transportation in rural areas, as well as look at uses communities could make of abandoned rail lines.

Under my proposal, no segment of the Amtrak system would be exempt from review. All routes would be carefully scrutinized. TRAC would also examine ridership forecasts and other assumptions underlying the Northeast corridor, especially in light of on-going electrification efforts. This electrification project currently has a price tag of about $3.2 billion, with nearly $1.2 billion already appropriated.

There is, however, an important factor which I mentioned earlier that I must reiterate which affects Amtrak's costs and efforts to achieve profitable operations. The Rail Labor Protection Act mandates payment of 6 years of full benefits to any rail worker who loses his or her job due to a route closure. As a result, many of the most unprofitable routes would actually cost even more to close than to keep going, albeit limping along at a loss. In fact, under the ''30-mile'' rule—also part of current law—an Amtrak employee is entitled to demand the full 6 year severance package if he or she is merely relocated 30 miles or more. No union workers in the private sector are afforded such generous severance compensation, and these astronomical costs are one of the reasons that every trip on Amtrak costs American taxpayers $25.

After conducting a thorough, system-wide economic review, TRAC would make its recommendations to Congress. These recommendations would then be considered by Congress under an expedited procedure—an accelerated time frame for consideration, with no amendments permitted, and an up-or-down vote.

TRAC would be comprised of 11 members. The President would appoint three members including the Secretary of the Department of Transportation, one representative of a rail labor union and one member of rail management. The majority leadership in the House and Senate would each appoint four members, in consultation with the minority leadership in both bodies. Members serving on this commission would offer expertise in rail finance, economic analysis, legal issues, and other relevant areas.

Saving passenger rail service requires objective analysis and urgent remedies. If Amtrak is to survive, and I want to emphasize my support for its survival, we must get out of the way and allow it to be run in a manner consistent with sound business practices. We must allow objective, business principles to govern Amtrak operations rather than outside considerations or constraints. Finally, we must be able to justify to taxpayers, whatever decisions we make regarding Amtrak and this is best accomplished based on sound assessments and recommendations.

I believe the TRAC legislation can help move Amtrak into the next century as a viable part of the Nation's transportation system and I urge my colleagues to support this legislation.

THE MEDICARE MEDICATION EVALUATION AND DISPENSING ACT OF 1997

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 20, 1997

Mr. STARK. Mr. Speaker, today, I am reintroducing a bill that could dramatically improve the quality of medical care received by our Nation's elderly. This legislation calls for implementation of an online prescription drug information management program for Medicare beneficiaries. This system, referred to as the Medicare Medication Evaluation and Dispensing System [MMEDS], would provide beneficiaries and their health care providers with tools and information that are necessary to reduce instances of adverse drug interactions, over-medication, prescription drug fraud, and other problems that plague the elderly related to prescription drug use.

BACKGROUND

The inappropriate use of prescription drugs is a health problem that is particularly acute for the elderly. The elderly not only use more prescription drugs than any other age group, but are more likely to be taking several drugs at once—thereby increasing the probability of adverse drug reactions.

In July 1995, the General Accounting Office reported that 17.5 percent of almost 30 million noninstitutionalized Medicare recipients 65 or older used at least one drug identified as generally unsuitable for elderly patients. In a study published by the Journal of the American Medical Association [JAMA], researchers concluded that nearly one in four noninstitutionalized elderly patients take prescription drugs that experts regard as generally unsuitable for their age group. Accounting for other scenarios, such as incorrect dosage levels, the number of Medicare patients affected by the inappropriate use of prescription drugs would far exceed 25 percent.

Several studies featured in the January 1997, issue of JAMA demonstrate the consequences of adverse drug reactions and errors in medication prescribing. One study found that adverse drug events [ADE's] lead to longer lengths of hospital stay, increased costs of hospitalization, and an almost twofold increase in the risk of death.

Inappropriate use of prescription drugs has been proven expensive as well as dangerous to the health of the elderly. The Food and Drug Administration estimates that 6.4 percent of all hospital admissions are caused by inappropriate drug therapy—imposing costs of $20 billion; others estimate costs to be as high as $77 billion. JAMA also recently reported that drug-related morbidity and mortality have been estimated to cost more than $136 billion per year in the United States. Researchers found that a major component of these costs was ADE's which may account for up to 140,000 deaths annually. The study analyzed one hospital in Salt Lake City and found that a total of 567 ADE's caused direct hospital costs of over $1 million in 1992 alone.

Moreover, another JAMA study concluded that the costs of ADE's are underestimated since they exclude malpractice as well as injuries to patients. The researchers concluded that the high cost of ADE's economically justify investment in preventive efforts. Therefore, the researchers recommended a solution similar to MMEDS—reduction of system complexity, improved education, expanded use of the expertise of pharmacists, and computerization and standardization of the drug prescribing process.

MEDICAID MEDICATION EVALUATION SYSTEM

The concept of using computer-based systems to improve patient care and identify potential problems is not new. Advanced online computer technology that permits prescriptions to be screened before they are filled is available. Thirty States currently operate automated drug utilization review information systems for their Medicaid populations.

In response to widespread knowledge of the high costs of adverse medical reactions, Congress required States to establish prospective prescription review for the Medicaid program. This MMEDS-like system reviews prescriptions before they are dispensed. In June 1996, the General Accounting Office studied five States using an automated prospective drug utilization review [PRODUR] system. Medicaid's online system screens the prescription against the patient's known medical and prescription history and sends the pharmacy a message stating whether any potential drug-therapy problems exist. Over a 12-month period, the automated systems for five States alerted pharmacists to over 6.3 million prescriptions that had a potential to cause ADE's—including drug-drug interaction, preventing overutilization, and pregnancy conflict; over 650,000 (10 percent) of these prescriptions were subsequently canceled.

COST EFFECTIVENESS

The 1996 GAO study found that automated prospective drug utilization review, like that called for in MMEDS, is cost-effective to implement and to operate. The GAO concluded that in addition to increasing patient safety, PRODUR's reduced Medicaid program costs by over $30 million over the course of 1 year. Savings were from rejecting early refills (preventing overutilization), cancellation of potentially wasteful prescriptions, and denials due to ineligibility; yet, a majority of savings were a result of using low-cost technology to avoid hospitalization due to drug reactions. Overall, the GAO found that program savings can more than offset the costs of relatively inexpensive online systems.

Moreover, in 1995, in the State of Tennessee, the GAO observed a reduction of over $4 million in Medicaid drug costs in just a 6-month period, representing 3.9 percent of the total cost of claims processed. In Maryland, over 7,000 prescription doses considered excessive for elderly Medicaid patients were modified, resulting in $385,252 in savings in just 10 months, and a total of $6.7 million in claims were reversed as a result of their online system, accounting for 7.1 percent of the cost of Medicaid claims processed overall.

The GAO recommends implementation of an automated drug utilization review system on a nationwide basis. There is no doubt that if Congress acts to approve this bill, the taxpayer's investment will be saved and Medicare beneficiaries will be healthier as a result.

PRESCRIPTION DRUG FRAUD

The August 18, 1996, edition of the Los Angeles Times featured an article on the massive amount of prescription drug fraud in the United States and the deaths and illnesses that are the result. The abuse of prescription drugs is believed to rival the estimated use of cocaine and crack. Hundreds of millions of prescription pills reportedly enter our Nation's illicit drug market each year. The abuse involves physicians who illegally prescribe drugs, patients who illegally obtain prescriptions, and a double standard of leniency toward doctors and the wealthy who may overuse prescription drugs.

Medicaid's PRODUR system can alert for early refills and therapeutic duplication—

providing tools needed to detect potential fraud and to prevent abuse before it occurs. When the GAO analyzed data from five States over the course of a 15-month period, over 2,200 Medicaid recipients were each found to have obtained a 20-months' supply or greater of controlled substances in the same therapeutic drug class. By employing a drug management monitoring program, the MMEDS program would help end prescription drug market abuse, save lives, and avoid billions of dollars in medical injuries and expense.

GOALS

The goal of this legislation is to provide a comprehensive outpatient prescription drug information system available to all Medicare beneficiaries which educates physicians, patients, and pharmacists concerning: instances or patterns of unnecessary or inappropriate prescribing and dispensing practices; instances or patterns of substandard care with respect to such drugs; potential adverse reactions and interactions; and appropriate use of generic products.

MMEDS PROGRAM

The Medicare Medication Evaluation and Dispensing System will build on the existing Medicaid infrastructure. MMEDS will give all Medicare beneficiaries and their health care providers the medication management tools needed to identify the direct threats posed by inappropriate medication. In the process, hospital and other medical costs otherwise absorbed by Medicare as a result of these adverse reactions will be reduced.

The program would provide online, real-time prospective review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under Medicare, as well as retrospective review. The review by a pharmacist would include screening for potential drug therapy problems due to therapeutic duplication, drug-drug interactions, and incorrect drug dosage or duration of drug treatment.

ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES

While the MMEDS system will be operated under contract with private entities, the Secretary of DHHS would be responsible for overseeing the development of the program to assure appropriate prescribing and dispensing practices for Medicare beneficiaries. The program would provide for prospective review of prescriptions, retrospective review of filled prescriptions, and standards for counseling individuals receiving prescription drugs. The program would include any elements of the State drug use review programs required under section 1927 of the Social Security Act that the Secretary determines to be appropriate.

As part of the prospective drug use review, any participating pharmacy that dispenses a prescription drug to a Medicare beneficiary would be required to offer to discuss with each individual receiving benefits, or the caregiver of such individual—in person, whenever practical, or through access to a toll-free telephone service—information regarding the appropriate use of a drug, potential interactions between the drug and other drugs dispensed to the individual, and other matters established by the Secretary.

The Secretary would be required to study the feasibility and desirability of requiring patient diagnosis codes on prescriptions, and the feasibility of expanding prospective drug utilization review to include the identification of drug-disease contraindications, interactions with over-the-counter drugs, identification of drugs subject to misuse or inappropriate use, and drug-allergy interactions.

The Secretary, directly or through subcontract, would provide for an educational outreach program to educate physicians and pharmacists on common drug therapy problems. The Secretary would provide written, oral or face-to-face communication which furnishes information and suggested changes in prescribing and dispensing practices.

In addition, the Secretary is instructed to, directly or through contract, disseminate a consumer guide to assist beneficiaries in reducing their expenditures for outpatient drugs and to assist providers in determining the cost-effectiveness of such drugs.

PHARMACY PARTICIPATION

Participation by pharmacies would be on a voluntary basis. Participants would be required to meet standards including, but no limited to, maintenance of patient records, information submission at point-of-sale, patient counseling, and performance of required drug utilization review activities. Participating pharmacies would be required to obtain supplier numbers from the Secretary. Supplier numbers would only be provided to pharmacies that meet requirements specified by the Secretary. Beneficiaries would be notified of which pharmacies are designated Medicare participating pharmacies.

PAYMENT OF SERVICES

Within a 2-year period after the initial operations of the MMEDS system, the Secretary would be required to submit to Congress an analysis of the effect of MMEDS on expenditures under the Medicare Program and recommend, in consultation with actively practicing pharmacists, a payment methodology for professional services provided to Medicare beneficiaries. The payment methodology would be designed in a manner that generates no net additional costs to the Medicare Program, after accounting for the savings to Medicare as a result of demonstrable reductions in the appropriate use of outpatient prescription services. The Secretary would submit a report to Congress regarding such recommendations as the Secretary determines appropriate.

PRIVACY OF PRESCRIPTION INFORMATION

Standards would be established to maintain the privacy of protected health information. Protected health information means any information collected in any form under this provision that identifies an individual and is related to the physical or mental health of the individual, or is related to payment for the provision of health care to the individual.

CONCLUSION

As the number of elderly in our society increases, the number and proportion of drugs used by these older Americans will also grow. It is true that drugs, when used appropriately, can reduce or eliminate the need for surgical and hospital care, prevent premature deaths, and improve quality of life. Unfortunately, a good deal of drug use among older persons is inappropriate, and often results in hospitalization. While some drug-related hospital admissions are unavoidable, many can be attributed to errors in prescribing. Utilizing an online prescription drug management program to reduce the cases of adverse drug reactions is clearly cost effective. Although the primary goal of MMEDS is safety, dollar savings are also a result. Most importantly, by implementing the Medicare Medication Evaluation and Dispensing System Act, we stand to greatly improve the quality of medical care received by our Nation's elderly.

THE AMERICAN HEALTH SECURITY ACT OF 1997

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 20, 1997

Mr. McDERMOTT. Mr. Speaker, I rise today to once again introduce the American Health Security Act. The single payer plan I propose is the only plan before Congress that will guarantee health care universality, affordability, security and choice.

While this Congress lacks the political will to enact comprehensive health reform, the underlying needs for reform remain prevalent: health care costs are more unaffordable to more people and the number of people without health insurance continuous to rise. These problems are compounded by increasing loss of health care choice and autonomy for those people who have insurance leading to disruptions in care and in relationships with providers.

The American Health Security Act I am introducing today embodies the characteristics of a truly American bill. It will give to all Americans the peace of mind—the security—to which all citizens should be entitled. It creates a system of health care delivered by physicians chosen by the patient. No one will have to leave their existing relationships with their doctors or hospitals or other providers. It is federally financed but administered at the state level, so the system is highly decentralized. And it provides new mechanisms to improve the quality of care every American receives.

The American Health Security Act (the bill) provides universal health insurance coverage for all Americans as of January 1, 1999. It severs the link between employment and insurance. The Federal Government defines the standard benefit package, collects the premium, and distributes the premium funds to the states. The States, through negotiating panels comprised of representatives from business, labor, consumers and the state government, negotiate fees with the providers and the government controls the rate of price increases. The result is health care coverage that never changes when your personal situation does, never requires you to change the way you seek health care, and never causes disruptions in your relationships with your providers.

The bill provides the coverage under a mechanism of global budgets to achieve controllable and measurable cost containment that will yield scorable savings over the next five years. Unlike other single-payer proposals of the past, it provides for almost exclusive State administration provided the States meet federal budget, benefit package, guarantee of free choice of provider, and quality assurance standards. This bill explicitly preserves free choice of provider by providing a mechanism for fee-for-service delivery to compete effectively with HMO's. It will not force Americans into HMO models.

The insurance mechanism of the American Health Security Act is easy to use and understand. Quite simply, a patient visits the doctor or other provider. The provider then bills the State for the services provided under the standard benefit package and the State pays