April 19, 2018

The Honorable Lamar Alexander
Chairman
Senate Health, Education, Labor, and Pensions Committee
428 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Senate Health, Education, Labor, and Pensions Committee
428 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

Re: Opioid Crisis Response Act of 2018

Dear Senator Alexander and Senator Murray,

On behalf of the American Society of Addiction Medicine (ASAM), the nation’s oldest and largest medical specialty society representing professionals who specialize in the prevention and treatment of addiction, and now with more than 5,000 physician and allied health professional members, I am writing to offer legislative comments and recommendations on S. 2680, the Opioid Crisis Response Act of 2018.

The cost of substance misuse, and untreated and ineffectively treated addiction in the United States is staggering, both in economic terms and in terms of human lives lost. During the twelve-month period ending January 2017, the Centers for Disease Control and Prevention (CDC) estimates there were approximately 64,000 drug overdose deaths.1 Recently, the White House Council of Economic Advisers announced that the cost of the opioid crisis, alone, approached $504 billion in 2015.2 And while opioid-related overdose deaths may dominate national headlines, the associated costs are a fraction of the total societal cost of substance misuse and addiction. Each year unhealthy drinking leads to approximately 88,000 deaths in America.3 Cigarette smoking contributes to another 480,000.4 These costs, however, could be dramatically reduced by utilizing evidence-based substance misuse prevention practices and programs and by addressing untreated, and ineffectively treated, addiction in this country.
Given these alarming statistics, we appreciate your leadership in the development of the *Opioid Crisis Response Act*, which is intended to address our country’s opioid misuse, addiction, and overdose epidemic. Turning the tide on the current crisis and preventing future crises related to substance misuse and addiction require a new approach to the delivery of substance use prevention, addiction treatment, and recovery support services. Considering all the lives we have lost and all the lives we still risk losing, the time for transformational change is now. Thus, ASAM respectfully offers these comments on the *Opioid Crisis Response Act*, with a focus on areas that we feel uniquely qualified to comment based on our expertise in addiction medicine.

**Reauthorization and Improvement of State Targeted Response Grants (Section 101)**

ASAM believes recipients of federal grants, loans and other funds for mental health or substance use disorder prevention or treatment programs should use evidence-based practices. We also support research and the development of new and innovative treatments for substance use disorder that will contribute to the body of knowledge that is needed for emergent or innovative programs and activities to become evidence-based.

We propose that one improvement to the State Targeted Response Grants program would be to require that grantees use evidence-based standards, consistent with the *Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse (RESULTS) Act* (H.R. 5272). The RESULTs Act would require grant, loan, and other recipients of funds from the Department of Health and Human Services (HHS) for a mental health or substance use disorder prevention or treatment program to use evidence-based practices.

There are many misconceptions about the disease of addiction, and we need a culture change in this country to drive patients to the treatment options that have been proven to be effective at reducing relapse and overdose deaths and supporting patients in remission and recovery. When it comes to addiction involving opioid use, the most effective treatment options involve the use of medications in combination with specific, psychosocial interventions to support remission and recovery and involve a certified addiction medicine specialist in the patient's care. When we say, “Treatment works,” we are not referring to every approach that claims to be treatment. Rather, as physicians and other clinicians who specialize in the treatment of addiction, we are specifically referring to those interventions that have scientific evidence to support their effectiveness.

The RESULTS Act would raise the clinical standard to a level that we demand from all other forms of medicine—the use clinical methods and practices based on evidence—and we support including that goal as part of the *Opioid Crisis Response Act*.

**Advancing Cutting-Edge (ACE) Research (Section 201)**

The ACE Research Act would facilitate additional research into treatments for public health epidemics such as the opioid addiction crisis by providing the National Institutes of Health (NIH) with new tools and flexibility to approve high-impact, cutting-edge research. A robust and varied array of treatment options should be available to patients with addiction and chronic pain as no one treatment modality is appropriate or therapeutic for everyone. We support research and the development of non-addictive pain treatment options and additional therapies to treat addiction. These new treatments could not only help save lives but help prevent addiction from taking hold in the first place. ASAM supports the ACE Research Act and its inclusion in the *Opioid Crisis Response Act*. 
Clarifying FDA Regulation of Non-Addictive Pain Products (Section 301)
While this Section 301 heading refers to non-addictive pain products, the actual text of Section 301 also refers to “non-addictive” medical products intended to treat addiction. ASAM has concerns that the use of the term “non-addictive” with respect to medical products intended to treat addiction could be stigmatizing of effective, opioid agonist and partial agonist medications currently used in the treatment of addiction involving opioid use and could contribute to the confusion between physical dependence and addiction. ASAM respectfully requests that such terminology not be used when describing medical products intended to treat addiction.

Opioid Packaging and Safe Disposal Systems (Section 302)
This section would help to limit excessive pharmaceutical opioid supplies by giving the Food and Drug Administration (FDA) the authority to require drug manufacturers to package certain opioids in blister packs and thereby allow for a set dose. The provision would also encourage manufacturers to provide a safe way to dispose of any leftover medication with the packaging.

ASAM supports a comprehensive response to the opioid misuse, addiction, and overdose epidemic and, as part of that response, welcomes new and innovative methods for limiting the excessive availability of opioids for misuse. We support the inclusion of this provision in the Opioid Crisis Response Act.

First Responder Training (Section 305)
This section would authorize funds primarily to make naloxone and related training available to first responders. While we know state and local governments would certainly welcome federal assistance for naloxone training and distribution, given the increasing cost of naloxone in this country, we urge you to consider including policy interventions which would allow the federal government to bulk purchase naloxone at discounted prices to increase access to this life-saving medication. The Vaccines for Children Program may be an existing model Congress could rapidly replicate to increase naloxone access for first responders, public health departments, and community organizations. A promising naloxone distribution program is described in Section 3435 of the Comprehensive Addiction Resources Emergency Act of 2018, recently introduced by Senator Elizabeth Warren and Representative Elijah Cummings. Such types of programs, coupled with investments aimed at enhancing the CDC surveillance capabilities for identifying overdose clusters and infectious disease outbreaks, could go a long way in preventing the spread of infectious diseases and death.

Delivery of a Controlled Substance by a Pharmacy to be Administered by Injection or Implantation (Section 308)
Foremost to ASAM’s mission is a goal to increase access to and improve the quality of addiction treatment. The introduction and use of novel addiction medications supports this goal. Addiction patients, like all patients, should have available to them a robust and varied array of treatment options, as no one treatment modality is appropriate or therapeutic for everyone. The recent approval of implantable and injectable buprenorphine formulations expands treatment options for patients. No product will be suitable for all patients, and many will still be best-served by oral formulations, other medications, or no medication at all, but they may help improve treatment adherence and reduce diversion among certain patients for whom they are
indicated. However, these options are only valuable if patients can access them. These changes to the Controlled Substances Act would facilitate access to these new products by allowing them to be delivered to administering practitioners on a patient-by-patient basis rather than requiring the practitioners anticipate demand, buy the medication in advance, store it on site, and hope they estimated the correct number of doses needed to meet demand and avoid waste. This is not a new pathway for medication delivery but would allow for these controlled substances to be delivered as many non-controlled substances are already. It is a technical, common-sense fix to the law that will expand treatment access while potentially reducing the buprenorphine diversion, and ASAM supports the inclusion of this provision in the Opioid Crisis Response Act.

The Comprehensive Opioid Recovery Centers (Section 401)
This section would authorize competitive grants for entities to establish or operate Comprehensive Opioid Recovery Centers (CORCs). Such grants would accomplish the two-fold objective of increasing access to treatment and ensuring that the treatment is comprehensive by offering a full continuum of clinical, vocational, and educational services to meet the needs of patients. In addition, the grants would prioritize entities in a state or Indian country with high per capita drug overdose mortality rates, so the resources are focused in areas that need it most.

We also support that the discussion draft gives priority for grants to entities utilizing technology-enabled collaborative learning and capacity building models as defined in the Expanding Capacity for Health Outcomes Act (PL 114-270).

ASAM supports the inclusion of Comprehensive Opioid Recovery Centers in the Opioid Crisis Response Act and believes CORCs will make great strides in increasing access to comprehensive treatment.

Program to Support Coordination and Continuation of Care for Drug Overdose Patients (Section 402)
With the rise in the use of potent synthetic opioids such as fentanyl and carfentanil, the rates of opioid overdoses and emergency department visits due to opioid overdose have increased significantly. Data from CDC’s Enhanced State Opioid Overdose Surveillance (ESOOS) program showed opioid overdose rates increased an average of 35% in the 16 states reporting from July 2016 through September 2017. Eight states reported substantial increases (25% or greater) in opioid overdose emergency department visits.6

People who are admitted to a hospital for a drug overdose and discharged without treatment are at elevated risk to relapse and overdose again. This section would work to prevent that from happening by authorizing the HHS Secretary to issue best practices for emergency treatment of a known or suspected drug overdose, coordination and continuation of care and treatment after an overdose, and provision of overdose reversal medication, as appropriate. It would also authorize a grant program for education on overdose prevention, the establishment or implementation of policies and procedure to treat and support recovery for individuals who have experienced a non-fatal overdose, and the use of recovery coaches to support recovery.

Addiction is a chronic brain disease and evidence shows that treatment is effective at achieving and sustaining remission and recovery. Continuity of care and hand-offs to appropriate
community-based providers is essential so that opportunities for life-saving interventions are not lost. It is past due that we stop discharging patients from emergency rooms without arranging for definitive treatment services for their addiction. We urge the inclusion of this provision in the Opioid Crisis Response Act.

**Medication Assisted Treatment (Section 405)**

To make a meaningful and sustainable impact on the current opioid misuse, addiction, and overdose epidemic, it is imperative that we build a robust treatment workforce. There are simply too few physicians and other clinicians with the requisite knowledge to meet the needs of the millions of Americans suffering from untreated substance use disorder.

However, we respectfully ask that the language in the *Addiction Treatment Access Improvement Act (S. 2317/HR 3692)* (as introduced (or the substitute amendment under consideration by the House Energy and Commerce Committee)) be included in the Opioid Crisis Response Act. As introduced, such replacement language would eliminate the sunset date for nurse practitioners’ (NPs) and physician assistants’ (PAs) prescribing authority for buprenorphine. We also support the inclusion of the language from the *Addiction Treatment Access Improvement Act* because:

1. It codifies the Final Rule issued by HHS in July 2016 that raised the DATA 2000 patient limit for only certain physicians to 275 patients. Eligible practitioners who want to increase their patient limit to 275 patients must certify that they meet several important safety and quality standards, which include:
   a. Adhering to nationally recognized evidence-based guidelines for treating patients with opioid use disorder
   b. Providing patients with necessary behavioral health services either directly or through a formal agreement with another entity
   c. Providing appropriate releases of information in accordance with federal and state laws and regulations to permit coordination of care with behavioral health, medical, and other practitioners
   d. Using patient data to inform improvement of outcomes
   e. Adhering to a diversion control plan to reduce the possibility of diversion of buprenorphine
   f. Having considered how to ensure continuous access in the event of an emergency situation
   g. Notifying all patients above the 100-patient limit that they will no longer be able to provide Medication-Assisted Treatment (MAT) services using buprenorphine in the event that their request for the higher patient limit is not renewed or the renewal request is denied, and will also make every effort to transfer patients to other treatment providers

2. It expands the definition of ‘qualifying practitioner’ to include nurse anesthetists, clinical nurse specialists, and nurse midwives.
It is essential that we expand the addiction treatment workforce while ensuring the provision of high-quality evidence-based treatment. We urge the Committee to incorporate the language from *Addiction Treatment Access Improvement Act* into the *Opioid Crisis Response Act*.

**Youth Prevention and Recovery (Section 408)**

ASAM supports ensuring youth, adolescents and young adults have access to a comprehensive array of services that include prevention, treatment and recovery. We support the inclusion of this provision to authorize grants to eligible entities for carrying out evidence-based and promising programs in the areas of prevention, recovery supports and treatment in the *Opioid Crisis Response Act*.

We also respectfully request that provisions from the *Youth Opioid Use Treatment (YOUTH) Act (S. 2055/HR 3382)* be incorporated into *The Opioid Crisis Response Act* to ensure adolescents and young adults have access to medication-assisted treatment (MAT). Specifically, the YOUTH Act would reauthorize grants to provide substance use disorder treatment services to children, adolescents and young adults and establish a demonstration program to expand access to MAT for opioid addiction among adolescents and young adults. Additionally, the bill would require the Comptroller General to conduct an important study on how federal agencies are addressing substance use disorder prevention, treatment and recovery among adolescents and young adults.

Sadly, adolescents and youth are not immune from the opioid misuse, addiction, and overdose epidemic and the National Survey on Drug Use and Health estimates 276,000 adolescents aged 12 to 17 were current nonmedical users of prescription pain medications in 2015. The same year, 5,000 adolescents were current users of heroin and 21,000 reported heroin use in the past year. Life-saving treatment options must be made available to our nation’s adolescents and young adults. We urge the inclusion of the YOUTH Act in the Opioid Crisis Response Act.

**Regulations Relating to Special Registration for Telemedicine (Section 410)**

As stated in testimony on behalf of ASAM before the House Energy and Commerce Subcommittee on Health, telemedicine provides significant opportunities to reach more patients in urban and rural communities. However, the current restrictions on internet prescribing under the Ryan Haight Act and the seven, specific “practice of telemedicine” exceptions it provides are of limited utility for expanding access to treatment with buprenorphine for opioid use disorders via telemedicine. As you know, the Ryan Haight Act generally requires an “in-person medical evaluation” in the physical presence of the prescribing clinician for the prescription to be considered valid.

The “practice of telemedicine” exceptions to this requirement provide for circumstances in which the patient is being treated by, and physically located in, a DEA-registered hospital or clinic, or in which the patient is being treated by and in the physical presence of another DEA-registered practitioner. It generally does not allow for circumstances in which a patient may have received a medical evaluation by another qualified practitioner but is not physically present in a DEA-registered hospital or clinic or with another DEA-registered practitioner. While *The ASAM’s Standards of Care* and *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* make it clear that patients presenting for treatment of addiction involving opioid use should receive a physical examination by a qualified and appropriately licensed healthcare professional as part of a
comprehensive assessment process, they specifically allow for this examination to be conducted by a healthcare professional other than the prescriber, as long as the prescriber “ensure[s] that a current physical examination is contained within the patient medical record before a patient is started on a new medication for the treatment of his/her addiction.”

ASAM appreciates the inclusion of this provision requiring the DEA to promulgate regulations relating to special registration for telemedicine and offers two additional recommendations:

1. *The Opioid Crisis Response Act* should include a provision to revise the Ryan Haight Act to include an additional exception to the requirement for an in-person physical exam by the prescribing clinician to allow for a current physical exam to be conducted by another appropriately licensed healthcare professional and documented in the patient’s medical record.

2. This exception should be limited to the in-person physical exam requirement for patients who will be treated with buprenorphine for opioid addiction to only those physicians who hold “additional certification” or who practice in a “qualified practice setting” per the definitions in the aforementioned 2016 SAMSHA rule that raised the DATA-2000 prescribing limit.

**Loan Repayment for Substance Use Disorder Treatment Providers (Section 412)**

This provision would allow masters level, licensed substance use disorder treatment counselors to receive loan repayment for practicing in underserved areas through the National Health Service Corps.

We are concerned that, as currently written, addiction medicine physicians may not be eligible for loan repayment. We respectfully ask addiction medicine specialists explicitly be included in the definition of “behavioral and mental health professionals” within the National Health Service Corps and that the provisions from the *Substance Use Disorder Workforce Loan Repayment Act (S 2524/HR 5102)* be incorporated into the *Opioid Crisis Response Act* to help clinicians who pursue full-time substance use disorder treatment jobs in high-need geographic areas repay their student loans. We support incentivizing clinicians to work in substance use disorder treatment programs to grow the addiction medicine workforce, particularly in these high-need areas.

**Study on Prescribing Limits (Section 501)**

ASAM supports studying the impact of federal and state laws and regulations that limit the length, quantity or dosage of opioid prescriptions. We also recommend that such a report review such limits in the context of evidence-based guidelines such as the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.

**Program for Education and Training in Pain Care (Section 502)**

ASAM supports increased education and training on both substance use disorder and pain and has recommended for years that medical, nursing, dental, pharmacy and other clinical schools increase curriculum time devoted to addiction screening and treatment, safe prescribing and pain management. From this perspective, we make the following recommendations for additional provisions to be included in the *Opioid Crisis Response Act*. 
1. **Incorporate the Enhancing Access to Addiction Treatment Act of 2018**

We recommend that Senator Hassan’s recently introduced bill, the *Enhancing Access to Addiction Treatment Act of 2018*, be incorporated into *The Opioid Crisis Response Act*. As proposed by Senator Hassan, this bill would create a new, voluntary training pathway for physicians to receive a waiver to treat patients with opioid addiction with evidence-based medications and would establish a new grant program to support accredited schools of allopathic medicine or osteopathic medicine that develop curricula on pain management and addiction which meet the requirements of said legislation.

By establishing this additional pathway to obtain a DATA waiver, not only will physicians be able to satisfy the waiver training requirement by taking approved courses during medical school, but the number of graduates who will enter the practice of medicine with an educational background that includes pain management and addiction medicine will be increased.

2. **Incorporate the Treatment, Education, and Community Help to Combat Addiction Act of 2018 (H.R. 5261)**

ASAM also recommends adding *The Treatment, Education and Community Help to Combat Addiction Act of 2018* to *The Opioid Crisis Response Act*. This legislation would amend the Public Health Service Act to provide for regional centers of excellence to enhance and improve how health professionals are educated in pain management and substance use disorder through development, evaluation, and distribution of evidence-based curriculum for health care professional schools.

ASAM supports the goals of these bills and their efforts to address the opioid misuse, addiction, and overdose epidemic by expanding a physician workforce that is knowledgeable about pain and addiction and hopes they will be incorporated into the *Opioid Crisis Response Act*.

**Education and Awareness Campaigns (Section 503)**

ASAM supports the inclusion of a public and provider education campaign conducted by the CDC to raise awareness regarding the risk of misuse and abuse of opioids; we particularly support that such a campaign would focus on disseminating and improving the use of evidence-based prescribing guidelines.

We believe that a sophisticated and robust national prevention strategy is in dire need. We recommend that this public awareness campaign also educate the public and health care providers about addiction as a chronic brain disease that can be effectively treated with evidence-based interventions. Public education should include information about the types of treatment options that have been shown to be effective, such as medications for opioid addiction, so that patients and families know how to identify quality treatment services. Only the federal government has the capacity and reach to raise public awareness effectively. We saw this in the 1980’s with the CDC’s America Responds to AIDS public information campaign (1987), and the distribution of Understanding AIDS (1988), a brochure that was delivered to every residential mailing address in the United States. Opioid overdose deaths have surpassed deaths at the height of the AIDS crisis, yet we have not seen similar efforts to educate the public about the disease of addiction or the treatment they should seek.
Preventing Overdoses of Controlled Substances (Section 505)

ASAM believes that prescription drug monitoring programs (PDMPs) are an important tool to inform safe prescribing. From 2014 to 2016, there was a 121 percent increase in the number of queries by health professionals to state PDMP databases. As a result, we applaud encouraging states to share PDMP data with one another by providing grants that will enable real time updates and enhance interoperability between the program and any health information technology, including integrating the program into such technology, among other purposes.

Integrating PDMPs into Electronic Health Records (EHRs) and clinician workflow in a meaningful, user-friendly manner is critical to improving utility. While PDMPs now exist in almost every state and practitioners are increasing their use of them, the lack of integration with electronic health records continues to inhibit the effective use of these clinical support tools.

Further, in addition to improving and integrating these programs, ASAM recommends that Congress urge HHS to support the development of training for primary care providers to know how to engage a patient whose PDMP report indicates he or she may be inappropriately accessing controlled substances. Without such training, many clinicians might simply dismiss patients from their practice without an assessment for substance use disorder or referral to treatment, if indicated. These clinicians are missing an important opportunity to engage patients in treatment and should be equipped to use the PDMP report as a conversation-starter with patients at risk of addiction or overdose death.

Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records (Section 509)

The federal regulations governing the confidentiality of drug and alcohol treatment and prevention records, 42 CFR Part 2 (Part 2), set requirements limiting the use and disclosure of patients’ substance use records from certain substance use treatment programs. Obtaining multiple consents from the patient is challenging and creates barriers to whole-person, integrated approaches to care, which are part of our current health care framework. Part 2 regulations may lead to a physician treating a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has a substance use disorder. Separation of a patient’s addiction record from the rest of that person’s medical record creates several problems and hinders patients from receiving safe, effective, high-quality substance use treatment and coordinated care.

The advent of integrated health systems and electronic medical records has improved the safety, quality, and coordination of care for patients with any other health condition. Part 2 requirements prevent patients with addiction from sharing in these benefits, even though electronic exchanges of other health information are governed by strict privacy and security standards set by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

ASAM supports Section 508 and the development of model training programs on how to protect and appropriately disclose confidential substance use disorder medical records. However, Part 2 currently presents barriers to coordinated, safe, and high-quality medical care, and those barriers can lead to significant patient harm; we urge the Committee to make thoughtful changes to the law to mitigate such harms while protecting patients’ privacy. Thus,
we support changes that would align Part 2 with HIPAA’s consent requirements for the purposes of treatment, payment, and healthcare operations. Such a change would allow for the sharing of patients’ addiction treatment records within the healthcare system under HIPAA’s well-established and modern privacy and security protections, while leaving in place Part 2’s prohibition on disclosure of records outside the healthcare system. Moreover, we also welcome changes that would strengthen protections against the use of addiction treatment records in criminal proceedings, a further improvement to Part 2 that we see as essential to protect patients in treatment for substance use disorder.

We urge the inclusion of H.R.3545, the Opioid Prevention and Patient Safety Act in the Opioid Crisis Response Act.

Additional Recommendations:

Incorporate New Federal Incentives to Promote High-Quality Addiction Treatment into The Opioid Crisis Response Act

On March 8, 2018, the Senate HELP Committee held a hearing titled “The Opioid Crisis: Leadership and Innovation in the States.” Hearing participants discussed recommendations from Governors across the U.S. expressed at the National Governors Association annual winter meeting. Toward the conclusion of that hearing, Chairman Alexander highlighted the problem of an “unevenness” in addiction treatment program quality across the country.

We know well that as the field of addiction treatment works to integrate more fully with traditional medical care, it is imperative that it “catch up” with other medical specialties in terms of clinical guideline development and quality measurement. Federal efforts to promote high-quality addiction treatment could include support for the following:

- Development and dissemination of model standards for the regulation of substance use disorder treatment services by the HHS Secretary in consultation with ASAM and incentivizing States to adopt those model standards, as further described in the Comprehensive Addiction Resources Emergency Act of 2018;

- Use of certain federal funding streams to reward States that have a Medicaid IMD waiver in effect or have applied for such a waiver, as part of a State’s efforts to ensure that a comprehensive continuum of care based on nationally-recognized, evidence-based patient placement criteria is available to individuals with a substance use disorder, similar to the proposal in the Comprehensive Addiction Resources Emergency Act of 2018;

- Development and dissemination of clinical practice guidelines for addiction treatment, such as the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use and of science-based patient guides, such as the Opioid Addiction Treatment: A Guide for Patients, Families and Friends, that include information on assessment, treatment overview (including treatment plans, patient
participation, and counseling), and all the medications available to treatment opioid use and overdose;

- Establishment and maintenance of addiction treatment programs that ensure intake and ongoing evaluations meet the clinical needs of patients by offering assessments for all substance use disorder services and level of care recommendations through an independent, research-validated verification process for reviewing patient placement in addiction treatment settings; and

- Implementation of, and related technical assistance for, nationally-recognized treatment center certification programs that can provide patients, families, and payers with a reliable indicator that providers are delivering a certain level of care and can enhance provider competencies to deliver substance use disorder services with fidelity to industry standard models such as The ASAM Criteria.

Efforts such as these are critically needed to help improve the overall quality of addiction treatment provided in our nation and assure those who are seeking and paying for treatment that they are receiving medically appropriate and high-quality care.

**Add the Behavioral Health Coverage Transparency Act of 2018 (S. 2301/H.R. 4778 ) to the Opioid Crisis Response Act**

This legislation would ensure greater oversight and transparency in parity implementation. ASAM was a part of the broader public health community that championed the passage of the Mental Health Parity and Addiction Equity Act of 2008, which secured strong federal rules for ensuring addiction and mental health treatment benefits are covered at parity with other health benefits. Since the law was passed in 2008, ASAM has been advocating for full implementation and enforcement of the law to end health insurance discrimination for mental health and addiction coverage.

Strengthening parity protections for people with addiction will have a long-term, positive impact on increasing access to quality addiction treatment and ultimately improved public health. The Behavioral Health Coverage Transparency Act details a thoughtful and actionable approach that supports this outcome. We urge the inclusion of the **S. 2301/H.R. 4778, the Behavioral Health Coverage Transparency Act** in the **Opioid Crisis Response Act**.
Conclusion
Thank you for the opportunity to make recommendations and offer additional tools that may be helpful to combat this public health emergency. We thank you again for the work thus far to develop the Opioid Crisis Response Act and we look forward to working with you as the legislative process moves forward. If you have any questions or concerns, please contact Kelly Corredor, ASAM’s Director of Advocacy and Government Relations, at kcorredor@asam.org or at 301-547-4111.

Sincerely,

Kelly J. Clark, MD, MBA, DFASAM
President, American Society of Addiction Medicine

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