Georgia, local governments, private foundations, corporate entities, private individuals, and other sources. The cost to the federal government will be less than half of the estimated cost of the effort and will almost certainly be much less.

I am very pleased to introduce a proposal that will promote private/public partnerships in protecting vital natural resources and in increasing recreational opportunities for citizens. Expanding the Chattahoochee National Recreation Area will ensure that future generations will have clean water to drink and will be able to enjoy the beauty of this nationally significant resource.

TRIBUTE TO NICK BACA

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 25, 1998

Mr. FILNER. Mr. Speaker and colleagues, I rise today to honor a hero and a pillar of our community—Nick Baca, who died in January, 1998 at the age of 76.

Although Nick served honorably in World War II and narrowly escaped death, he rarely spoke of his service and kept the memories buried for many years. In June of 1944, as a Ranger scout with the Second Ranger Battalion, he scaled the cliffs of Pointe du Hoc on the Normandy coast of France to destroy enemy bunkers. He was one of 24 out of 120 who reached the top in a barrage of gunfire and grenades.

He fought in the Battle of the Bulge and was taken prisoner. In December of 1944, he was lined up with his fellow prisoners in a column three men deep to be shot, but miraculously escaped a bullet in the massacre by the German guards. Covered with bodies, Nick lay still so the soldiers with bayonets did not notice him. The man on top of him was stabbed to death by a bayonet and Nick's leg was cut. He hid for several days before making his way back to friendly lines—one of only a handful who survived this massacre of American prisoners of war in Malmedy, Belgium.

After the war, he returned as an Army sergeant to his life in Los Lentes, New Mexico where his family had lived since the 1600s. When jobs became scarce, he became the first of his family to leave this area, and he moved to National City, California. Here he established himself in the construction industry and became a leader in the community. He was especially active in the Veterans of Foreign Wars. He was president of an Hispanic social organization in the 1970s.

His was a wonderful life. He was a man who did his duty to his country, who contributed to his community, and who raised his family well. He is survived by Eloise, his wife of 56 years, and his children, Rosalie Ortega, George Baca, Robert Baca and Herman Baca, who is a prominent Mexican-American activist in San Diego County—along with 18 grandchildren and 11 great grandchildren.

My thoughts and prayers go out to his wife and children and to the larger community who was touched by his presence. We will all miss him.

IN SUPPORT OF H.R. 3905, FAIRNESS IN ASBESTOS COMPENSATION ACT OF 1998

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 25, 1998

Mr. CONYERS. Mr. Speaker, today I have agreed to cosponsor H.R. 3905, the ''Fairness in Asbestos Compensation Act of 1998,'' legislation originally introduced by Chairman HYDE.

I have done so because litigation over asbestos claims may have reached a crisis point. Hundreds of thousands of American workers who were exposed to asbestos, and who have suffered or are suffering from serious diseases as a result, have to wait for years to have their legitimate claims paid. In some cases, innocent victims are in danger of not receiving any compensation at all, because the liable corporations have protected themselves, or will protest themselves, under the bankruptcy laws.

In 1994, negotiators between labor unions representing the bulk of the asbestos worker victims, on one side, and asbestos manufacturers, on the other side, resulted in a settlement agreement that was designed to alleviate the crisis. This agreement, know as the ''Georgine Settlement' after Robert Georgine, President of the Building and Construction Trades Department of the AFL–CIO and the lead negotiator for labor in the settlement talks, would have established an administrative procedure for resolving asbestos claims. The U.S. District Court that oversees much of the federal class-action asbestos litigation approved the settlement as fair and reasonable. *Georgine v. Amchem Products, Inc.*, 157 F.R.D. 246 (E.D. Pa 1994).

Last year, however, in *Amchem Products, Inc. v. Windsor*, 117 S. Ct. 2231 (1997), the Supreme Court invalidated the Georgine Settlement, not on grounds of unfairness, but because the settlement agreement did not fit within the technical requirements of Rule 23 of the Federal Rules of Civil Procedure, which governs class-action lawsuits. The Court held that the federal courts lacked statutory authority to order so sweeping a settlement. Writing for the Supreme Court majority, Justice Ruth Bader Ginsburg stated: ''The argument is sensibly made that a nationwide administrative claims processing regime would provide the most secure, fair, and efficient means of compensating victims of asbestos exposure. Congress, however, has not adopted such a solution.'

Given the Supreme Court's decision, I believe that the relevant parties should again come to the table to work out a legislative solution if at all possible. That is why I have agreed to cosponsor H.R. 3905. I do want to note, however, that I have some specific concerns about the language of the bill as it is currently drafted. I am concerned the bill would eliminate the availability of punitive damages in those cases in which asbestos victims choose to pursue ordinary tort remedies instead of the administrative claims procedure. I have always believed, and I continue to believe strongly, that punitive damages must be available to sanction outrageous wrongdoing by corporate defendants. Otherwise, some unscrupulous businesspeople will simply choose to treat the damage caused by unsafe products as a cost of doing business. This in no way means that I believe those defendants in the Georgine Settlement engaged in such conduct, but I do believe that such judgments should be left to the judicial process.

In addition, it is my position that any legislation we enact in the asbestos area should hew as closely as possible to the terms of the Georgine Settlement. To the extent H.R. 3905 may depart from those terms, I believe we should examine such departures very closely.

I look forward to working with Chairman HYDE on a bipartisan basis on this important legislation.

THE MEDICARE+CHOICE PHARMACEUTICAL MANAGEMENT ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 25, 1998

Mr. STARK. Mr. Speaker, I am pleased to introduce the Medicare+Choice Pharmaceutical Management Act of 1998.

This bill would provide important protections for Medicare beneficiaries receiving prescription drug benefits through Medicare+Choice plans. These plans would be required to disclose important information about how they manage their drug benefits to cut costs, including any incentives offered to doctors to get them to switch to cheaper, but sometimes less effective, medications.

While many health plans still manage their own drug benefits, an increasing number of plans are hiring a new breed of management consultants known as pharmaceutical benefit managers (PBMs) to do their work for them. These companies currently manage prescriptions for some 115 million Americans and the number is expected to reach 200 million by the year 2000.

Plans have turned to PBMs in the hopes that they will be able to cut rising prescription drug costs. PBMs accomplish that goal by setting up lists of approved drugs (known as formularies), requiring specific authorization of non-formulary drugs, and urging doctors—often by providing financial and other incentives—to switch prescriptions for less expensive medications.

Of greater concern is the fact that PBMs are often given free reign to manage benefits through their own programs, with little oversight from the health plan. And, PBMs are neither licensed health care providers nor subject to federal regulation by the Food and Drug Administration (FDA).

Several of the largest PBMs are now owned by drug manufacturers and many independent PBMs have formed ''strategic alliances'' with drug manufacturers, exchanging preferential treatment on a formulary with millions of dollars in rebate payments from the drug companies. Since 1993, the three largest PBMs, serving fully 80% of covered enrollees, have been acquired by drug manufacturers at a total cost of $12.8 billion. And, a January 1998 study showed that drug-company-owned PBMs covered 41% of the lives enrolled in PBM programs.

Drug companies that ow PBMs say that they have ''firewalls'' in place to prohibit the two companies from sharing proprietary information or conducting joint marketing efforts

and other deals that benefit the drug company. But can any company policy resolve this inherent conflict of interest, especially when the goal is to maximize profit? If you've the CEO of a major drug company, wouldn't it be tempting to try to get more doctors to prescribe your company's new medication for high blood pressure?

I certainly think so. But, in case you think I'm just being cynical, consider the case of PCS, the largest PBM covering 50 million lives. When PCS was acquired by Eli Lilly, which manufactures Prozac, in 1994, Lilly's chairman openly declared that ''this purchase will help us sell even more Prozac.'' Internal PCS memos obtained by the New York City Public Advocate revealed a plan to steer the company's managed care customers toward Prozac and another top Lilly drug, the ulcer medication Axid. Millions of messages would be sent to physicians and pharmacists urging switches, leading to a projected $171 million in additional sales.

Given that there are millions of dollars at stake for drug manufacturers and PBMs, it's very tempting for these companies to join forces to steer physicians to prescribe their products. But, there's more at stake than just money—the health and welfare of Medicare beneficiaries who join Medicare+Choice plans is also at risk. I am attaching testimony given by the Public Advocate for the City of New York before President Clinton's Advisory Commission on Consumer Protection and Quality that clearly shows just how low these companies will go to push their products.

I have introduced the Medicare+Choice Pharmaceutical Management Act of 1998 to discourage these types of activities by requiring Medicare+Choice plans to disclose the following information about their pharmacy benefits management: the committee (if any) used to develop and oversee drug formularies, including the composition of the committee and how they decide what drugs to include on the formulary; and incentives to physicians, pharmacists, and patients associated with formulary compliance programs, including drug switching and any known health risks associated with such a program; all policies and procedures for any drug utilization reviews of physicians and pharmacists, including any counseling, intervention, enforcement actions, or penalties associated with these reviews; any expedited process for amendment drug formularies to include new drugs that become available, particularly those that treat or alleviate potentially life-threatening illnesses; and any requirements for prior treatment failures of a particular drug before approving alternative drug therapies.

Medicare+Choice plans will be required to disclose this information when they apply for a contract with Medicare and to make this information and their drug formularies available to the public upon request. That way, the Health Care Financing Administration (HCFA), the agency that reviews these contracts, will know about a health plan's pharmacy program—and any financial incentives to push certain drugs—and can make the decision whether to contract with that plan or require changes in their pharmacy benefits management. And, even more important, the information will allow consumer groups and individuals to make recommendations and choices about the managed care plans that best serve the patient.

I urge my fellow Members of Congress to join with me in cosponsoring the Medicare+Choice Pharmaceutical Management Act of 1998. Together, we can ensure that Medicare beneficiaries get access to the prescription drugs ordered by their physician, not by a benefits manager focused on the bottom line.

TESTIMONY OF MARK GREEN, PUBLIC ADVOCATE FOR THE CITY OF NEW YORK, BEFORE THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY—FEBRUARY 26, 1998

We all know that there is no more common health care experience in America than filling a prescription. But few Americans know that the terms of our every day drug-counter transactions are changing more fundamentally and rapidly than anytime in modern medical history. I suggest that your report to the President reflect this fact and propose reforms that protect patients from the adverse consequences of ''drug switching.''

A two-year investigation by my office has concluded that health plans are now frequently intervening in the prescription process, pressuring physicians and pharmacists to switch medications to less therapeutically valuable drugs. In addition, the approved ''drug formularies'' sometimes exclude critical drugs from coverage altogether. These preferences seldom have anything to do with medical appropriateness. Indeed, for some individual patients, the substituted drug is not as efficacious as the original prescription and can lead to harmful side effects.

While the original intent of these now widespread substitution strategies was to lower costs without affecting the quality of care, existing research indicates that this practice results in higher overall costs. Instead of cost-containment, commercial interests have become the guiding force behind drug preferences. Health care organizations have established a variety of business relationships with drug manufacturers that are shaping, and in some cases compromising, drug choice. The exposure of these arrangements has sounded a sudden alarm among those concerned abut the independence and trust implicit in the prescription tradition of American medicine.

Five federal agencies have weighed in critically on the drug switching issue in the last few years: the FDA [US Food and Drug Administration], the OIG [US Office of the Inspector General], the HCFA [US Health Care Financing Administration], the FTC [US Federal Trade Commission] and the GAO [US General Accounting Office]. The FDA recently issued draft guidelines to attempt to monitor these practices. Yet it is estimated that 71 percent of HMOs will have programs encouraging substitutions by the end of the year.

The American Medical Association says that the ''frequency and intensity'' of HMO substitution interventions ''pit the interest of patients against the economic interest of their health care providers'' and have risen ''to the level of harassment.'' The American College of Cardiology argues that heart medications are highly specific to particular patients and warns that substitutions represent ''a real and present danger'' that could involve patients being switched to drugs that might produce ''life threatening toxicity'' or other adverse reactions. My own surveys of almost 400 New York physicians and pharmacists found that 75 percent of both believe substitutions are diminishing care, while almost all said plans routinely contact and urge them to make substitutions.

Recent academic and governmental reports have concluded that both the employer groups paying the premiums and the HMOs engaging in drug management tactics are becoming increasingly concerned about the care-consequences of these switches. Fourteen medical journal articles have reached critical conclusions, six of which suggested that these new drug preference practices may be leading to extended illness, more visits to doctors and emergency rooms, longer hospital stays and greater total costs.

What has galvanized this concern is the growing power of a new force in drug selection—PBMs [pharmaceutical benefit managers]. HMOs retain PBMs as consultants to help them administer drug coverage. These companies, which have overnight become billion dollar giants in their own right, manage prescriptions for 115 million Americans. They are the engines driving the new substitution initiatives. With 90 percent of HMOs now employing one form or another of pharmacy management, 200 million Americans are expected to be covered by PBMs by the end of the decade.

Though the initial rationale for turning over drug management to PBMs was cost containment, drug costs continue to increase as a share of total health costs and faster than inflation. Indeed, drug costs have risen from $21 billion ten years ago to $50 billion today, and ambulatory costs for drug-related problems, including reactions to PBM-induced substitutions, are how estimated at $76.6 billion.

PBMs develop the formularies, a list of covered and preferred drugs, thereby determining prescription access for millions of patients. They pay incentives to pharmacists to get them to push doctors to switch prescriptions, and drop independent pharmacists who do not engineer switches often enough. PBM consultants call and visit doctors to discuss specific patients and urge the use of specific drugs. They impose rock-bottom prescription budgets on doctors, and review the prescribing records of recalcitrant physicians to make sure they make the favored drug selections. They even punish patients who do not accept switches by charging them higher co-pays. Yet PBMs are neither licensed as health care providers nor regulated by any oversight agency.

But PBM drug preferences are frequently of questionable independence. Since 1993, the three largest PBMs, serving fully 80 percent of covered enrollees, have been acquired by pharmaceutical manufacturers at a total cost of $12.8 billion. Other manufacturers have formed ''strategic alliances'' with major PBMs, paying millions of dollars in rebate payments for preferential treatment on a formulary. The overarching corporate purpose of these acquisitions and arrangements has clearly been to increase market share for certain widely used drugs. Studies have shown, for example, that the manufacturer-owned PBMs are unsurprisingly pushing the prime pharmaceuticals of their owner.

PCS, for example, is the largest PBM, covering 50 million lives. It was acquired by Eli Lilly, the manufacturer of Prozac, in 1994. Lilly's chairman openly declared after the PCS merger that ''this purchase will help us sell even more Prozac.'' Internal PCS memos obtained by my office revealed a plan to steer the company's managed care customers toward Prozac and another top Lilly drug, the ulcer medication Axid. Millions of messages would be sent to physicians and pharmacists urging switches, leading to a projected, almost instant, burst of $171 million in additional sales. Yet both drugs cost more than effective competitors'.

PCS hired outside experts to justify the Prozac switch. Though only one of the three consultants recommended knocking a top competitor, Zoloft, off the preferred list, PCS did it anyway. In fact, the one consultant they followed found that Prozac had the longest dose adjustment time of three main antidepressants—two and a half months

compared to Zoloft's five and a half days. The consultant also found that Prozac produced far more side effects, including headaches, sexual dysfunction, insomnia, diarrhea, anxiety and agitation. Yet the PCS letter subsequently sent to thousands of physicians erroneously suggested that Prozac had the shortest adjustment time and fewest side effects.

The misuse of this PCS drug utilization letter for transparent promotional purposes was one of the reasons the FDA recently decided to monitor drug substitutions. HCFA recently reported that PCS believes that 30 percent of the prescriptions written under its preferred drug program are successfully switched, providing some measure of how extensive this practice is becoming.

Such drug policies influenced by commercial interests can have damaging effects on care. Patients are being switched to chemically dissimilar agents that are not rated as equivalent by the FDA, and usually have different side effects, dosages and efficacy rates. Patients stabilized on one medication are also being moved to another without any clinical cause, leading one doctor to label these switching strategies ''massive unfunded human experimentation.'' With doctors constrained by preferred lists, the many differences between patients—age, ethnicity, multiple disease states—are not always factored into prescribing decisions.

Hurt most by these practices are the elderly and chronically ill because they often consume daily dosages of a variety of highly competitive medications. Take the example of 65-year-old Clara Davis, a retired grocery store manager from Bolivar, Tennessee. She lost a third of her stomach after her ulcer medication was switched. Her physician tried to persuade her plan not to force the substitution but it insisted. While recovering from the operation she suffered a paralyzing stroke.

As we meet, several states—Maine, New York, California and Virginia—are considering legislative action to protect the Clara Davis' of this country and to restrict drug formularies based more on commercial, rather than health, considerations. But ultimately, since drug sales are obviously national in scope, there must be a national policy on drug substitutions. I urge you not to squander your once-in-a-generation opportunity to stop this new and growing trend of HMOs—not physicians and pharmacists—prescribing the pills that we all swallow.

Given how extensive and harmful managed-care-driven drug substitutions have become, I urge the Commission to include this language in their final report. I believe that these recommendations implement the mandates of the Consumer Bill of Rights on Information Disclosure and Participation in Treatment Decisions:

''Consumers should be fully informed about all factors affecting a prescription choice. Health care organizations and physicians should disclose any possible side effects or economic reasons for a recommended therapeutic switch. Health care organizations should restrict substitutions to those that are found to be therapeutically equivalent by the FDA. Consumers should be free to reject these recommended switches without penalty, such as the imposition of a higher copayment. Consumers have the right to continue on a drug regimen that has been medically beneficial for them, without pressures on their physician to switch. Health care organizations should make their preferred drug lists, as well as formularies, available to consumers. Drug substitutions should take into account the potential overall cost of a change in care, not merely the comparative costs of two medications in the same therapeutic category.

''The President should provide strong, continuous leadership to improve the quality and delivery of prescription drug care in the United States. The President should act to eliminate all commercial interests advising, selecting or influencing prescription drug treatments and act to improve the health of all Americans by developing a patient-specific prescription drug policy.''

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IN RECOGNITION OF JETER NIMMO

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 25, 1998

Mr. HALL of Texas. Mr. Speaker, I rise today to pay my respects to a good friend, fine Texan and more importantly a great American—Mr. Jeter Nimmo. Jeter was born on January 24, 1920 in Delta County, Texas, where he learned the importance of family, church and community. Jeter took these values with him to the University of Texas at