Congressional Research Service
Informing the legislative debate since 1914

TESTIMONY

Statement of

Lisa N. Sacco
Analyst in Illicit Drugs and Crime Policy

Before

Joint Economic Committee
U.S. Joint Committee

Hearing on

"Economic Aspects of the Opioid Crisis"

June 8, 2017

Congressional Research Service
https://crsreports.congress.gov
TE10017

Overview

Chairman Tiberi, Vice-Chairman Lee, Ranking Member Heinrich, and distinguished Members of the Committee, my name is Lisa Sacco, and I am a CRS analyst on crime and drug policy. Thank you very much for inviting me to speak with you. My testimony will focus on the supply of heroin and other opioids in the United States.

Heroin, fentanyl, and controlled prescription drugs have been ranked as the most significant drug threats to the United States.[1] While the reported availability of controlled prescription drugs has declined over the last several years, the reported availability of heroin has increased substantially. Further, there has been a rise in the availability of illicit fentanyl pressed into counterfeit prescription opioid pills.[2] The availability of these drugs contributes to rising consumption.[3]

The supply of heroin and other opioids varies by region of the United States. More than 60% of National Drug Threat Survey (NDTS) respondents in the Northeast, Midwest, and Mid-Atlantic reported high availability of heroin in their areas while just over 20% of respondents in the Southwest and Southeast reported high availability.[4] Availability can vary within regions as well. For example, in 2015, the Drug Enforcement Administration (DEA) Field Division in Dallas reported high availability of controlled prescription drugs, while El Paso and Houston reported only moderate availability.[5]

Historically, the federal government has concentrated on reducing the supply of illicit drugs, but in recent years, efforts for drug treatment and prevention have increased.[6]

Brief History of Opioid Supply in the United States, 1990s-2017

Opioids have been available in the United States since the 1800s, but the market for these drugs shifted significantly beginning in the 1990s. This testimony focuses on this latter period (see **Figure 1**).

[1] Drug Enforcement Administration, *2016 National Drug Threat Assessment Summary*, November 2016.

[2] Executive Office of the President, Office of National Drug Control Policy, *National Drug Control Budget*, May 2017, p. 19.

[3] National Institute on Drug Abuse, *Prescription Drugs and Heroin*, December 2015, p. 4.

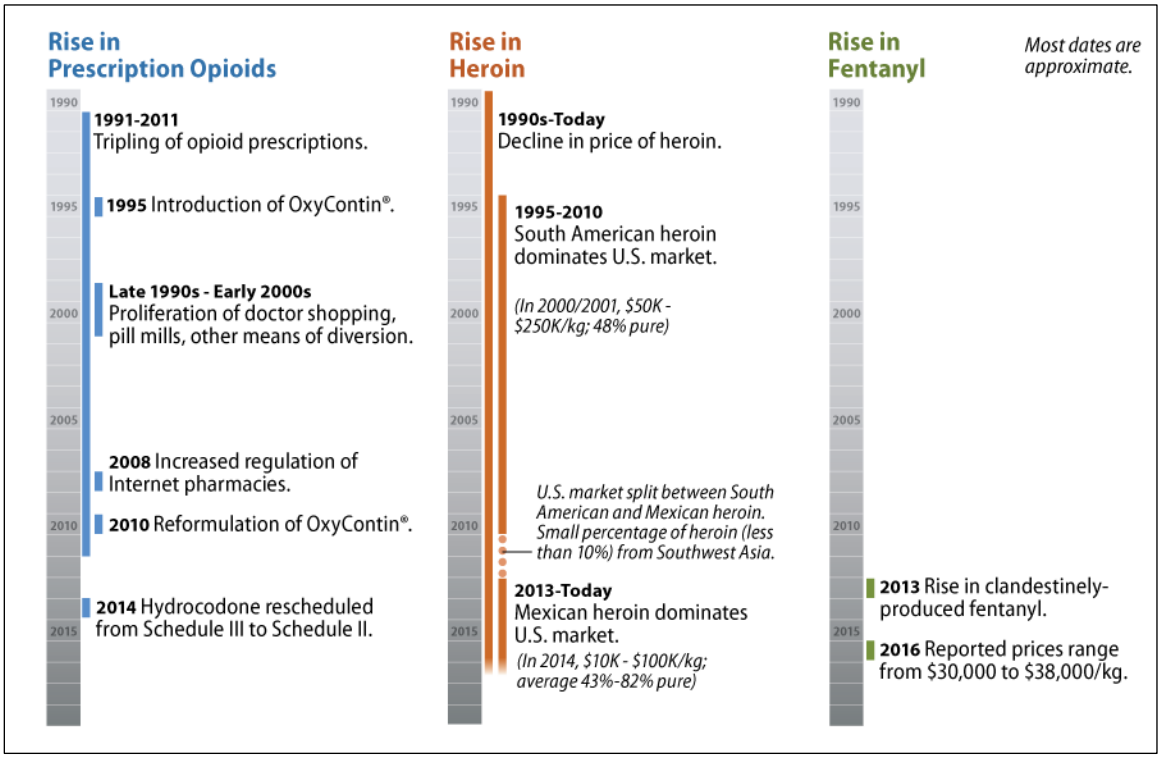
[4] Drug Enforcement Administration, *2016 National Drug Threat Assessment Summary*, November 2016.

[5] Ibid., p. 26. Controlled prescription drugs include opioids, amphetamines, and other controlled substances.

[6] Executive Office of the President, Office of National Drug Control Policy, *National Drug Control Budget*, May 2017.

Figure 1. Timeline of Opioid Supply

1990s - Today



Source: U.S. Drug Enforcement Administration, National Institute on Drug Abuse, and National Drug Intelligence Center.

Notes: See text of testimony for further detail.

Prescription Drug Supply

In the 1990s, the availability of prescription opioids, including opioids such as hydrocodone and oxycodone, increased as the legitimate production of these drugs and diversion increased sharply.[7] This continued into the early 2000s as abusers attained their prescription drugs through "doctor shopping," bad-acting physicians,[8] pill mills, the Internet, pharmaceutical theft, prescription fraud, and through family and friends.

Government Response to Proliferation of Prescription Drugs

The federal government and state and local governments undertook a range of approaches to reduce the unlawful prescription drug supply and abuse: diversion control through prescription drug monitoring

[7] National Drug Intelligence Center, *National Drug Threat Assessment 2005*, February 2005.

[8] One such doctor was David Procter who established a pill mill operation from 1992 through 2001 in South Shore, Kentucky. He is viewed as the "godfather of pills." See "How Heroin Made its Way From Rural Mexico to Small-Town America," *NPR*, May 19, 2015.

programs,[9] a crackdown on pill mills, the increased regulation of Internet pharmacies in 2008,[10] the reformulation of OxyContin® (oxycodone hydrochloride controlled-release) in 2010,[11] and the rescheduling of hydrocodone in 2014.[12]

Some experts have highlighted the connection between the crackdown on the unlawful supply of prescription drugs and the subsequent rise in heroin supply and abuse. Heroin is a cheaper alternative to prescription drugs that is often more accessible to some who are seeking an opioid high. While most users of prescription drugs will not go on to use heroin, accessibility and price are central factors cited by patients with opioid dependence in their decision to turn to heroin.[13]

Heroin Supply

The trajectory of the heroin supply over the last several decades is much different compared to prescription opioids, but the stories of their supply are connected.[14] In the late 1990s and early 2000s, white powder heroin produced in South America dominated the market east of the Mississippi River, and black tar and brown powder heroin produced in Mexico dominated the market west of the Mississippi.[15] Most of the heroin destined for the United States at that time came from South America, while smaller percentages were from Mexico and Southwest Asia.

Price and purity varied considerably by region. The average retail-level purity of South American heroin was around 46%, which was considerably higher than that of Mexican, Southeast Asian, or Southwest Asian heroin. At that time, Mexican heroin was around 27% pure, while Southeast and Southwest Asian

---

[9] For more information on prescription drug monitoring programs, see CRS Report R42593, *Prescription Drug Monitoring Programs*, by Lisa N. Sacco, Erin Bagalman, and Kristin Finklea.

[10] In response to the problem of rogue Internet websites that illegally sell and dispense controlled prescription drugs, Congress passed the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (P.L. 110-425) which amended the Controlled Substances Act to expressly regulate online pharmacies. For more information, see CRS Report R43559, *Prescription Drug Abuse*, by Erin Bagalman et al.

[11] The Food and Drug Administration (FDA) approved the reformulation of OxyContin® to make it harder to crush and abuse. The FDA also required a label warning of its addictive quality.

[12] On August 22, 2014, the Drug Enforcement Administration published a final rule in the Federal Register that administratively reschedules hydrocodone combination products from Schedule III to Schedule II, which subjects anyone who manufactures, distributes, or dispenses hydrocodone combination products to the more stringent regulatory requirements and administrative, civil, and criminal sanctions that are applicable to Schedule II controlled substances. For more information on these actions, see CRS Report R43559, *Prescription Drug Abuse*, by Erin Bagalman et al.

[13] National Institute on Drug Abuse, *Prescription Drugs and Heroin*, December 2015; Pradip K. Muhuri, Joseph C. Gfroerer, and M. Christine Davies, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, August 2013, http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf; Theodore J. Cicero, Matthew S. Ellis, and Hilary L. Surratt, "Effect of Abuse-Deterrent Formulation of Oxycontin," *New England Journal of Medicine*, vol. 367, no. 2 (July 12, 2012), pp. 187-189; U.S. Department of Justice, National Drug Intelligence Center, *National Drug Threat Assessment 2003*, "Narcotics", January 2003; and U.S. Department of Justice, National Drug Intelligence Center, National Drug Threat Assessment 2011, August 2011, p. 37.

[14] National Institute on Drug Abuse, *Prescription Drugs and Heroin*, December 2015, pp. 4-5.

[15] Heroin has several different forms including black tar, brown powder, and white powder. For more information, see Drug Enforcement Administration, *Drugs of Abuse, 2015 Edition*, p. 38.

heroin were around 24 and 30% pure respectively.[16] Prices for heroin fell dramatically in the 1990s—heroin prices were 55 to 65% lower in 1999 than prices in 1989.[17]

Over the last several years, heroin prices have further declined while purity, in particular the purity of Mexican heroin, has increased. The availability of Mexican heroin has also grown. Over 90% of the heroin seized now is from Mexico and a much smaller portion is from South America. Mexico dominates the U.S. heroin market because of its proximity to the U.S. and its established transportation and distribution infrastructure, which improves traffickers' ability to satisfy U.S. heroin demand. Increases in Mexican heroin production have ensured a reliable supply of low-cost heroin, even as demand for these drugs has increased. Mexican traffickers have particularly increased their production of white powder heroin and may be targeting those who abuse prescription opioids.[18]

Fentanyl Supply

Compounding the current opioid problem is the rise of non-pharmaceutical fentanyl on the black market. Diverted pharmaceutical fentanyl represents only a small portion of the fentanyl market. Non-pharmaceutical fentanyl largely comes from China, and it is often mixed with or sold as heroin. It is 50 to 100 times more potent than heroin, and over the last two years, reported prices ranged between $30,000 and $38,000 per kilogram. The increased potency of synthetic fentanyl compounds, such as the recently emerged, so-called "gray death,"[19] are extremely dangerous, and law enforcement expect that the fentanyl market will continue to expand in the future as new fentanyl products attract additional users.[20]

Supply of Opioids Across the United States

The supply of opioids varies by region of the United States. In 2016, approximately 45% of National Drug Threat Survey respondents reported heroin as the greatest drug threat in their area. In contrast, 8% of respondents reported heroin as the greatest threat in 2007. Reports of heroin as the greatest threat are concentrated in the Northeast, Midwest, and Mid-Atlantic regions.[21]

Opioids are the main cause of drug overdose deaths. Reports indicate that increases in overdose deaths are most likely driven by illicitly manufactured fentanyl and heroin. [22] The increasing availability of heroin throughout the United States largely, but not entirely, corresponds to high drug overdose deaths (see **Figure 2**). For example, New Mexico and Utah rank 8th and 9th, respectively, in the country in drug overdose deaths, but only 4.7% of NDTS respondents in the Southwest reported heroin as the greatest

[16] National Drug Intelligence Center, *National Drug Threat Assessment 2005*, February 2005.

[17] Executive Office of the President, Office of National Drug Control Policy, *The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003*, November 2004, p. 11.

[18] Drug Enforcement Administration, *2016 National Drug Threat Assessment Summary*, November 2016.

[19] Gray death is a new illicit synthetic opioid mix that is reportedly 10,000 times more powerful than morphine. The ingredients of seized samples have varied.

[20] Drug Enforcement Administration, *2016 National Drug Threat Assessment Summary*, November 2016. Current pricing information provided by the Drug Enforcement Administration.

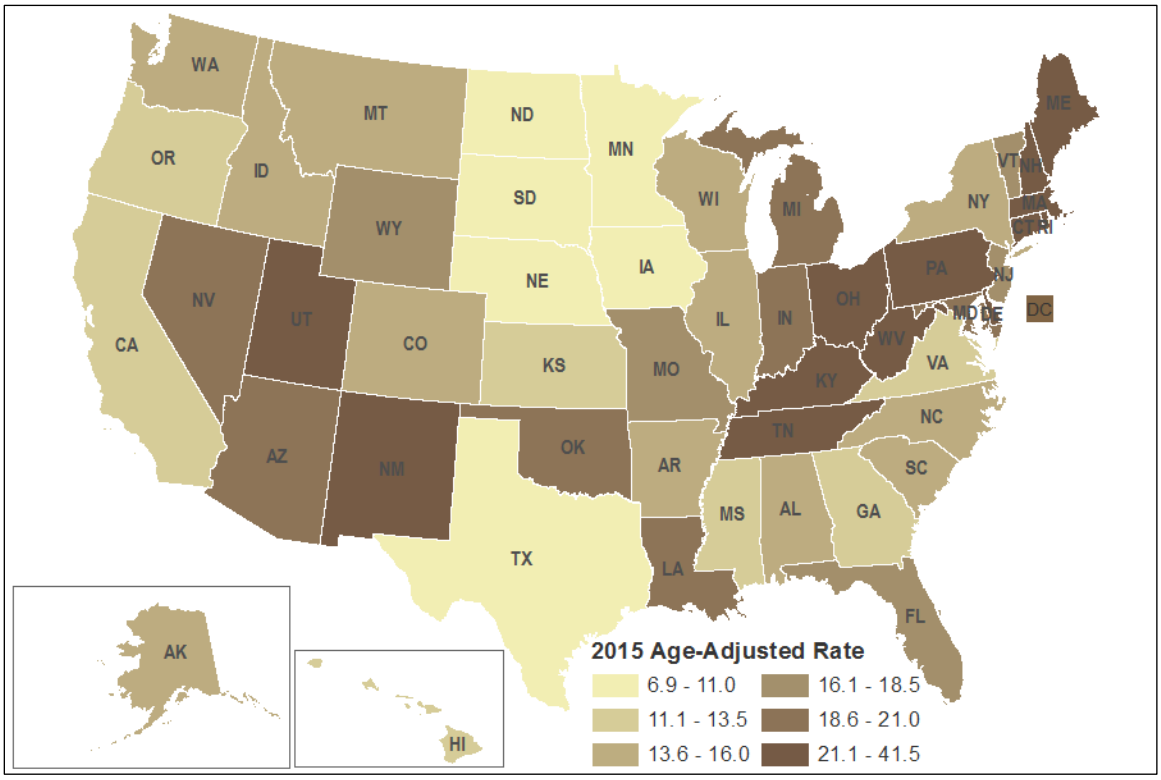
[21] Drug Enforcement Administration, *2016 National Drug Threat Assessment Summary*, November 2016.

[22] Centers for Disease Control and Prevention (CDC), *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*, Morbidity and Mortality Weekly Report, December 30, 2016, https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm.

drug threat and 22.6% reported high availability of heroin in their region.[23] This discrepancy may be explained by a number of factors including the lethality of fentanyl.

Figure 2. Age-Adjusted Rates of Drug Overdose Deaths

United States, 2015



Source: CRS presentation of data from the Centers for Disease Control and Prevention (CDC), *Drug Overdose Death Data*, 2016, https://www.cdc.gov/drugoverdose/data/statedeaths.html.

Notes: CDC calculated age-adjusted death rates as deaths per 100,000 population using the direct method and the 2000 standard U.S. population.

Federal Drug Control Spending and Recent Legislation

Historically, the federal government has concentrated on reducing the supply of illicit drugs, but in recent years, increased efforts have been placed on reducing demand. Federal drug control dollars largely go toward reducing supply, however, federal drug control funding for supply reduction has remained relatively flat over the last several years while funding for drug treatment and prevention has increased (see **Table 1**).

Similarly, over the last year, Congress has enacted comprehensive legislation—for example, the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) and the 21st Century Cures Act (P.L. 114-255)—that promotes prevention, treatment, and law enforcement methods to address the opioid problem.

[23] Ibid., pp. 156 and 158.

Table 1. Federal Drug Control Budget by Function

FY2013-FY017, amounts in billions of dollars

Function	FY2013	FY2014	FY2015	FY2016	FY2017
Treatment	$7.889	$9.482	$9.553	$9.845	$10.580
Prevention	1.275	1.317	1.342	1.486	1.507
Domestic Law Enforcement	8.857	9.349	9.395	9.283	9.299
Interdiction	3.941	3.949	3.961	4.735	4.569
International	1.849	1.637	1.643	1.525	1.521
Total	**$23.811**	**$25.734**	**$25.894**	**$26.874**	**$27.476**
Demand Reduction[a]	9.164	10.799	10.895	11.332	12.088
Percent of Total Drug Control Budget	*38.5%*	*42.0%*	*42.1%*	*42.2%*	*44.0%*
Supply Reduction[b]	14.646	14.934	14.998	15.543	15.389
Percent of Total Drug Control Budget	*61.5%*	*58.0%*	*57.9%*	*57.8%*	*56.0%*

Source: Amounts were taken from Office of National Drug Control Policy, *National Drug Control Budget: FY2018 Funding Highlights*, p. 19. Percentages were calculated by CRS.

Notes: Amounts may not add to total due to rounding.

a. Demand reduction includes treatment and prevention

b. Supply reduction includes domestic law enforcement, interdiction, and international.

Disclaimer