seems to be an obstacle of prevention from us modernizing our systems and several people have referenced the panel of family members that we had here a couple of weeks ago and it was a tough afternoon, tough morning listening to their stories.

I appreciate, Dr. Clark, that you say that there are emergency provisions, but I'm sorry. I practiced for 25 years. I'm not sure that I knew that. And we had a young woman tell us about the problems she'd had in her family and she talked about her son and he suffered a fatal overdose and his fatal overdose, April 20th of 2016, he'd been seen at the hospital and revived with Narcan seven times over the previous year. Her words, seven missed opportunities to intervene and save this young man's life.

Okay. There was an emergency provision that they perhaps could have disclosed the data, but it didn't do them any good. Does it?

CLARK: Neither 42 CFR Part 2 nor HIPAA were relevant to that...

BURGESS: Here's the problem, Dr. Clark, and I'm sympathetic with a lot of the points you bring up, but we have created so much confusion that the practitioners don't even -- the doctors don't even know.

Okay. A very high profile case. A young man flying on his Learjet from one point to another, got some bad Vicodin that caused his respiratory depression. They landed his plane and took two doses of Narcan to bring him back around. And own, the emergency room doctor is being sued for not picking up on the fact that two doses of Narcan was an unusual amount to require and

this individual -- according to news reports, I'm not mentioning a name on purpose, but according to news reports refused the tox screen.

I mean, we got to open up and talk to each other. The siloing of this stuff is what's killing people in my opinion. And again, I'm just a simple country doctor. But hearing this story after story after story, we've got to do better than what we're doing.

And, Mr. DeLoss, I wanted to give you an opportunity to talk about this a little bit. I know that you said with 42 CFR -- of course, 42 CFR, there were data breaches, right, or there were, we didn't know what they were. We used to call it theft back then. So, there's no protection or duty to inform about a data beach, but there's no data breach notification requirement in 42 CFR, but there would be under the Mullin bill, is that correct?

DELOSS: That is correct. There has been historically no breach notification provision and the bill does require that.

BURGESS: So the people who are really, really spun up about privacy, there's actually more protection and what Mr. Mullin has proposed to us to what exists under the 1972 law.

DELOSS: Agreed. Yes.

BURGESS: Dr. Clark, since you're here and you're a doctor and a lawyer, let me ask you a question. Of course, you're never supposed to ask a question if you know the answer to it and I don't know the answer to it. So, I'm going to ask you.

Current law, Mr. Griffith kind of alluded to it a little bit, I think the situation that he described where an employer is a covered entity, I think that would be running afoul of law. But just in general, is it -- is someone who is in recovery, is that information that has to be disclosed to an employer or may be withheld from an employer?

CLARK: If they're truly undercover under the ADA, they can't use it. On the other hand, the information, if the employer has the information, they just don't have to announce it. So, if an employer knows something, they don't have to acknowledge it, they simply penalize the applicant for other reasons.

BURGESS: So, if they're on medication-assisted therapy, they're going to have a positive chemical test urinalysis, is that correct?

CLARK: And unless they're on the DOT -- for instance, if you're on methadone on the DOT, you can't get a safety sensitive position.

BURGESS: You can't get what, I'm sorry.

CLARK: Safety sensitive, you can't be a driver of -- you can't get a commercial driver's license on methadone. It's not true for Buprenorphine, but those are the kinds of arcane rules that these people have to live with.

BURGESS: But if you wanted to work in a department store, that information may not be disclosed to the HR person of the department store?

CLARK: It wouldn't have to be.

BURGESS: And yet, at the same time, if there were something that happened that resulted in liability on the part of the department store owner, would all of that information be discoverable? I mean, I'm not a lawyer.

CLARK: Will be discoverable subsequently.

BURGESS: It would be discoverable.

CLARK: Depending upon court orders. So, all information once it's subject to a court order including under HIPAA, they would be able to reach it.

BURGESS: So, who bears the liability, does the department store owner then who couldn't get the information, are they...

CLARK: That would be subject to the litigation and that's...

BURGESS: Okay. And I realize that's far field. That's not part of the Mullin bill, but it's a question I've had some for some time.

CLARK: But important question, sir.

BURGESS: I need to recognize Mr. Engel for five minutes for questions.

ENGEL: Thank you, Mr. Chairman and Mr. Ranking Member Green.

During our subcommittee's April 12th hearing, I asked Michael Botticelli about HR 3545. Mr. Botticelli is currently the executive director of the Grayken Center for Addiction at Boston Medical Center and served as the director of the Office of National Drug Control Policy. When asked if he had concerns about authoring the protections provided by 42 CFR Part 2, Mr. Botticelli said and I quote, "I do both as a policymaker and as a person in long term recovery." He went on to say, "Unfortunately, substance use disorders are different from other diseases," unquote.

We know that Americans living with substance abuse disorders face stigma and discrimination that people living with other diseases do not and we know that as a result, those Americans might be hesitant to seek what could be remained -- what could be the life-saving treatment for fear of the discrimination that remains pervasive. It's our responsibility to ensure that our actions do not make this problem worse and that's why today's discussion is so important and I thank all the witnesses for being here and for sharing your insights.

Let me ask Ms. Metcalf. I was here before when you gave your testimony. And thank you for sharing your story with us. You note in your testimony that you do regularly encounter medical providers who do not understand the 42 CFR Part 2 protections and mistakenly believe it to be a barrier to care because they do not understand how 42 CFR Part 2 works or the reasons changes made to them, so they work in our 21st Century healthcare environment. That's what you said.

Could you please describe the sorts of questions you typically get from providers about 42 CFR Part 2 and what kinds of misunderstandings have you seen?

METCALF: From what we have heard that's been reported to us, providers, medical providers don't understand the rule changing or the updates to the rules. So, there's a lot of education that's now being done and that SAMHSA is rolling out and we haven't given that enough time, enough chance to educate medical providers or the community to understand how the new rules fit in with the new healthcare system.

ENGEL: So, let me ask you this given what you've said in your testimony. Do you believe better provider education would mitigate the perception that 42 CFR Part 2 creates barriers to care?

METCALF: Yes, greater provider education will help to -- would work to support 42 CFR to protect the patient.

ENGEL: Okay. Let me ask you this and let me ask -- let me ask you this. We've heard that requiring patient consent to disclose their treatment records is problematic because it is argued patients won't do something that could keep them from getting certain substances. Could you respond to that argument?

METCALF: I'm sorry. I didn't understand.

ENGEL: That requiring patient consent before disclosing treatment records is problematic because it's argued patients won't do something that could keep them from getting certain substances. Yes.

METCALF: I mean it may be hard to get consent to share information about previous substance use treatment, but that's a part of that process when they engage in treatment and that's what the counseling -- when they're able to provide that. It's encouraged that they provide that so that they can share that information with their doctors.

ENGEL: Dr. Clark, can I ask you that question, too? I'll repeat it. We've heard that requiring patient consent to disclose their treatment record is problematic because it's argued that patients won't do something that could keep them from getting certain substances.

CLARK: I don't think that's the case. By the time people present to treatment, they've had a number of problems associated in their lives either with family, employment, with housing, with the law and as a result, they -- even if they're ambivalent about treatment, they will be engaged. And it's incumbent upon the professionals to help facilitate that.

You have to keep in consideration that the delivery system is more of a cottage industry delivery system despite the fact that people are trying to commercialize it and as a result, the lack of electronic health information for the delivery -- the substance use disorder delivery system that keeps information being shared rather than the patient not being able to share that information.

ENGEL: Okay. Thank you. My time is up.

Thank you, Mr. Chairman.

BURGESS: The chair thanks the gentleman.

The chair recognizes the gentleman from Florida for five minutes for questions.

BILIRAKIS: Thank you. Thank you, Mr. Chairman. I appreciate it.

First question for Mr. Gardner and Mr. McKee, in your opinion from your own experiences, do you think the legislation we're reviewing today will discourage people from seeking substance use disorder treatment, first Mr. Gardner please.

GARDNER: Thank you for the question, Congressman. I do not believe that it will discourage people from help seeking.

BILIRAKIS: Okay. That's so important.

Mr. McKee?

MCKEE: I do not think that it will discourage people from seeking treatment. I think that there are a number of factors that motivate people to move towards treatment. And if they truly are in the phase for action, confidentiality is not necessarily something that's going to keep them from getting the treatment that they want.

BILIRAKIS: Okay, very good. I agree.

Again, for both of you, could patients in an SUD treatment today be referred to a primary care physician who is unable to view the patient's diagnosis due to 42 CFR Part 2 and be unknowingly prescribed opioids? Mr. Gardner?

GARDNER: Is it possible...

BILIRAKIS: Under the current law.

GARDNER: You're referred by the SUD provider to a primary without consent.

BILIRAKIS: Yes. So, in other words -- well, so, the primary care doctor would prescribe the opioid not knowing that this person may have a substance abuse issue and you see what I'm getting at?

GARDNER: I think so. Yes. That is definitely possible. Yes.

BILIRAKIS: And we're trying to prevent that from happening with this legislation. Alright, sir, can you answer that question please?

MCKEE: Excuse me. Congressman, yes, in the case of my brother, the orthopedist did not have the luxury of a substance use counselor or psychiatrist in order to build rapport to move them through pre-contemplation, contemplation preparation and action stages that are associated with addiction. They had to give him after care.

There wasn't time to wait. And they gave a loaded gun to a person who is suicidal. You're giving opiates to an addict.

BILIRAKIS: Yes.

MCKEE: And there was no time for him to build that rapport in order to get that consent.

BILIRAKIS: Right. Okay.

BURGESS: Will the gentleman yield on that?

BILIRAKIS: Yes, please.

BURGESS: And just, Mr. McKee, a further observation in the way things have evolved, now, if you're not even being discharged from the hospital by the orthopedist, it's a hospitalist who probably has never seen you before and that's an unfortunate derivation of when you're brother was injured. But current practice says, the orthopedist in fact would delegate care to the hospitalist who would be in charge of the post hospital care.

MCKEE: Thank you for that clarification and that just underscores the need for better care coordination which requires some transparency under the protections of HIPAA law.

BURGESS: Thanks. Thank you.

MCKEE: Thank you.

BILIRAKIS: So, next question for Mr. DeLoss, the VA has sorted out its system for gathering a patient's consent to share their full health record across providers and the benefits administration for filing claims.

They've established this system where the VA can sense the consent form is valid for 12 months and if protocols are followed, the entire record can be shared. This aligns much more closely with HIPAA than current practices for nonveterans. In your opinion, are veterans suffering from this policy? Now, I happen to be the vice chairman of the Veterans Committee. So, I'm familiar with this. So, in your opinion, are veterans suffering from this policy if you're familiar with the VA?

CLARK: I'm not very familiar with the veterans system. But with respect to having additional information to treat the veteran, I would assume that yes, they would be treated much better.

BILIRAKIS: Okay. Okay. So, do you know if we have seen disproportionately fewer veterans seeking treatment as a result of this policy?

CLARK: I am not familiar.

BILIRAKIS: You're not as familiar.

Anyone else want to answer that question that's familiar with the VA, with this system?

GARDNER: I'm familiar with the VA I've spent 14 years in addiction practice in the VA working with PTSD and other conditions. And the fact of the matter is clearly it's better off if there's more information being shared. I won't argue with that at all.

So, with the VA establishing working relationships, because the VA has had EHR issues in the past establishing relationships with external entities sharing that information, but the receiving entity and the VA if you're going to use electronic health record has to be interoperable and I can tell you interoperability continues to be a problem. So, often, the record is not read because maybe the hospitalist hasn't had time to read it, my mother was just in the hospital and she went from a skilled nursing facility to the same system. They hadn't read the records.

So, we need to be careful about these panaceas of assuming things that will happen that in practice actually don't happen. But, if you've got inoperability, you've got a working relationship, you can enhance the care possibly with the veterans okay because the patient doesn't show up if the system is seen as hostile.

BILIRAKIS: Yes. And in this case, we get the veteran's consent. So, if it works like it should work, then, I think that it's in the best interests of the veteran.

Thank you very much and I yield back, doctor.

BURGESS: The chair thanks the gentleman. The gentleman yields back.

I do want to thank our panelists. Seeing no further members who wish to ask questions, we really do owe you a debt of gratitude for being here today and being with us for so long. There you have it. We're going to have a vote on the floor. So, we finished right on the nick of time.

I have a lengthy list of statements in support of the Mullin bill that I would like to submit for the record, the Kennedy Forum, Magellan Health, Health Care Leadership Council, United States Department of Health in Human Services, Substance Abuse and Mental Administration, America's Essential Hospital, American Society of Addiction Medicine, National Association of State Mental Health Program Directors, the American Association on Health Disability, National Alliance on Mental Illness, the American Hospital Association, the Academy of Managed Care Pharmacy, Avera, OCHIN, Pharmaceutical Care Management Association, Shatterproof, Trinity Health, Association for Behavioral Health and Wellness, Mental Health America, the National Association of Medicaid Directors, Oregon Association of Hospitals and Health Systems, American Health Information Management Association, Blue Cross Blue Shield Association, Association for Community Affiliated Plans, Hazelden Betty Ford, Centerstone, Premier Health Care Alliance, Catholic Health Association, Information Management, College of Health Care Information Management Executives, Partnership to Amend Part 2, Confidentiality Coalition, House of Representative Relief Initiative, Port Gamble Tribe, American Psychiatric Association, America's Health Insurance Plans, National Association of Accountable Care Organizations, and a joint statement from the National Association of ACOs, Premier, and the American Medical Group Association.

Additionally, Mr. Green had asked unanimous consent for the following letters expressing opposition to HR 3545 be in the record. This includes the National Advocates for Pregnant Women, the National Association for Children of Addiction, Opioid Treatment Association of Rhode Island, Rengel Premed Center, Victory Clinical Services, Recovery Network of Programs, S.C. Association for the Treatment of Opioid Dependence, Northern Parkway Treatment Services Incorporated, BHL Services, Serenity Health, Kentucky

Mental Health Coalition, President of the Kentucky Association for the Treatment of Opioid Dependence, People Advocating Recovery, Long Island Recovery Association, Faces and Voices of Recovery, Pennsylvania Recovery Organizations Alliance, Campaign to Protect Part 2, National Council on Alcoholism and Drug Dependence of the San Fernando Valley, Opioid Treatment Providers of Georgia, Mid-Michigan Recovery Services, Southwest Carolina Treatment Center, Futures Without Violence, Sally Carr , parents of a son with addiction and representative of Never Surrender Hope, Lauren Wiggs , National Independent of Family Recovery Advocate, National Association for Children of Addiction, Shamey E. Seacrest , Addiction Educator, Randy Flood, Recovery Coach, Recovery Coaching Services.

Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask witnesses to submit their responses within 10 business days upon receiving those questions. Without objection, the subcommittee stands adjourned.

END

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