COALITION FOR HORSE RACING INTEGRITY

July 10, 2018

Chairman Bob Latta
Ranking Member Jan Schakowsky
Energy & Commerce Subcommittee on
Digital Commerce and Consumer Protection
2125 Rayburn H.O.B
Washington, DC 20515

Dear Chairman Latta and Ranking Member Schakowsky,

Thank you both for holding the June 22 hearing on H.R. 2651, the Horseracing Integrity Act. We are writing to you today in response to comments made during the hearing to set the record straight on several key assertions made by witnesses.

As supporters of the passage of H.R. 2651, the Horseracing Integrity Act of 2017, we believe that the current state-based system of medication control for racing in America is far from uniform and has resulted in a set of widely different rules and competencies from jurisdiction to jurisdiction. We propose the establishment of a new, federally established comprehensive regime of medication control, operated by a private entity composed of members of the United States Anti-Doping Agency (USADA) and the racing industry. The new entity would greatly improve the standards and practices of testing, including expanding out-of-competition testing, increasing research for the detection of new performance-enhancing drugs, and, by law, ceasing the practice of allowing a drug to be administered to a racehorse on the day that it races.

The testimony provided at the hearing was at times lively, and each of the witnessed brought a relevant perspective on the subject. Not surprisingly, our opponents, choosing to defend the status quo, suggested four main points:

- The current system of state-based medication control is not broken and is in fact better than all other sports, as one witness testified.

- The rules and standards that the states employ in this area are largely similar across all jurisdictions.

- USADA's lack of specific equine anti-doping experience discredits its ability to manage the new entity.

- Continued, pervasive use of the powerful diuretic drug Lasix in horses on the day they race is in the best interests of racing and equine welfare.

We are writing you today to challenge these assertions with rock-solid facts.

The Current System

First, as we testified, the state-based regulations for the narrow area of medication control are grossly inadequate and several levels below those of Olympic and professional sports.

A. The rule-making process is slow.

Subject to the procedures in each state for rule-making, new rules often take several months, and in some jurisdictions, several years from initial proposal to implementation. For example, it took nearly five years for California regulators to approve third-party administration of Lasix. In addition, the West Virginia Senate passed a measure in 2011 that served as a complete overhaul of the state's rules of racing and included safety measures such as required pre-race exams. The updated rules took more than a year to pass.

Keeping a nation of 38 different racing jurisdictions in synch when each is subjected to unique procedures is an impossible objective.

B. The current system relies primarily on outdated, post-race testing and little out-of-competition testing.

Out-of-competition testing (OOCT) is the cornerstone of any anti-doping program, and less than 1% of U.S. Thoroughbred racing tests is out-of-competition. For comparison, in 2017 approximately 14% of British Horseracing Authority testing was out-of-competition, and OOCT has been 21% in Australia, 11% in France, and 10% in Hong Kong.

By way of example, more than two-thirds of USADA's tests were conducted out-of-competition in 2017.

At the most recent meeting of the California Horse Racing Board on June 21, Dr. Rick Arthur, California's equine medical director, expressed frustration with the board's failure to advance rules that would expand OOCT:

"*Here is the question for this board and the leaders in this sport: Do you want a real anti-doping program or not? Bluntly, without an OOCT program with teeth, you won't have one. I don't know about commissioners, but I doubt I have gone a week in the 11-plus years I have been the equine medical director when I haven't had an owner, trainer, or someone else inside the industry complain that we weren't doing enough to control doping. This is a major step forward for horse racing—if horse racing wants to have a real anti-doping program.*"

C. There are no double-blind testing or consistent laboratory standards across the country.

Claims of laboratories' testing proficiency that do not include double-blind, third-party, quality assurance programs designed to test the laboratories themselves should be regarded as substandard at best. As of March 2018, 13 laboratories in the United States are ISO-accredited, and nine have earned full accreditation by the Racing Medication & Testing Consortium (RMTC). Only one lab, UC-Davis in California, is certified by the International Federation of Horseracing Authorities (IFHA).

Currently, the RMTC lab accreditation program relies upon a suboptimal system of testing the ability of the labs themselves to detect substances. In fact, RMTC-accredited labs periodically receive samples in clearly marked vials containing spiked samples of substances. Spotlighting samples in such a manner runs completely contrary to the objective of testing the daily operational efficacy of the lab. When a

sample is known to contain a material designed to test the lab, the lab will understandably give such samples additional attention, confounding the purpose of the test.

The differences in the types of accreditation are below:

ISO – 17025 Accreditation:
ISO accreditation involves a series of criteria to specify the general requirements for the competence, impartiality and consistent operation of laboratories. These requirements, while specific in nature, are not focused on analytical laboratories serving the racing industry or even drug testing laboratories in general. ISO does not operate its own proficiency testing program but requires participation by accredited laboratories. ISO accreditation is required prior to applying for RMTC Accreditation or IFHA Certification.

RMTC Accreditation:
RMTC Accreditation is an optional program underwritten by the RMTC designed for laboratories servicing the racing industry in the United States. The RMTC requirements are modeled from the World Anti-Doping Agency accreditation requirements used for human drug testing for international sporting events. The requirements are more targeted for racing chemistry both through evaluation of the analytical methodology and drug coverage. The RMTC assessment reviews the lab's capabilities to conduct testing for threshold substances at the RMTC-recommended concentration in the specified matrix (e.g., urine and/or serum). RMTC operates its own proficiency testing program specifically targeting drugs of concern to the horse racing industry. The RMTC proficiency testing includes therapeutic thresholds in serum (e.g., corticosteroids, NSAIDs).

IFHA Certification:
IFHA certification has established international standards for testing horses competing in group and graded stakes racing events. The IFHA specifically identified major doping agents and proficiency testing to demonstrate that laboratories are capable of detecting all compounds. These major doping agents require extensive resourcing, comprehensive validation, and much lower limits of detection. It is not intended that all racing analytical laboratories are able to meet these enhanced requirements to become IFHA Reference Laboratories.

As Mr. Janney said in his testimony, when you don't know when you're going to be tested, when you know your samples will be tested by an accredited lab and held for years, when you know you will be penalized, then you have a real deterrent against cheating.

D. There is insufficient research.

In 2017, fewer than $200,000 was dedicated toward research into drugs and other substances potentially affecting approximately 47,000 Thoroughbred racehorses and another 14,000 Quarter Horse racehorses. Meanwhile, the Partnership for Clean Competition, the coordinating body for research into performance enhancing substances in human sports, spent approximately $2.5 million. The current state-by-state regulation of pari-mutuel horse racing drug testing and enforcement is uncoordinated and woefully underfunded and incapable of keeping pace with the challenges to integrity the industry continually faces.

E. There is no national investigative arm.

Within the industry, it is well-known that the systems in place are not conducive to catching cheaters. An investigation conducted on behalf of The Jockey Club by 5 Stones Intelligence in 2016 found, among other observations:

- *"Violators knowingly leverage the absence of national compliance and enforcement by orchestrating comprehensive illegal doping regiments that occur, while the horse is placed in strategic jurisdictional training areas and not subjected to out-of-competition testing."*

- *"Violators are well-versed in doping methods, industry gaps in compliance and cognizant that there are minimal risks in being caught doping or abusing their horses."*

Although the witnesses testifying against H.R. 2651 claimed that our 38 regulatory systems are effectively policing the sport, we recognize the unfortunate truth that our patchwork is not deterring cheaters. It is enabling them.

Lack of Uniformity

Second, our opponents asserted that the rules regarding medication control were "essentially the same." Nothing could be further from the truth.

Our research found only 14 jurisdictions representing less than 50% of pari-mutuel handle operate under the latest controlled therapeutic medication list as approved by the Association of Racing Commissioners International (ARCI). In fact, a high-level study of only nine of the 30 more commonly used therapeutic medications in horse racing among 33 pari-mutuel jurisdictions (there are 38 jurisdictions, but only 33 currently conduct live racing) yielded the following results:

- Eight of 33 regulate phenylbutazone differently
- Two of 33 regulate banamine differently and three of 33 do not publish the regulatory threshold
- Seven of 33 regulate ketoprofen differently and three of 33 do not publish the regulatory threshold
- Six of 33 regulate omeprazole differently and five of 33 do not publish the regulatory threshold
- Four of 33 regulate clenbuterol differently and six of 33 do not publish the regulatory threshold
- 13 of 33 do not publish regulatory thresholds for cetirizine
- 10 of 33 regulate detomidine differently and eight of 33 do not publish the regulatory threshold
- Three of 33 regulate butorphanol differently and seven of 33 do not publish the regulatory threshold
- Six of 33 regulate xylazine differently and eight of 33 do not publish the regulatory threshold

Based upon these facts, it is impossible to conclude that anywhere close to 95% of wagering dollars in the United States are generated from racing jurisdictions operating under the same list of controlled therapeutic medications as published by the ARCI version 4.0.

For illustration, the following table compares the withdrawal periods and regulatory thresholds published in NYCRR Title 9, Executive Subtitle T New York Gaming Commission Chapter 1 Division of Horse Racing and Pari-Mutuel Wagering Subchapter A Thoroughbred Racing as found at: https://www.gaming.ny.gov/pdf/legal/New%20York%20State%20Gaming%20Commission%20rules%20Chapter%20I%20,Subchapter%20A%20(Thoroughbred%20Racing)%20updated%202018-02.pdf as

compared to the Association of Racing Commissioners International Controlled Therapeutic Medication Schedule for Horses – Version 4.0 Revised April 20, 2017.

The variances are highlighted in yellow.

Rules in New York versus ARCI NUMP

Drug	New York (hours of withdrawal prior to post time)	ARCI Version 4.0 (hours of withdrawal prior to post time)
Acepromazine	96	48
Albuterol	96	72
Atropine	96	Unregulated
Betamethasone	7 days	7 days
Butorphanol	96	48
Cetirizine	unregulated	48
Cimetidine	24	24
Clenbuterol	14 days	14 days
Dantrolene	72	48
Detomidine	96 1ng/ml urine or any in blood	48 2ng/ml urine or 1ng/ml blood
Dexamethasone	5 days	72
Diclofenac	48	48
DMSO	48	48
Firocoxib	14 days	14 days
Furosemide	4	4
Glycopyrrolate	96	48
Guaifenesin	96	48
Hydroxyzine	96	Unregulated
Isoflupredone	7 days	7 days
Isoxuprine	96	Unregulated
Ketamine Hydrochloride	72	Unregulated
Lidocaine	96	72
Mepivacaine	96	72
Methocarbamol	72	48
Methylprednisolone	7 days	21 days (dose dependent)
Omeprazole	24 1 ng/ml urine	24 10 ng/ml serume
Pentoxifylline	96	Unregulated
Phenytoin	96	Unregulated
Pyrilamine	96	Unregulated
Prednisolone	5 days	48
Procaine Penicillin	5 days	Zero after entry
Ranitidine	Unregulated	24
Triamcinolone Acetonide	7 days	7 days
Xylazine	96	48

Rules published in the Florida Administrative Code & Florida Administrative Register chapter 61D-§6.008 found at https://www.flrules.org/gateway/RuleNo.asp?ID=61D-6.008 as compared to the Association of Racing Commissioners International Controlled Therapeutic Medication Schedule for Horses – Version 4.0 Revised April 20, 2017.

Drug	Florida (regulatory thresholds)	ARCI Version 4.0 (regulatory thresholds)
Acepromazine	10 ng/ml urine	10 ng/ml urine
Albuterol	1 ng/ml urine	1 ng/ml urine
Betamethasone	10 pg/ml serum	10 pg/ml serum
Butorphanol	300 ng/ml urine or 2 ng/ml serum	300 ng/ml urine or 2 ng/ml serum
Cetirizine	unregulated	6 ng/ ml serum
Cimetidine	Unregulated	400 ng/ml serum
Clenbuterol	140 pg/ml urine or LOD in serum	140 pg/ml urine or LOD in serum
Dantrolene	100 pg/ml in serum	100 pg/ml in serum
Detomidine	1ng/ml urine or LOD in blood	2ng/ml urine or 1ng/ml in blood
Dexamethasone	5 pg/ml in serum	5 pg/ml in serum
Diclofenac	5 ng/ml in serum	5 ng/ml in serum
DMSO	10 ug/ml serum	10 ug/ml serum
Firocoxib	20 ng/ml in serum	20 ng/ml in serum
Furosemide	100 ng/ml in serum	100 ng/ml in serum
Glycopyrrolate	3 pg/ml in serum	3 pg/ml in serum
Guaifenesin	unregulated	12 ng/ml in serum
Isoflupredone	100 pg/ml in serum	100 pg/ml in serum
Lidocaine	20 pg/ml in serum	20 pg/ml in serum
Mepivacaine	10 ng/ml in urine or LOD in serum	10 ng/ml in urine or LOD in serum
Methocarbamol	1 ng/ml in serum	1 ng/ml in serum
Methylprednisolone	100 pg/ml in serum	100 pg/ml in serum
Omeprazole	1 ng/ml in urine	10 ng/ml in serum
Prednisolone	1 ng/ml in serum	1 ng/ml in serum
Procaine Penicillin	25 ng/ml in serum	25 ng/ml in serum
Ranitidine	Unregulated	40 ng/ml in serum
Triamcinolone Acetonide	100 pg/ml in serum	100 pg/ml in serum
Xylazine	10 pg/ml in serum	200 pg/ml in serum

Credibility of Regulators

Third, our opponents' dismissal of USADA, arguably the world's premier anti-doping agency, on the grounds of its lack of equine-related experience, seems to imply that the current state of regulators are experts without peer. In fact, these regulators, or racing commissioners, govern with widely different standards. **In our review of the regulations in 38 states, there are NO qualifying expertise standards, and each position is politically appointed.** In just a handful of states are there requirements that a member not have an active financial interest in the business they are regulating. In one jurisdiction, an active jockey served as one of the racing commissioners, and in several others, breeders and owners are represented.

Witness Ed Martin, president of the ARCI, offered the following statement in his written testimony regarding rule-making procedures under H.R. 2651:

"Equine medication policies would be determined by a private entity and federal agency with no veterinary expertise or background with horses."

It is interesting that Mr. Martin would make this claim. Before he accepted his current position at ARCI, he led the New York Racing and Wagering Board, the New York State racing industry's regulatory authority. Mr. Martin's areas of expertise, however, showed NO background in racing, testing, investigations, research or veterinary medicine. Prior to leading this important state agency, Mr. Martin's business experiences as listed in his LinkedIn biography included On-air radio personality; Director, External Affairs, Federal Energy Regulatory Commission; Press Secretary, United States Senate, Senator Alfonse D'Amato; Director of Communications, New York Senate; President, Armadillo Group, a strategic communications consulting firm; and Executive Deputy Commissioner, Empire State Development.

Again, Mr. Martin demonstrated no prior background or expertise in operating an anti-doping regulatory agency; yet, according to his statements, this experience is now imperative.

Under H.R. 2651, the USADA-led Horseracing Anti-Doping and Medication Control Authority board will be made up of experts in anti-doping AND in horse racing, with strong conflict-of-interest standards.

Lasix

Finally, on the often confusing and passionately debated issue on the injection of Lasix in a racehorse on the day of the race, we offer the following facts based on peer-reviewed scientific studies:

- "*There is no association between EIPH grades 0, 1, 2 and 3 and long-term racing performance of Thoroughbred racehorses*" (Sullivan, S. L., Anderson, G. A., Morley, P. S., & Hinchcliff, K. W., 2014).
- In a study of 152 Thoroughbreds, two of them had an EIPH score of four, the most severe grade. In other words, 150 of 152 horses had EIPH scores of three or below, supporting the previous point that the vast majority of horses race and enjoy long and productive careers on the racetrack without Lasix (Hinchcliff, K. W., Morley, P. S., & Guthrie, A. J., 2009).
- Horses that received Lasix ran 3 to 5.5 lengths faster than horses that did not (Gross D.K., Morley P.S., Hinchcliff K.W., & Wittum T.E., 1999).

Lasix is given to almost 95% of starters in the U.S. to treat a condition that affects the racing careers of a small percentage of horses. When Lasix is administered, varying levels of performance enhancement are observed. Eric Hamelback stated in his testimony that he takes Lasix every day for his heart and that it is no different from taking Advil. This ignores the fact that Advil is an over-the-counter medication, while Mr. Hamelback undoubtedly needs to get a prescription from his doctor for Lasix.

Racehorses are put on a track's Lasix list because their trainers ask veterinarians to sign off on their horses needing the medication, not because the veterinarians have actually diagnosed the horses as needing Lasix – and in many cases, the veterinarians have never even examined the horses. However, in the words of Dr. Sheila Lyons, "*Racehorse is not a diagnosis*." While Mr. Hamelback is correct that Lasix is often treated like Advil on the backstretch in terms of how often it is purchased for and given to horses, the fact that he needs a prescription to purchase the potent medication indicates the magnitude of its effects. In American horse racing, no such prescription is needed for the equine patient.

The American Association of Equine Practitioners has stated its opposition to the elimination of Lasix on race day. However, this speaks more to its prioritizing its members' livelihoods over equine welfare, for no veterinary groups in other countries have voiced their support for Lasix. In the United States, private veterinarians have the ability to prescribe and/or sell medications to horsemen, Lasix included. Thus, to defend the use of Lasix in racehorses is to guard a revenue stream for veterinarians.

Most of our international colleagues don't permit Lasix on race day, period — yet still manage top-tier racing programs without the need to medicate their athletes on race day. Statistics from the Hong Kong Jockey Club reveal that about 1% of their racing population is compulsorily retired annually due to issues related to EIPH.

These facts raise questions that bear repeating over and over: Why is the United States the only major racing jurisdiction in the world that allows Lasix when horses in other countries race safely and successfully without the influence of medication on race day? Why can our horses compete successfully without Lasix in other countries but "need" Lasix to race in our country?

Mr. Foreman cited that in some countries, trainers may withhold water from horses that demonstrate EIPH symptoms, and that Lasix prevents this maltreatment of horses. What he failed to mention is that Lasix makes a horse lose 20 to 25 pounds of water before it races, and the horse will have to maintain a regimen of electrolyte supplements for weeks to recover after using Lasix in just one race.

Conclusion

Witnesses opposed to H.R. 2651 stated during the hearing that they represent the majority of the horse racing industry in their reservations about this bill. Yet they failed to mention that H.R. 2651 is supported by some of the most prominent groups in the industry, including the New York Racing Association, Keeneland Association, The Stronach Group, and the Thoroughbred Owners and Breeders Association, and that track associations and organizations that support the bill represent 59% of all pari-mutuel handle generated and 63% of all graded races run for Thoroughbreds in North America in 2017. Besides these stakeholders, we have seen support from the rank and file members of our sport. According to a poll conducted by Paulick Report, one of the largest online news sources in horse racing, more than 70% of respondents support H.R. 2651. Opponents may not want to admit it, but the majority of those involved in horse racing know that the current system is not working, and that it is time for meaningful change. That change is the Horseracing Integrity Act of 2017.

Sincerely,

Stuart Janney
Chairman
The Jockey Club

Craig Fravel
President & CEO,
Breeders' Cup

Cc: Members of the Energy & Commerce Committee

Studies Cited:

Gross D.K., Morley P.S., Hinchcliff K.W., Wittum T.E.; Effect of furosemide on performance of Thoroughbreds racing in the United States and Canada; J Am Vet Med Assoc., 1999 Sep 1;215(5):670-5.

Hinchcliff, K. W., Morley, P. S., & Guthrie, A. J. (2009). Efficacy of furosemide for prevention of exercise-induced pulmonary hemorrhage in Thoroughbred racehorses. *Journal of the American Veterinary Medical Association,235*(1), 76-82. doi:10.2460/javma.235.1.76

Sullivan, S. L., Anderson, G. A., Morley, P. S., & Hinchcliff, K. W. (2014). Prospective study of the association between exercise-induced pulmonary haemorrhage and long-term performance in Thoroughbred racehorses. *Equine Veterinary Journal,47*(3), 350-357.