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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
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MEMORANDUM

September 19, 2016

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Markup of H.R. 2566 Improving Rural Call Quality and Reliability Act of 2015; H.R. 2669, Anti-Spoofing Act of 2015; H.R. 1192, National Diabetes Clinical Care Commission Act; H.R. 1209, Improving Access to Maternity Care Act; H.R. 1877, Mental Health First Aid Act of 2015; H.R. 2713, Title VIII Nursing Workforce Reauthorization Act of 2015; H.R. 3537, Synthetic Drug Control Act of 2015, and H.R. 4365, Protecting Patient Access to Emergency Medications Act of 2016

On **Tuesday, September 20, 2016, at 5:00 p.m. in room 2322 of the Rayburn House Office Building**, the Committee on Energy and Commerce will conduct opening statements for the full committee markup of H.R. 2566, Improving Rural Call Quality and Reliability Act of 2015; H.R. 2669, Anti-Spoofing Act of 2015; H.R. 1192, National Diabetes Clinical Care Commission Act; H.R. 1209, Improving Access to Maternity Care Act; H.R. 1877, Mental Health First Aid Act of 2015; H.R. 2713, Title VIII Nursing Workforce Reauthorization Act of 2015; H.R. 3537, Synthetic Drug Control Act of 2015; and, H.R. 4365, Protecting Patient Access to Emergency Medications Act of 2016. The committee will reconvene on **Wednesday, September 21, at 10:00 a.m. in HVC-210** to consider the legislation**.**

I. H.R. 2566, IMPROVING RURAL CALL QUALITY AND RELIABILITY ACT OF 2015

A. Background – Rural Call Quality and Reliability

Several years ago, the Federal Communications Commission (FCC) recognized that customers were having significant problems with telephone calls not going through to rural areas. Customers reported false busy signals, calls not arriving at their destination, or long

periods of dead air on the calling party's end after dialing a number.[1] Because consumers do not know how the calls they make and receive are handled and carried over these networks, they are often inclined to blame their local telephone company for dropped calls and call quality problems.

Long distance and wireless carriers typically pay local phone companies when they need to connect a call to the local company's customers. To minimize how much they have to pay to connect these calls, long distance and wireless carriers can contract with a third party provider to handle the call.[2] This is called "least cost routing."[3] The companies that facilitate least cost routing are called "intermediate providers."[4] Intermediate providers often use complicated routes that minimize their own expenses.[5] Unfortunately, these complicated routes can result in dropped or poor quality calls as they are passed around from one carrier to another.

B. Summary of H.R. 2566

H.R. 2566, the Improving Rural Quality and Reliability Act of 2015, is a bipartisan bill that would require intermediate providers to register their companies with the FCC and to comply with service quality standards to be set by the FCC. The bill is supported by the National Association of Regulatory Utility Commissioners, NTCA-The Rural Broadband Association, and WTA-Advocates for Rural Broadband.

C. Hearing and Subcommittee Markup

A legislative hearing on H.R. 2566 was held by the Subcommittee on Communications and Technology on September 8, 2016. The bill was considered at a subcommittee markup held on September 12 and 13, 2016, along with H.R. 2669, which is described and discussed below in Section II.

At the subcommittee markup, Rep. Walden (D-OR) offered an Amendment in the Nature of a Substitute (AINS) to the bill to (1) extend the deadline for the FCC to set service quality standards for intermediate providers from 180 days to one year; (2) exempt intermediate providers that have been certified as safe harbor providers under the FCC's rules; and (3) amend

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[1] Federal Communications Commission, *Rural Call Completion*, Report and Order and Further Notice of Proposed Rulemaking, WC Docket No. 13-139 (Rel. Nov. 8, 2013) (apps.fcc.gov/edocs_public/attachmatch/FCC-13-135A1.pdf).

[2] Federal Communications Commission, *Rural Call Completion: Problems with Long distance or Wireless Calling to Rural Area* (fcc.gov/general/rural-call-completion-problems-long-distance-or-wireless-calling-rural-areas)(accessed Aug. 30, 2016).

[3] Ohio Public Utilities Commission, *Rural Call Completion Issues* (www.puco.ohio.gov/puco/index.cfm/be-informed/consumer-topics/rural-call-completion-issues/#sthash.mmZGKOHQ.dpbs) (accessed Aug. 30, 2016).

[4] 47 C.F.R. § 64.1600(f).

[5] *See* Note 3.

the definition of "intermediate provider" to ensure that non-intermediate providers are not covered under the bill. The AINS was adopted by voice vote and the amended bill was favorably forwarded to the full committee.

II. H.R. 2669, THE ANTI-SPOOFING ACT OF 2015

A. Summary of H.R. 2669

Rep. Meng (D-NY) introduced H.R. 2669 on June 4, 2015. The bill would expand an inaccurate and fraudulent caller identification prohibition in the Communications Act of 1934 to cover calling parties outside the United States, include certain text messages in caller identification related definitions, provide a new definition for "text message", and expand the categories of IP-enabled voice services that are subject to the above-referenced prohibition. The bill is identical to the language that passed the House under suspension in the 113th Congress.

B. Hearing and Subcommittee Markup

A legislative hearing on H.R. 2669 was held by the Subcommittee on Communications and Technology on January 8, 2016. A copy of the minority memorandum for that hearing may be accessed here.

H.R. 2669 was considered at a subcommittee markup held on September 12 and 13, 2016, along with H.R. 2566, which is described and discussed immediately above in Section I. At the subcommittee markup, the bill was favorably forwarded to the full committee by voice vote.

III. H.R. 1192, NATIONAL CLINICAL CARE COMMISSION ACT

A. Summary of H.R. 1192

Rep. Olson (R-TX) introduced H.R. 1192 on March 2, 2015. The bill would create the National Diabetes Clinical Care Commission to improve the clinical care for individuals with diabetes and associated conditions. The commission would be composed of governmental and nongovernmental members and would be charged with improving federal efforts related to the prevention and treatment of those conditions. The commission would sunset in three years.

B. Subcommittee Markup

H.R. 1192 was considered at a Subcommittee on Health markup on September 12 and 13, 2016. At that markup, an AINS was offered by Rep. Pitts (R-PA) and adopted by voice vote. Among other things, the AINS would substitute the Secretary of Health and Human Services (HHS) for the Comptroller General as the appointing authority of commission members; add safety net providers as an additional category from which commission members are appointed; and eliminate the allowance for HHS appropriations to be redirected to the commission.

IV. H.R. 1209, IMPROVING ACCESS TO MATERNITY CARE ACT

A. Summary of H.R. 1209

Reps. Burgess (R-TX), Capps (D-CA), and Duckworth (D-IL) introduced H.R. 1209 on March 3, 2015. The goal of this legislation is to expand access to maternity care services by better identifying areas with maternity care shortage. The legislation would create a new Health Professional Shortage Area (HPSA) designation to specifically designate communities that have a shortage of maternity care providers.

B. Full Committee Markup

No amendments were offered to H.R. 1209 at the September 12th and 13th subcommittee markup. The legislation was favorably forwarded to the full committee by a voice vote.

At full committee markup, an AINS to H.R. 1209 will be considered. The AINS would amend the legislation to require the Secretary of HHS to identify maternity health professional target areas within HPSAs that have a shortage of maternity care providers. The Secretary would be required to use this information to place maternity care providers within the National Health Service Corps.

V. H.R. 1877, MENTAL HEALTH FIRST AID ACT OF 2015

A. Summary of H.R. 1877

Reps. Jenkins (R-KS) and Matsui (D-CA) introduced H.R. 1877 on April 16, 2015. The bill would authorize grants for mental health first aid training programs. The purpose of those programs is to train certain categories of individuals on the safe de-escalation of crisis situations, recognition of the signs and symptoms of mental illness, and the timely referral to mental health services in the early stages of developing mental disorders. An AINS was adopted at the subcommittee markup that would amend an authorized mental illness awareness training grant program to be consistent with the mental health first aid training program requirements included in the introduced version of H.R. 1877. H.R. 1877 would authorize appropriations of $14,963,000 for each of fiscal years 2017 through 2021.

VI. H.R. 2713, TITLE VIII NURSING WORKFORCE REAUTHORIZATION ACT OF 2015

A. Summary of H.R. 2713

H.R. 2713 was introduced by Reps. Capps (D-CA) and Joyce (R-OH) on June 10, 2015. This legislation would reauthorize Title VIII nursing workforce programs through 2020. H.R. 2713 would also make technical changes to the statute to reflect advancements in the field of nursing. The legislation would add the definition of nurse-managed health clinic to the Title VIII statute.

The legislation would further amend the Advanced Education Nursing Grants and the National Advisory Council on Nurse Education and Practice to include clinical nurse specialists. Additionally, the legislation would amend the Advanced Education Nursing Grants program to include clinical nurse leaders.

VII. H.R. 3537, SYNTHETIC DRUG CONTROL ACT OF 2015

A. Background – Legal Classifications of Synthetic Drugs

The particular synthetic drugs that are the target of the legislation are chemically modified versions of existing Schedule I drugs, modified to escape control by the Drug Enforcement Agency (DEA) while still retaining or enhancing their potential for abuse. For example, some are designed to mimic or enhance the effects of drugs such as marijuana, cocaine, or methamphetamine. The effects and potential dangers of these substances are not well known. Use of synthetic drugs is reportedly on the rise, leading some to call on Congress to legislatively schedule specific substances. In June 2012, Congress passed the Synthetic Drug Control Act of 2011, to among other things, schedule selected synthetic stimulants and other synthetic substances. Criticisms have been raised about scheduling substances legislatively, with some arguing that the current formal scheduling process is too laborious to schedule synthetic drugs, which chemists can manipulate and modify relatively quickly. Concerns have also been raised by stakeholders, including pharmaceutical companies and the research community, about the difficulty of conducting research on substances that are listed on Schedule I, and including the list of substances outlined in the legislation on Schedule I could preclude scientific or medical research into these substances.

B. Summary of H.R. 3537

H.R. 3537 was introduced by Reps. Dent (R-PA), Himes (D-CT), Holmes Norton (D-DC), and Jolly (R-FL) on September 17, 2015. This legislation would add a list of 316 synthetic drugs identified by DEA to Schedule I of the Controlled Substances Act (CSA), broken out into nine different classes including cannabinoids and opioids. The legislation would also make any compound that is chemically or pharmacologically similar to a controlled substance in Schedule I or II of the CSA to be legally treated as though it was listed in that same schedule.

Currently, under the Controlled Substances Analogue Enforcement Act (the Analogue Act), substances must be substantially similar in chemical structure and pharmacologically similar to be considered as listed in Schedule I or II. The legislation would also narrow the Analogue Act so that it would only apply to the manufacture, importation, distribution, and sale of drugs, not possession. These changes are intended to assist with the prosecution of synthetic drug manufacturers and distributors and inhibit its use in the prosecution of people who are simply users of the drugs.

C. Full Committee Markup

At a November 4, 2015 markup, the Subcommittee on Health favorably forwarded H.R. 3537 to the full committee by a voice vote. An AINS will be offered at the full committee

markup to narrow the list of Schedule I synthetic substances to 22 substances, including 11 cannabimimetic agents used to create synthetic marijuana and three derivatives of fentanyl, a synthetic opioid.

VIII. H.R. 4365, PROTECTING PATIENT ACCESS TO EMERGENCY MEDICATIONS ACT OF 2016

A. Background – Emergency Medical Service Administration of Controlled Substances During Medical Emergencies

It is the current practice of emergency medical service (EMS) personnel to administer necessary drugs during a medical emergency under a standing order. A standing order is a protocol issued by an EMS medical director that details how and when EMS professionals can administer or dispense a controlled substance to a patient during time-sensitive emergency situations without first seeking approval of the EMS medical director.

In 2011, in response to a question from a Kentucky paramedic, DEA issued a letter stating that, per the requirements of the CSA (21 U.S.C. § 801 et seq.)[6] and its implementing regulations, for the administration or dispensing of a controlled substance to be valid, EMS personnel must have a patient- and issue-specific order from the EMS medical director.[7] Therefore, dispensing a controlled substance under a standing order is not valid. Currently, DEA is not enforcing this interpretation of the CSA.

B. Summary of H.R. 4365

Reps. Hudson (R-NC), Butterfield (D-NC), and others introduced H.R. 4365 on January 12, 2016. H.R. 4365 would provide for a streamlined emergency medical services registration process to allow for a single registration for a state EMS agency, rather than requiring registration by each EMS medical director or each EMS agency location. To help safeguard against diversion, the bill would hold EMS agencies responsible for delivering, storing, and tracking controlled substances.

C. Subcommittee Markup

At the September 12th and 13th Health Subcommittee markup, Rep. Butterfield (D-NC) offered an AINS to the bill, which made technical changes in the bill to clarify the bill's requirements, ensure the bill's consistency with the CSA, limit disruptions to state EMS agencies, and ensure DEA has necessary information to conduct oversight. The AINS amends

[6] Enacted in 1970, the Controlled Substances Act outlines federal policy relating to the manufacture, importation, possession, use, and distribution of several categories of drugs (referred to as "scheduled" drugs in the Act).

[7] Letter from John W. Partridge, Chief, Liason and Policy Section, Office of Diversion Control, Drug Enforcement Administration, to Jeremy R. Urekew, Paramedic, Anchorage Fire & Ambulance Districts (Dec. 19, 2011).

the CSA to clarify that EMS personnel can administer controlled substances under a standing order from an EMS medical director who oversees emergency care, effectively codifying current practice across the United States and helping ensure that patients have ready access to important, and often life-saving, drugs during times of crisis.

After considering the AINS, the Subcommittee on Health favorably forwarded H.R. 4365, as amended, to the full committee by a voice vote.

D. Full Committee Markup

At the full committee markup, an AINS to H.R. 4365 will be considered. The AINS would substitute language forwarded out of the subcommittee markup to clarify requirements under the Act, ensure consistency with the CSA, limit disruptions to state EMS agencies, and ensure DEA has necessary information to conduct oversight. More specifically, these changes in the AINS include the following:

- Refining statutory definitions to better harmonize with the CSA and reflect current EMS agency best practices.
- Making clear that EMS professionals may administer controlled substances pursuant to a verbal order given by either a medical director or an authorizing medical professional, to the extent it is authorized by the law of the state in which the administration occurs.
- Clarifying that controlled substances may be stored in a secured EMS vehicle or in an EMS vehicle that is in active use.