Mr. DEAL of Georgia. Mr. Speaker, I would simply urge my colleagues to support this legislation.

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

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and pass the Senate bill, S. 45.

The question was taken.

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

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

The yeas and nays were ordered.

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

## NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING ACT OF 2005

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1132) to provide for the establishment of a controlled substance monitoring program in each State, as amended.

The Clerk read as follows:

H.R. 1132

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''National All Schedules Prescription Electronic Reporting Act of 2005''.

**SEC. 2. PURPOSE.**

It is the purpose of this Act to—

(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and

(2) establish, based on the experiences of existing State controlled substance monitoring programs, a set of best practices to guide the establishment of new State programs and the improvement of existing programs.

**SEC. 3. CONTROLLED SUBSTANCE MONITORING PROGRAM.**

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding after section 399N the following:

**''SEC. 399O. CONTROLLED SUBSTANCE MONITORING PROGRAM.**

''(a) GRANTS.—

''(1) IN GENERAL.—Each fiscal year, the Secretary shall award a grant to each State with an application approved under this section to enable the State—

''(A) to establish and implement a State controlled substance monitoring program; or

''(B) to make improvements to an existing State controlled substance monitoring program.

''(2) DETERMINATION OF AMOUNT.—

''(A) MINIMUM AMOUNT.—In making payments under a grant under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an amount that equals 1.0 percent of the amount appropriated to carry out this section for that fiscal year.

''(B) ADDITIONAL AMOUNTS.—In making payments under a grant under paragraph (1) for a fiscal year, the Secretary shall allocate to each State with an application approved under this section an additional amount which bears the same ratio to the amount appropriated to carry out this section for that fiscal year and remaining after amounts are made available under subparagraph (A) as the number of pharmacies of the State bears to the number of pharmacies of all States with applications approved under this section (as determined by the Secretary), except that the Secretary may adjust the amount allocated to a State under this subparagraph after taking into consideration the budget cost estimate for the State's controlled substance monitoring program.

''(3) TERM OF GRANTS.—Grants awarded under this section shall be obligated in the year in which funds are allotted.

''(b) DEVELOPMENT OF MINIMUM REQUIREMENTS.—Prior to awarding a grant under this section, and not later than 6 months after the date on which funds are first appropriated to carry out this section, after seeking consultation with States and other interested parties, the Secretary shall, after publishing in the Federal Register proposed minimum requirements and receiving public comments, establish minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).

''(c) APPLICATION APPROVAL PROCESS.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary at such time, in such manner, and containing such assurances and information as the Secretary may reasonably require. Each such application shall include—

''(A) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(A)—

''(i) a budget cost estimate for the controlled substance monitoring program to be implemented under the grant;

''(ii) criteria for security for information handling and for the database maintained by the State under subsection (e) generally including efforts to use appropriate encryption technology or other appropriate technology to protect the security of such information;

''(iii) an agreement to adopt health information interoperability standards, including health vocabulary and messaging standards, that are consistent with any such standards generated or identified by the Secretary or his or her designee;

''(iv) criteria for meeting the uniform electronic format requirement of subsection (h);

''(v) criteria for availability of information and limitation on access to program personnel;

''(vi) criteria for access to the database, and procedures to ensure that information in the database is accurate;

''(vii) criteria for the use and disclosure of information, including a description of the certification process to be applied to requests for information under subsection (f);

''(viii) penalties for the unauthorized use and disclosure of information maintained in the State controlled substance monitoring program in violation of applicable State law or regulation;

''(ix) information on the relevant State laws, policies, and procedures, if any, regarding purging of information from the database; and

''(x) assurances of compliance with all other requirements of this section; or

''(B) with respect to a State that intends to use funds under the grant as provided for in subsection (a)(1)(B)—

''(i) a budget cost estimate for the controlled substance monitoring program to be improved under the grant;

''(ii) a plan for ensuring that the State controlled substance monitoring program is in compliance with the criteria and penalty requirements described in clauses (ii) through (viii) of subparagraph (A);

''(iii) a plan to enable the State controlled substance monitoring program to achieve interoperability with at least one other State controlled substance monitoring program; and

''(iv) assurances of compliance with all other requirements of this section or a statement describing why such compliance is not feasible or is contrary to the best interests of public health in such State.

''(2) STATE LEGISLATION.—As part of an application under paragraph (1), the Secretary shall require a State to demonstrate that the State has enacted legislation or regulations to permit the implementation of the State controlled substance monitoring program and the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained in such program.

''(3) INTEROPERABILITY.—If a State that submits an application under this subsection geographically borders another State that is operating a controlled substance monitoring program under subsection (a)(1) on the date of submission of such application, and such applicant State has not achieved interoperability for purposes of information sharing between its monitoring program and the monitoring program of such border State, such applicant State shall, as part of the plan under paragraph (1)(B)(iii), describe the manner in which the applicant State will achieve interoperability between the monitoring programs of such States.

''(4) APPROVAL.—If a State submits an application in accordance with this subsection, the Secretary shall approve such application.

''(5) RETURN OF FUNDS.—If the Secretary withdraws approval of a State's application under this section, or the State chooses to cease to implement or improve a controlled substance monitoring program under this section, a funding agreement for the receipt of a grant under this section is that the State will return to the Secretary an amount which bears the same ratio to the overall grant as the remaining time period for expending the grant funds bears to the overall time period for expending the grant (as specified by the Secretary at the time of the grant).

''(d) REPORTING REQUIREMENTS.—In implementing or improving a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subsection (a)(1)(B) submit to the Secretary for approval a statement of why such compliance is not feasible or is contrary to the best interests of public health in such State, with the following:

''(1) The State shall require dispensers to report to such State each dispensing in the State of a controlled substance to an ultimate user not later than 1 week after the date of such dispensing.

''(2) The State may exclude from the reporting requirement of this subsection—

''(A) the direct administration of a controlled substance to the body of an ultimate user;

''(B) the dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less; or

''(C) the administration or dispensing of a controlled substance in accordance with any

other exclusion identified by the Secretary for purposes of this paragraph.

''(3) The information to be reported under this subsection with respect to the dispensing of a controlled substance shall include the following:

''(A) Drug Enforcement Administration Registration Number (or other identifying number used in lieu of such Registration Number) of the dispenser.

''(B) Drug Enforcement Administration Registration Number (or other identifying number used in lieu of such Registration Number) and name of the practitioner who prescribed the drug.

''(C) Name, address, and telephone number of the ultimate user or such contact information of the ultimate user as the Secretary determines appropriate.

''(D) Identification of the drug by a national drug code number.

''(E) Quantity dispensed.

''(F) Number of refills ordered.

''(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

''(H) Date of the dispensing.

''(I) Date of origin of the prescription.

''(J) Such other information as may be required by State law to be reported under this subsection.

''(4) The State shall require dispensers to report information under this section in accordance with the electronic format specified by the Secretary under subsection (h), except that the State may waive the requirement of such format with respect to an individual dispenser that is unable to submit such information by electronic means.

''(e) DATABASE.—In implementing or improving a controlled substance monitoring program under this section, a State shall comply with the following:

''(1) The State shall establish and maintain an electronic database containing the information reported to the State under subsection (d).

''(2) The database must be searchable by any field or combination of fields.

''(3) The State shall include reported information in the database in a manner consistent with criteria established by the Secretary, with appropriate safeguards for ensuring the accuracy and completeness of the database.

''(4) The State shall take appropriate security measures to protect the integrity of, and access to, the database.

''(f) USE AND DISCLOSURE OF INFORMATION.—

''(1) IN GENERAL.—Subject to subsection (g), in implementing or improving a controlled substance monitoring program under this section, a State may disclose information from the database established under subsection (e) and, in the case of a request under subparagraph (D), summary statistics of such information, only in response to a request by—

''(A) a practitioner (or the agent thereof) who certifies, under the procedures determined by the State, that the requested information is for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a bona fide current patient;

''(B) any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, who certifies, under the procedures determined by the State, that the requested information is related to an individual investigation or proceeding involving the unlawful diversion or misuse of a schedule II, III, or IV substance, and such information will further the purpose of the investigation or assist in the proceeding;

''(C) the controlled substance monitoring program of another State or group of States with whom the State has established an interoperability agreement;

''(D) any agent of the Department of Health and Human Services, a State medicaid program, a State health department, or the Drug Enforcement Administration who certifies that the requested information is necessary for research to be conducted by such department, program, or administration, respectively, and the intended purpose of the research is related to a function committed to such department, program, or administration by law that is not investigative in nature; or

''(E) an agent of the State agency or entity of another State that is responsible for the establishment and maintenance of that State's controlled substance monitoring program, who certifies that—

''(i) the State has an application approved under this section; and

''(ii) the requested information is for the purpose of implementing the State's controlled substance monitoring program under this section.

''(2) DRUG DIVERSION.—In consultation with practitioners, dispensers, and other relevant and interested stakeholders, a State receiving a grant under subsection (a)—

''(A) shall establish a program to notify practitioners and dispensers of information that will help identify and prevent the unlawful diversion or misuse of controlled substances; and

''(B) may, to the extent permitted under State law, notify the appropriate authorities responsible for carrying out drug diversion investigations if the State determines that information in the database maintained by the State under subsection (e) indicates an unlawful diversion or abuse of a controlled substance.

''(g) LIMITATIONS.—In implementing or improving a controlled substance monitoring program under this section, a State—

''(1) shall limit the information provided pursuant to a valid request under subsection (f)(1) to the minimum necessary to accomplish the intended purpose of the request; and

''(2) shall limit information provided in response to a request under subsection (f)(1)(D) to nonidentifiable information.

''(h) ELECTRONIC FORMAT.—The Secretary shall specify a uniform electronic format for the reporting, sharing, and disclosure of information under this section.

''(i) RULES OF CONSTRUCTION.—

''(1) FUNCTIONS OTHERWISE AUTHORIZED BY LAW.—Nothing in this section shall be construed to restrict the ability of any authority, including any local, State, or Federal law enforcement, narcotics control, licensure, disciplinary, or program authority, to perform functions otherwise authorized by law.

''(2) NO PREEMPTION.—Nothing in this section shall be construed as preempting any State law, except that no such law may relieve any person of a requirement otherwise applicable under this Act.

''(3) ADDITIONAL PRIVACY PROTECTIONS.—Nothing in this section shall be construed as preempting any State from imposing any additional privacy protections.

''(4) FEDERAL PRIVACY REQUIREMENTS.—Nothing in this section shall be construed to supersede any Federal privacy or confidentiality requirement, including the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) and section 543 of the Public Health Service Act.

''(5) NO FEDERAL PRIVATE CAUSE OF ACTION.—Nothing in this section shall be construed to create a Federal private cause of action.

''(j) STUDIES AND REPORTS.—

''(1) IMPLEMENTATION REPORT.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of this section, the Secretary, based on a review of existing State controlled substance monitoring programs and other relevant information, shall determine whether the implementation of such programs has had a substantial negative impact on—

''(i) patient access to treatment, including therapy for pain or controlled substance abuse;

''(ii) pediatric patient access to treatment; or

''(iii) patient enrollment in research or clinical trials in which, following the protocol that has been approved by the relevant institutional review board for the research or clinical trial, the patient has obtained a controlled substance from either the scientific investigator conducting such research or clinical trial or the agent thereof.

''(B) ADDITIONAL CATEGORIES OF EXCLUSION.—If the Secretary determines under subparagraph (A) that a substantial negative impact has been demonstrated with regard to one or more of the categories of patients described in such subparagraph, the Secretary shall identify additional appropriate categories of exclusion from reporting as authorized under subsection (d)(2)(C).

''(2) PROGRESS REPORT.—Not later than 3 years after the date on which funds are first appropriated under this section, the Secretary shall—

''(A) complete a study that—

''(i) determines the progress of States in establishing and implementing controlled substance monitoring programs under this section;

''(ii) provides an analysis of the extent to which the operation of controlled substance monitoring programs have reduced inappropriate use, abuse, or diversion of controlled substances or affected patient access to appropriate pain care in States operating such programs;

''(iii) determines the progress of States in achieving interoperability between controlled substance monitoring programs, including an assessment of technical and legal barriers to such activities and recommendations for addressing these barriers;

''(iv) determines the feasibility of implementing a real-time electronic controlled substance monitoring program, including the costs associated with establishing such a program;

''(v) provides an analysis of the privacy protections in place for the information reported to the controlled substance monitoring program in each State receiving a grant for the establishment or operation of such program, and any recommendations for additional requirements for protection of this information;

''(vi) determines the feasibility of implementing technological alternatives to centralized data storage, such as peer-to-peer file sharing or data pointer systems, in controlled substance monitoring programs and the potential for such alternatives to enhance the privacy and security of individually identifiable data; and

''(vii) evaluates the penalties that States have enacted for the unauthorized use and disclosure of information maintained in the controlled substance monitoring program, and reports on the criteria used by the Secretary to determine whether such penalties qualify as appropriate pursuant to this section; and

''(B) submit a report to the Congress on the results of the study.

''(k) PREFERENCE.—Beginning 3 years after the date on which funds are first appropriated to carry out this section, the Secretary, in awarding any competitive grant that is related to drug abuse (as determined by the Secretary) and for which only States are eligible to apply, shall give preference to any State with an application approved under this section. The Secretary shall have the discretion to apply such preference to States with existing controlled substance monitoring programs that meet minimum requirements under this section or to States that put forth a good faith effort to meet those requirements (as determined by the Secretary).

''(l) ADVISORY COUNCIL.—

''(1) ESTABLISHMENT.—A State may establish an advisory council to assist in the establishment, implementation, or improvement of a controlled substance monitoring program under this section.

''(2) LIMITATION.—A State may not use amounts received under a grant under this section for the operations of an advisory council established under paragraph (1).

''(3) SENSE OF CONGRESS.—It is the sense of the Congress that, in establishing an advisory council under this subsection, a State should consult with appropriate professional boards and other interested parties.

''(m) DEFINITIONS.—For purposes of this section:

''(1) The term 'bona fide patient' means an individual who is a patient of the practitioner involved.

''(2) The term 'controlled substance' means a drug that is included in schedule II, III, or IV of section 202(c) of the Controlled Substance Act.

''(3) The term 'dispense' means to deliver a controlled substance to an ultimate user by, or pursuant to the lawful order of, a practitioner, irrespective of whether the dispenser uses the Internet or other means to effect such delivery.

''(4) The term 'dispenser' means a physician, pharmacist, or other person that dispenses a controlled substance to an ultimate user.

''(5) The term 'interoperability' with respect to a State controlled substance monitoring program means the ability of the program to electronically share reported information, including each of the required report components described in subsection (d), with another State if the information concerns either the dispensing of a controlled substance to an ultimate user who resides in such other State, or the dispensing of a controlled substance prescribed by a practitioner whose principal place of business is located in such other State.

''(6) The term 'nonidentifiable information' means information that does not identify a practitioner, dispenser, or an ultimate user and with respect to which there is no reasonable basis to believe that the information can be used to identify a practitioner, dispenser, or an ultimate user.

''(7) The term 'practitioner' means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he or she practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

''(8) The term 'State' means each of the 50 States and the District of Columbia.

''(9) The term 'ultimate user' means a person who has obtained from a dispenser, and who possesses, a controlled substance for his or her own use, for the use of a member of his or her household, or for the use of an animal owned by him or her or by a member of his or her household.

''(n) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated—

''(1) $15,000,000 for each of fiscal years 2006 and 2007; and

''(2) $10,000,000 for each of fiscal years 2008, 2009, and 2010.''.

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

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

GENERAL LEAVE

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

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

There was no objection.

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

Mr. Speaker, we are facing a growing national health care crisis involving the abuse of prescription drugs. Earlier this month, Columbia University released a report that showed that more Americans are now abusing controlled prescription drugs than cocaine, hallucinogens, inhalants and heroin combined. The report also stated the number of Americans who admit abusing prescription drugs nearly doubled to over 15 million from 1992 to 2003, while abuse among teens has tripled. H.R. 1132 will provide immediate assistance to States to help them reduce prescription drug abuse. The bill will provide new funding to help States establish and operate data systems that will allow physicians to detect and prevent prescription drug abuse.

Physicians are on the front line of providing care to patients and understand the need to stop prescription drug abuse before it starts. H.R. 1132 will provide physicians with the tools they need to learn when their patients attempt to obtain multiple prescriptions for addictive drugs. The bill will also allow physicians to continue to provide proper medication therapy to their patients. This is why groups like the American Medical Association, the American Society of Anesthesiologists, and the American Society of Interventional Pain Physicians all support this legislation.

I would like to thank the gentleman from Kentucky (Mr. WHITFIELD), the gentleman from Georgia (Mr. NORWOOD), the gentleman from New Jersey (Mr. PALLONE), and the gentleman from Ohio (Mr. STRICKLAND), members of the Energy and Commerce Committee, for their efforts on this bill. As a result of their hard work, the bill has been strengthened and improved from last year when the House approved similar legislation by voice vote.

Among the many improvements are requirements that drug monitoring programs meet new standards for the security of information handling, availability of information, limitations on access to the database, and procedures to ensure database accuracy.

I would also like to thank the staff of the Energy and Commerce Committee for their hard work and in particular thank Ryan Long and John Ford for their efforts to negotiate a bipartisan agreement on this bill.

H.R. 1132 will allow States to reduce the improper abuse of prescription drugs and ensure that monitoring programs can communicate with each other to stifle interstate drug diversion. I urge my colleagues to support this needed legislation.

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

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

Prescription pain relievers, stimulants, and other controlled substances play a crucial role in health care; but when misused, these same medicines can be enormously destructive. Some are addictive. Some are life-threatening. Many are both. As these medicines proliferate, so, unfortunately, does the risk of misuse. Over the last decade, use of prescription pain relievers increased by almost 200 percent while the use of stimulants increased by more than 150 percent. An estimated 6.2 million Americans misuse prescription medications for nonmedicinal purposes.

In 1999, a quarter of those taking prescription drugs for nonmedical purposes were new users. In other words, this problem is not just growing, it is exploding. To combat this abuse, physicians and pharmacists need information. This legislation, the culmination of hard work and compromise, as the gentleman from Georgia pointed out, by the gentleman from New Jersey (Mr. PALLONE), the gentleman from Kentucky (Mr. WHITFIELD), the gentleman from Georgia (Mr. NORWOOD) who is here today, and the gentleman from Ohio (Mr. STRICKLAND), will provide the information and coordination necessary to stem the misuse of prescription medicines.

The legislation creates grants to establish State-run programs for prescription monitoring that will be administered and coordinated at the Federal level. Over 20 States currently have such a program in place or are working to develop one. Fighting prescription abuse and preventing nonmedical use is a difficult problem that requires doctors and law enforcement authorities to acquire and share information. For this reason, groups like the American Medical Association and the American Society of Interventional Pain Physicians have lent their endorsement to this bill. I believe this bill is an important step forward in this fight and am pleased to support it.

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

Mr. DEAL of Georgia. Mr. Speaker, I yield 5 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. I thank my friend for yielding me the time.

Mr. Speaker, this is a bill that we have been working hard to get passed for some time now. I would like to begin by really thanking all the people who have helped us get this bill to the floor. The gentleman from Kentucky (Mr. WHITFIELD) and his staff have just done amazing work. A few years ago, I had a bill like this and the gentleman from Kentucky had a bill like this and it shows that we can work together. We merged our bill and came out with a good product today. I do appreciate the efforts of our Democratic cosponsors, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Ohio (Mr. STRICKLAND). I would like to also thank Chairman BARTON and Chairman DEAL and Ranking Members DINGELL and BROWN for recognizing the importance of this issue and helping us move forward.

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Mr. Speaker, prescription drug abuse in this country is a serious problem. I know it. I have seen it. It is a subject with which I have some experience. I experienced it in Vietnam treating wounded soldiers. I experienced it in my dental practice. Some say there is no such thing as doctor-shopping. That is pure nonsense. I have seen it many times in my own life. I have experienced it personally after a car wreck. I feel strongly that we do not do a good enough job in this country to alleviate pain, and morally and ethically we should. But if we do not deal with this misuse of prescription drugs, we are going to have less pain relief than more.

I also know that the drugs that relieve the most severe pain can always, almost always, be the most dangerous. They can create a dependency. They can be diverted by the abusers. We have a responsibility to find ways to fight drug abuse without in any way dampening the ability of doctors to treat their patients in severe pain.

In fact, the abuse and diversion of prescription drugs is a growing public health issue for this Nation, and we need to recognize it and understand it.

From major cities to the smallest rural towns, we have had to deal with the consequences of prescription drug abuse. Prescription drugs now rank second only to marijuana in abuse. Think about that. Over 31 million American adults and adolescents have at one time abused pain relievers. Prescription medications are emerging as the drugs of choice for abuse by America's teenagers. According to a national study released earlier this year, approximately one in five teenagers, that is over 4 million of our sons and daughters, have abused prescription painkillers. Surveys also show that they abuse them because they can, because access is just simply too easy. Mr. Speaker, those numbers are appalling. But there are human faces behind each headline and report of abuse. Their families and their communities suffer along with those who become addicted.

Those who help divert drugs allow these medications to get into the hands of our children as well as adults who have no medical needs. Most physicians have recognized the tremendous benefit State programs in place today are already having, and they have lined up behind our legislation because we could cross State lines.

In an effort to address the problem of prescription drug abuse, 21 States have implemented prescription drug monitoring programs. They are in place today. But in our case, if we have one in Georgia, right across the river in South Carolina we cannot deal with it. In a prescription drug monitoring program, pharmacists are required to provide a standard set of information to a State database when dispensing a controlled substance. The administrator of the State database can then alert appropriate authorities if data indicates abuse or diversion.

A doctor or a pharmacist can check that database to see if a patient could be abusing a prescription drug. Think about it. There are other great consequences from that. The confidentiality of, and access to, the information is protected to the best of our ability, and we think it has been done very well. We have worked very hard on that to try to get privacy rights. H.R. 1132 is a bill that would allow the Secretary of Health and Human Services to fund more of these State-monitoring programs. In exchange for Federal funding, the States agree to set up these programs if they do not have them or, if they do have them, improve the ones they already have.

But there must be some basic Federal standards. Border States must also be able to communicate. This closes a serious loophole in States' current efforts to fight drug abuse. If an abuser can simply cross a State line to avoid detection, the monitoring system cannot work; or if an abuser is doctor-shopping, as I have seen happen, it is very hard to catch him. Through this bill we are encouraging all the States to get on board with a system that works while respecting States' rights and people's privacy.

I ask and encourage all of our colleagues to join us in supporting this very important bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. STUPAK), on the Committee on Energy and Commerce.

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding me this time.

Since 2001, I have been an original cosponsor of the National All Schedules Prescription Electronic Reporting Act, or NASPER, as we call it; and I rise today in strong support of its passage.

I would like to thank the gentleman from Kentucky (Mr. WHITFIELD), the gentleman from New Jersey (Mr. PALLONE), the gentleman from Ohio (Mr. STRICKLAND), the gentleman from Ohio (Mr. BROWN), and the gentleman from Georgia (Mr. NORWOOD) for their leadership on this issue. I would also like to recognize the valuable input of the stakeholders, including the States and physician groups, including the American Society of Interventional Pain Physicians.

The prescription drug abuse problem is growing at an alarming rate. According to a new report by Columbia University, between 1992 and 2003 the number of people abusing controlled prescription drugs jumped 94 percent. Prescription drugs are now the fourth most abused substance in America, behind only marijuana, alcohol, and tobacco.

''Particularly alarming,'' the authors write, ''is the 212 percent increase in the number of 12 to 17 year olds abusing controlled prescription drugs and the increasing number of teens trying these drugs for the first time.''

Today, Congress has taken an important first step towards addressing this huge and growing problem by ensuring that all schedule II, schedule III and schedule IV controlled substances are prescribed safely.

The NASPER Act builds on efforts already under way in many States, including my home State of Michigan, to create electronic monitoring systems. The Government Accounting Office, GAO, found in 2002 that these systems help health care providers ensure that patients are not overprescribed powerful, potentially addictive prescription drugs.

The NASPER Act also addresses the problem of people going to other States to circumvent one State's tracking system. This loophole was also identified by the GAO. The NASPER Act will strengthen the ability of practitioners in other States to contact each other and make sure they are not overprescribing these drugs.

To conclude, Mr. Speaker, this is a good bill. NASPER is more necessary than ever, and now is the time for Congress to pass it and for President Bush to sign it.

Mr. DEAL of Georgia. Mr. Speaker, I yield 5 minutes to the gentleman from Kentucky (Mr. WHITFIELD), who is one of the leaders on the drafting of the House counterpart to this legislation.

Mr. WHITFIELD. Mr. Speaker, I thank the gentleman for yielding me this time to give me an opportunity to speak on behalf of H.R. 1132, the National All Schedules Prescription Electronic Reporting Act of 2005.

Mr. Speaker, the gentleman from Georgia (Chairman DEAL) referred to the study at Columbia University noting the increase in abuse of prescription drugs in this country, and I would point out that one of the most disturbing aspects of the report out of Columbia University was the finding that a 212 percent increase in the number of children between the ages of 12 and 17 are now abusing prescription drugs. So with this legislation today, we have

the opportunity to combat this problem not only with children but also with adults around the country.

I would also mention that, and I think someone has already referred to this, that 20 States are already operating these programs; and with this legislation we establish a grant program at HHS, but more important than that, we provide some Federal standards on this program with this legislation today. In doing that, we will help foster interstate communication by establishing uniform standards on information collection and privacy protections that together will make it easier for States to share information.

I think it is also important to note that the Committee on Appropriations has already been appropriating money for these types of programs. So with this legislation, the Committee on Energy and Commerce, which has exclusive jurisdiction in this area, we now set the guidelines for this, and I think it will do a tremendous job of improving this program and improving our health care program and giving doctors more information to better treat their patients.

I want to thank the gentleman from Texas (Chairman BARTON) for his leadership, the gentleman from Georgia (Chairman DEAL) for his leadership, and, of course, the gentleman from Georgia (Mr. NORWOOD). We have all been working on this program for 3 years. The gentleman from New Jersey (Mr. PALLONE) has been involved in it for 3 years, the gentleman from Ohio (Mr. STRICKLAND), the gentleman from Ohio (Mr. BROWN). So it truly is a bipartisan effort. It is going to do a tremendous job in improving our health care program. And I would urge every Member of Congress to support this important legislation.

And I want to thank particularly Ryan Long, one of the staffers who has worked on this; John Ford of the minority the staff; and my personal staffer John Halliwell; and the many others who were involved, including Warren Burke, who actually wrote the legislation over at the legislative counsel's office.

So after 3 years, I think we are getting ready to move this bill. We know that the Senate is going to take it up in its entirety. And so we look forward to President Bush signing this legislation and improving our health care system.

Mr. BROWN of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. PALLONE), a member of the Health Subcommittee.

Mr. PALLONE. Mr. Speaker, I thank the gentleman from Ohio (Mr. BROWN) for yielding me this time.

I rise in strong support of the National All Schedules Prescription Electronic Reporting Act, or NASPER, legislation which has been mentioned that the gentleman from Kentucky (Mr. WHITFIELD) has introduced, along with myself, the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Ohio (Mr. STRICKLAND).

This critical legislation provides an avenue for addressing the illegal diversion and misuse of prescription drugs. Prescription drug abuse constitutes one of the fastest growing areas of drug abuse in our Nation today, affecting people of all areas of our Nation, all ages, and all income levels.

Health care practitioners and pharmacists desperately need electronic prescription drug monitoring systems to ensure that they are only prescribing and dispensing schedule II, III, and IV controlled substances that are medically necessary. This bill provides the resources to States to create and operate State-based drug monitoring programs, allows physicians to access this information, and allows for States to communicate with one another. NASPER would help physicians prevent their patients from becoming addicted to prescription medications and would help law enforcement with criminal investigations in the illicit prescription drug market.

NASPER legislation represents a work of great bipartisan and bicameral effort, and I want to thank the gentleman from Kentucky (Mr. WHITFIELD), the gentleman from Georgia (Mr. NORWOOD), the gentleman from Ohio (Mr. STRICKLAND), obviously the gentleman from Ohio (Mr. BROWN). And I also want to mention my staff person who is no longer with me, Kathy Kulkarni, but worked very hard on this legislation.

In the other body, Senator SESSIONS, Senator KENNEDY, and Senator DURBIN, all of these people have been willing to move forward with this effort both here in the House, and it will be taken up in the Senate to alleviate the prescription drug abuse problem plaguing our Nation.

In addition, I applaud the tremendous leadership of the American Society for Interventional Pain Physicians for working with Congress in this significant public health initiative.

Mr. Speaker, I hope my colleagues will join me in supporting this critical measure to help our health care providers begin to stem the burgeoning problems of prescription drug abuse.

Mr. MARKEY. Mr. Speaker, I rise to express my strong concerns about the lack of adequate patient privacy protections in H.R. 1132—the National All Schedules Prescription Electronic Reporting, NASPER, Act of 2005. H.R. 1132 is being considered on the House Floor under suspension of the rules; therefore it cannot be amended. Because of the absence of urgently needed patient privacy safeguards, I oppose this bill, and I urge my colleagues to vote no on this legislation.

H.R. 1132 is intended to support States' efforts to prevent the abuse of certain controlled substances through the provision of Federal grants to the States for the purpose of establishing and implementing controlled substance monitoring programs. States would use the grants to develop and maintain an electronic database containing information about the type of medication prescribed, quantity dispensed, number of refills, and similar product information. The database also would collect personal information about each patient receiving prescriptions of the covered controlled substances, such as the patient's name, address and telephone number.

The abuse of controlled substances such as oxycontin and amphetamines is a serious problem that plagues many Americans. In response to the seriousness of the problem of prescription drug abuse, more than 20 States, including Massachusetts, have taken steps to prevent such abuse through the establishment of reporting requirements on pharmacists and the creation of drug monitoring databases similar to those contemplated by H.R. 1132. In Massachusetts, for example, pharmacies are required to report the prescriptions they fill for substances in Schedules I and II to the State's department of Public Health.

The problem is that H.R. 1132 does not provide the safeguards that are required to shield patients—the vast majority of whom will be law-abiding citizens receiving medications as part of a legitimate plan of care—from unauthorized disclosure of their personal medical information. Instead, the legislation provides the States broad leeway to establish databases of patients' private medical records with little guidance on the privacy protections that must be in place in order to quality for the grants.

For example, H.R. 1132 permits disclosure of individually-identifiable patient information in the database to a wide range of professionals in addition to practitioners and law enforcement personnel, including any local, State or Federal ''narcotics control, licensure, disciplinary or program authority'' who can make specific certifications as to the need for access to the information. Any ''agent of another state'' with a monitoring program approved by the bill also could gain access to patient records in the database, provided that the purpose of the access is for ''implementing the state's controlled substance monitoring program.'' Such easy access puts the privacy of potentially hundreds of thousands of law-abiding citizens at risk of unauthorized disclosure.

Additional privacy protections that are missing from H.R. 1132 include: a requirement that States receiving grants under the terms of the bill periodically notify patients whose information in the database has been lost, stolen or used for an unauthorized purpose; a mandate that States inform patients before dispensing medications covered by the bill's reporting requirement that their name, address, and phone number will be stored in a State-run database, potentially in perpetuity, as a result of the dispensing of the medication; and a requirement at the States purge the database of information about any particular prescription after a limited amount of time.

While I strongly support efforts to prevent the abuse of controlled substances, H.R. 1132 does not contain sufficient guidance to the states on the level of privacy protections that they must provide in the creation and maintenance of the databases authorized under the legislation. Since that breach of 145,000 personal records form the databases of data profiler ChoicePoint in February 2005, 50 million records with private information have been leaked from public companies, hospitals, universities and other organizations. During consideration of this legislation in the Energy and Commerce Committee, I offered a reasonable amendment to incorporate a fundamental privacy protection in the bill. My amendment was

supported by the American Conservative Union, the American Psychoanalytic Association, the American Psychiatric Association, the American Association of Practicing Psychiatrists and the Massachusetts Medical Society. While my amendment would have simply required patient notification if their information in these databases were lost, stolen or used for an unauthorized purpose, it was defeated.

Without such fundamental protections for patients, this bill is not worthy of support. This bill—which is opposed by a broad, bipartisan coalition—does not belong on the suspension calendar, where it is not subject to amendment.

I urge my colleagues to oppose H.R. 1132. Send it back to committee, where the needed privacy protections can be added. The important goals of this bill can be accomplished without sacrificing the privacy of law-abiding patients.

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

Mr. DEAL of Georgia. Mr. Speaker, I urge the adoption of this bill, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. FOLEY). The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and pass the bill, H.R. 1132, as amended.

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

A motion to reconsider was laid on the table.

## ENCOURAGING TRANSITIONAL NATIONAL ASSEMBLY OF IRAQ TO ADOPT A CONSTITUTION GRANTING WOMEN EQUAL RIGHTS

Ms. ROS-LEHTINEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 383) encouraging the Transitional National Assembly of Iraq to adopt a constitution that grants women equal rights under the law and to work to protect such rights.

The Clerk read as follows:

H. RES. 383

Whereas the regime of Saddam Hussein in Iraq systematically violated the human rights and fundamental freedoms of the Iraqi people;

Whereas on April 9, 2003, United States and coalition forces brought an end to the regime of Saddam Hussein;

Whereas on June 28, 2004, an Iraqi interim government was sworn in after sovereignty was restored;

Whereas in Iraq's January 2005 parliamentary elections, more than 2,000 women ran for office and currently 31 percent of the seats in Iraq's National Assembly are occupied by women;

Whereas women lead the Iraqi ministries of Displacement and Migration, Telecommunications, Municipalities and Public Works, Environment, Science and Technology, and Women's Affairs;

Whereas United States Government-sponsored programs are helping Iraqi women develop in multiple areas from literacy, computer and vocational training, to human rights education and election training;

Whereas through grants funded by the United States Government's Iraqi Women's Democracy Initiative, nongovernmental organizations are providing training in political leadership, communications, coalition-building skills, voter education, constitution drafting, legal reform, and the legislative process;

Whereas a 275-member Transitional National Assembly, which is charged with the responsibility of drafting a new constitution, was elected to serve as Iraq's national legislature for a transition period.

Whereas Article 12 of Iraq's Transitional Administrative Law states that ''[a]ll Iraqis [are] equal in their rights without regard to gender . . . and they are equal before the law'';

Whereas Article 12 of the Transitional Administrative Law further states that ''[d]iscrimination against an Iraqi citizen on the basis of his gender . . . is prohibited'';

Whereas on May 10, 2005, Iraq's National Assembly appointed a 55-member committee, composed of Assembly members, to begin drafting a permanent constitution for Iraq;

Whereas in visits with legislators and officials of the Government of the United States, Iraqi women have raised perceived limitations on their rights in a current draft of the Iraqi constitution;

Whereas the central principles of a true democracy, ''liberty and justice for all'', ''equal justice under law'', and ''government of the people, by the people and for the people'' apply equally to women;

Whereas, in the words of Supreme Court Justice Sandra Day O'Connor: ''[s]ociety as a whole benefits immeasurably from a climate in which all persons, regardless of race or gender, may have the opportunity to earn respect, responsibility, advancement and remuneration based on ability'';

Whereas the House of Representatives recognizes the commitment and dedication of the United States to ensure that the full rights of women are granted in the Iraqi constitution;

Whereas the House of Representatives recognizes the need to affirm the spirit and free the energies of women in Iraq who have spent countless hours, years, and lifetimes working for the basic human right of equal constitutional protection; and

Whereas the House of Representatives recognizes the risks Iraqi women have faced in working for the future of their country and admire their courageous commitment to democracy: Now, therefore, be it

*Resolved,* That the House of Representatives—

(1) commends United States and coalition forces in liberating the Iraqi people from the repressive regime of Saddam Hussein and their ongoing efforts in support of the freedom and stability of Iraq;

(2) recognizes the progress achieved by the Iraqi people toward the establishment of a representative democratic government;

(3) recognizes the importance of ensuring women in Iraq have equal rights under the law and in society;

(4) recognizes the commitment and dedication of the Administration to ensuring the full rights of women are granted in the Iraqi constitution;

(5) strongly encourages Iraq's Transitional National Assembly to adopt a constitution that grants women equal rights under the law and to work to protect such rights; and

(6) pledges to support the efforts of Iraqi women to fully participate in a democratic Iraq.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Florida (Ms. ROS-LEHTINEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentlewoman from Florida (Ms. ROS-LEHTINEN).

□ 1315

GENERAL LEAVE

Ms. ROS-LEHTINEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this important resolution. It supports the full participation of Iraqi women in the political, in the economic, and in the social life of a free Iraq on the path to democratic governance.

Today Iraq stands in stark contrast to Iraq under Saddam Hussein. While Saddam Hussein's brutal regime indiscriminately slaughtered Iraqis, the women were among the most vulnerable. The notorious Fedayeen beheaded women in public, dumping their severed heads at their families' footsteps. The regime used widespread rape to extract confessions from the detainees. Saddam Hussein's legacy of terror knew no boundaries.

In assessing the progress achieved and the U.S. contributions to the empowerment of Iraqi women, I look to leaders such as Dr. Khuzai, who served as a member of the Iraqi Governing Council and the National Council on Women. After being prisoners in their own country for 35 years, Dr. Khuzai said, ''For the Iraqi women, the morale is so high that you can't even understand it unless you go and see. We will be grateful forever.''

I was fortunate, Mr. Speaker, to have the opportunity to visit Iraq as part of an historic all-female congressional delegation. We met with women from all sectors and all educational backgrounds, and the message we heard from all of these women was very clear, that they want a say, they want a role, they want to participate, and they want us to help them get there.

To achieve this end, the U.S. is helping Iraqi women reintegrate themselves into Iraqi society and to the outside world. The administration embarked on the Iraqi Women's Democracy Initiative to train Iraqi women in the skills and practices of democratic public life. It also established the U.S. Iraqi Women's Network, helping to mobilize the private sector in the United States and to link important resources here to critical needs on the ground.

The administration continues to provide assistance and sponsors programs that help Iraqi women develop in multiple areas, from literacy programs and vocational training to human rights education and election training.