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

the bill on the patient's behalf, just as insurance companies pay medical bills on the patient's behalf now. The difference is that complicated and expensive formulas for patient copayments, coinsurance, and deductibles in addition to premium costs are eliminated.

The standard benefit package is in fact extremely generous. It covers all inpatient and outpatient medical services without limits on duration or intensity except as delineated by outcomes research and practice guidelines based on quality standards. It provides for coverage of comprehensive long-term care, dental services, mental health services and prescription drugs. Cosmetic procedures and other ''frill'' benefits such as private rooms and comfort items are not covered.

The extent of State discretion is substantial. The Federal budget is divided into quality assurance, administrative, operating, and medical education components. The system is financed 86% by the Federal Government and 14% by the States. That Federal pie is then apportioned among the States. For example, States with large elderly populations can be expected to require a larger volume of higher intensity services and will receive a larger Federal contribution. However, the States are free to determine how that money is allocated among types of providers and to negotiate those allocations according to the State's individual needs, provided Federal standards are met. The ability of HMO's to operate and compete on a capitated basis is preserved.

The States must demonstrate the efficacy of their methodologies or Federal models will be imposed. However, States are not required to seek waivers in advance. While the Federal Government will not make separate allocations to states for capital and operating budgets, the states are free to allocate capital separately to assure adequate distribution of resources throughout the State and to develop their own mechanisms for doing so.

The financing package reflects the CBO scoring of this bill's predecessor, H.R. 1200, in the 103d Congress. The numbers were provided by the Joint Committee on Taxation [JCT] on the basis of the CBO scoring. Accordingly, the Bill is fully financed. In fact, JCT estimates that the American Health Security Act will lead to deficit reduction approximating $100 billion per year by the year 2004.

Everyone will contribute to the health insurance system, except the very poor. Employers will pay 8.7 percent of payroll and individuals will pay 2.2 percent of their taxable income. A tobacco tax equal to $0.45 per cigarette pack is also imposed. These payroll deductions are lower than current insurance costs for most businesses and individuals, even while providing universal coverage and a more generous benefit package than exists in the private market today. The key is that the money necessary to provide coverage to people who cannot afford it comes from the administrative savings achieved through the elimination of the insurance company middle man. Americans are freed from the hassle of obtaining and keeping their insurance and have a federal guarantee that their health care costs will be paid for, regardless of who their employer is, where they move, or how their personal or family situation changes.

In addition to providing realistic and affordable financing, the Bill provides quality assurance mechanisms that enhance systemwide quality and truly protect the consumer. It attempts to end the interference between doctor and patient. It establishes a system of profiling practice patterns to identify outliers on a systematic basis. Pre-certification of procedures and hospitalization—getting permission from insurers before your doctor can treat you—is prohibited except for case management of catastrophic cases.

Practice guidelines and outcomes research are emphasized as the main quality and utilization control mechanisms which gives physicians latitude to deviate from cookbook medicine where required for individual cases without going through intermediaries. Only if practitioners consistently deviate are they subject to review to ascertain the basis for the pattern of practice. This system includes mechanisms for education and sanctions including case-by-case monitoring when the review indicates serious quality problems with a specific provider.

The need for a 1:1 ratio of primary care physicians to specialists is explicitly set forth. Federal funding to graduate medical education is tied to achieving this ratio. Funding to the National Health Service is also provided to achieve this goal.

Special grants are provided to meet the needs of underserved areas through enhanced funding to the community health centers, both rural and urban, to enable outreach and other social support mechanisms. In addition, states have discretion to make special payment arrangements to such facilities to improve local access to care. It is anticipated that the revenue streams established for the public health service, community health centers, and education of primary care providers will double the primary care capacity of rural and other underserved areas in this country.

In summary, the American Health Security Act will provide all the citizens with the health care they need at a price both they and their country can afford. It is clear that we cannot afford the price of doing nothing.

WILLIAM J. ''BUD'' FLANAGAN ADMIRAL, U.S. NAVY, RETIRED

HON. OWEN B. PICKETT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 20, 1997

Mr. PICKETT. Mr. Speaker, I rise today to recognize and applaud the career of Adm. William J. ''Bud'' Flanagan, Jr. Admiral Flanagan retired on February 1, 1997, after 29 years of service, having successfully served in several of the Navy's most demanding jobs and concluding that service as the Commander in Chief of the U.S. Atlantic Fleet. ''Bud Flanagan'', the private citizen, has moved on to new and exciting challenges. ''Admiral Flanagan'', Naval career officer, left a legacy of unique accomplishments and an impact on the Atlantic Fleet, Southeastern Virginia, and the Navy at large that invites our praise and deserves our applause.

I first came to know Admiral Flanagan in 1987, when he served as Navy's Deputy Chief of Legislative Affairs to the House of Representatives. He worked tirelessly to represent the U.S. Navy and facilitate the Department's liaison with the Congress. After successfully meeting his responsibilities as Commander of Destroyer Squadron Five, he returned to Washington and served from 1988 to 1991 as the Department of the Navy's Chief of Legislative Affairs. Following that tour, in 1992 Bud was assigned command of the U.S. Second Fleet. In 1994, he was nominated to the rank of Admiral and assigned Commander in Chief of the U.S. Atlantic Fleet.

I have had the pleasure of working with and knowing some of this nation's finest military officers in all branches of the armed forces, and I include Bud Flanagan in that honored company. He is a noted operational strategist, an ''operator's operator'', who brought a distinctive combination of vision, strength and humanity to the various responsibilities he carried out, in and out of Washington. I worked with him on many issues impacting the second district of Virginia and the Tidewater region. Bud was unfailing in his genuine concern for the welfare of the communities where he commanded and the Navy he led and loved. Admiral Flanagan developed innovative solutions to community needs, most especially for the Tidewater region, as our community moved to address the changing demands of the next millennium. Admiral Flanagan's initiatives, all of which were innovative, ranged from working intermodal transportation issues; housing initiatives for sailors and marines that would facilitate home ownership, public/private ventures to facilitate local economic development and modernization of Naval Base Norfolk, and the application of business practices in the management of the fleet. Bud's innovative ideas saved taxpayers and the Department of the Navy millions of dollars. These were just the latest in a series of contributions that have been the hallmark of Admiral Flanagan's career.

Today I say congratulations to an outstanding career that made a real difference in the lives of many Americans. I extend my sincerest best wishes to the Admiral and his family in the next phase of their life's journey. I know whatever Bud Flanagan decides to accomplish, he will be successful. Fortunately, despite retirement, the Admiral remains a true Virginian, maintaining a home in Eastville, VA. Fair winds, following seas and Happy Birthday.

MIDDLE EAST PEACE DEPENDS ON ECONOMIC DEVELOPMENT

HON. JAMES P. MORAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 20, 1997

Mr. MORAN of Virginia. Mr. Speaker, I rise to express my support for more projects like the new Marriott Hotel to be built on the beachfront in Gaza. I offer the recent essay by my constituent, Mr. Ralph Nurnberger, from the Christian Science Monitor (3/6/97), as an excellent recognition of the need for more targeted economic aid to the West Bank and Gaza. As Mr. Nurnberger states, ''. . . the real test of the peace process is how it affects the daily lives of Israelis and Palestinians. If substantive and visible improvements do not result, no international agreements can succeed.'' He is absolutely right. Only the development of a strong economic infrastructure will ensure that progress and peace will succeed.