Approved: 3-28-01
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on March 7, 2001 in Room 231-N of the Capitol.

All members were present except: Senator Haley (EA)

Committee staff present: Ms. Emalene Correll, Legislative Research Department
Mr. Norman Furse, Revisor of Statutes
Ms. Lisa Montgomery, Revisor of Statutes
Ms. Rebecca Zapick, Intern for Senator Barnett
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Ms. Mary Blubaugh, Executive Director, Board of Nursing
Ms. Terry Roberts, Lobbyist,
Kansas State Nurses Association

Others attending: See attached guest list.

Hearing on HB 2313 - State Board of Nursing approval of schools and programs

Upon calling the meeting to order, Chairperson Wagle announced that there would be a hearing on **HB 2313** and **SCR 1609** and asked that Mr. Norman Furse, Revisor of Statutes, give an overview of the bills

Mr. Furse began with **HB 2313**. Highlights of Mr. Furse's overview included: terminology changes from "accredited," referring to schools, to "approve," refresher courses for mental health technicians who had not practiced for a period of time, allow the Board to approve schools of nursing and programs for up to ten years, and two technical points in the bill. The two technical points touched on were: 1) if you are enrolled in the study of nursing you are not prohibited from distributing anesthesia, and 2) language adjustment regarding IV therapy. He stood before the Committee for questions.

Discussion between Senators Barnett and Salmans, Ms. Correll and Mr. Furse regarding literature Senator Barnett had received earlier in the session relating to nursing licenses and history of felons and so forth and was this a separate bill. Ms. Correll stated that the nurse practicing act was the only act that prohibited some persons who had been convicted of certain felonies from ever being licensed and that the Health Care Oversight Committee bill deleted that provision. Mr. Furse stated this was a House bill which had hearings and the House committee did not recommend the legislation.

Chairperson Wagle then recognized Ms. Mary Blubaugh, Executive Director, Board of Nursing to give the first of two proponent testimonies. Ms. Blubaugh defined the term "approved" as a mandatory and legal recognition of a program to begin or continue to operate by meeting essential standards. She defined "accreditation " stating it generally considered a voluntary process that focuses on program excellence and is conducted by peers. She stated in summary that **HB 2313** contains a number of changes that clarify or updates current statutory language and that the Board has responded to the needs of the nursing community while considering the safety issues of the public. A copy of her written testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference.

The second proponent recognized by the Chairperson was Ms. Terry Roberts, Lobbyist, Kansas State Nurses Association. Ms. Roberts stated that the KSNA supports the license sections because it more accurately reflects the process that the agency goes through in determining the appropriateness of the qualification of applicants for licensure and the new language proposed on page eight should reduce the duplication that programs now experience when participating in the BON approval/renewal process. A copy of her written testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference.

Ms. Roberts stated that the Senate Subcommittee is having hearings on the Board of Nursing budget regarding grace periods for nurses seeking to renew their licences, issuing of temporary permits and on-line renewal, and auditing of license applications for CE's. She asked the Committee for a couple of days before working the bill so that they can dialogue with the Board about whether they can work on some grace period language in an amendment to **HB 2313** or work with the agency so that the temporary permits could be issued in a more customer friendly way. Chairperson Wagle stated that the minority leader had to be out of town today and he did request that she not work any bills today as he wanted to be here and be involved. So no bills will be worked today and they do have another week to work.

Senator Brungardt asked Mr. Furse if he was comfortable with the language. Ms. Roberts stated that Mr. Furse was the one who revised this. But Chairperson Wagle did remind Mr. Furse that this bill still needed some technical revisions on pages12 and 15 and he agreed and also included pages 3 and 11. Chairperson Wagle stated that since this issue had already been discussed in Appropriations, the Committee would dialogue with Senator Salmans, who was on the subcommittee, and Ms. Roberts and Ms. Blubaugh may dialog and see if the Committee wants to amend the bill before we work it. Senator Salmans said the subcommittee asked all of the Boards in attendance to go back and review to see if they wanted to have that 30-day grace period after a birthday, which was when the permit was up for renewal.

As this would close the hearing on **HB 2313**, Chairperson Wagle introduced Senator Barnett, who began proponent testimony

Hearing on SCR 1609 - memorializing Congress regarding the high cost of prescription drugs.

Senator Barnett began pulling out, from boxes he had brought from his practice, "freebies" he had received from the pharmaceutical companies which included clocks, golf shirts, Kleenex boxes, and an invitation paying him to attend a pharmaceutical conference out of town. He said he would gladly forgo all of this sort of marketing if it would help in the reduction of prescription drugs. He also explained how his patients have no other choice but to seek alternatives for the high cost of their medications. A copy of his written testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference.

The next to give proponent testimony was Mr. Don Hill, owner of two retail community pharmacies in Emporia. Mr. Hill provided copies of manufacturers' price updates he receives each Friday from a service provider showing how price increases range in the four to five 1/2% range and this being the second or third prices increase for most of the items in the last 12 months. A copy of his written testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference.

Mr. Bob Williams, Executive Director of the Kansas Pharmacists Association, submitted written testimony. A copy of his written testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference.

The last conferee to testify was Ms. Nancy Zogleman, Senior Manager, State Government Relations for Pfizer, Inc. Ms. Zogleman stated Pfizer, Inc. was concerned with some of the information in the whereas clauses. She walked the Committee through handouts of attachments and suggested balloon amendments which she believed might clarify the provisions. A copy of her written testimony and handouts are (Attachment #6 and 7) attached hereto and incorporated into the Minutes by reference.

Chairperson Wagle then asked if there were questions or comments from the Committee. Questions were asked by Senators Harrington and Barnett and Ms. Correll of Mr. Hill and Ms. Zogleman ranging from price control, discounts and co-pay, does TV advertising impact the market, and inherent safeguards, to questioning spending 20M on marketing to change a box for over the counter medicine.

Adjournment

As there were no more questions, Chairperson Wagle thanked the conferees. The meeting adjourned at 2:25 p.m.

The next meeting is scheduled for March 12, 2001.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Wednesday, March 7

NAME	REPRESENTING
Nancy Zogleman	Pfizer
Carolyn Middendorf	Ks St Nurses Assn
TOM SIPE	KHA
Tom Rickman	AVENTIS
Michelle Peterson	PhRMA
Mike Huffles	Ks. Govt. Consulting
Michelle-Lee Wymer	Hiawatha Redskins
Amy Yarger	Hiawatha High School Redskins
Beverly Burke	Coffey Co Republican Women
Esther Osborn	" " " "
Scott Brunner	DOB
Nancy Shaughnessy	Federico Consult.
Leticia G. Hammond	Visitor CC Co Women
Joan Freeman	Visitor Coffey Co. Co Women
Glenda Bruninga	" Lyon Co. Rep. "
Barb Wells	Elmdale, KS
Kristen Barnett	Emporia State University
Kay Hale	Kansas Hospital Association
Jerri Roberts	Kansas State Nurses Assn.
Chris Collins	Ks Medical Society
Bill Sneed	Merck & Co

Kansas State Board of Nursing

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To: Senator Susan Wagle, Chair
Senator James Barnett, Vice-Chair
Members of the Public Health and Welfare Committee

From: Mary Blubaugh MSN, RN
Executive Administrator
Kansas State Board of Nursing

Date: March 7, 2001

Re: House Bill 2313

Good afternoon Senator Wagle and members of the Public Health and Welfare Committee. Thank you for the opportunity to appear before you today. My name is Mary Blubaugh and I am the Executive Administrator of the Kansas State Board of Nursing. I am here on behalf of the Board Members to offer testimony for the support of House Bill 2313.

Though out this bill, when there is reference to accreditation of schools or programs of nursing or mental health technician, that language is changed to approval. The term approval is defined as "official or formal consent, confirmation or sanction". Approval refers to mandatory and legal recognition of a program to begin or to continue to operate by meeting essential standards.

The term accreditation is defined as "recognition of an institution of learning as maintaining prescribed standards for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice". National Council of State Board of Nursing defines accreditation (see attachment A) as "the official authorization or status granted by an agency other then a state board of nursing". Accreditation is generally considered a voluntary process that focuses on program excellence and is conducted by peers.

The amendments to 65-1115, 65-1116, and 65-4203 provides a clear list of the qualifications an applicant for professional nurse, practical nurse, and mental health technician must meet to be issued a license. This language basically clarifies that the applicant will pass a written test and deletes the language that the examination may be supplemented by an oral or practical examination. These amendments also list and clarify the requirements for an applicant who does not take or is unsuccessful in passing the examination within 24 months of graduation. In both cases the applicant must petition the board for permission to sit for the examination and the board may require the

Senate Public Health & Welfare Committee
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Attachment 1-1

applicant to submit and complete a plan of study. This provision assists the applicant to pass the examination.

65-1119 and 65-1133 will allow the board of nursing to extend the approval of schools of nursing and educational program for advance registered nurse practitioners for a period not to exceed 10 years after granting the approval. Deleted from these regulations is the statement "from time to time, as deemed necessary by the board, it shall cause to be made a resurvey of accredited schools and written reports of such resurveys submitted to the board". The replacement for this statement is "the board shall resurvey approved schools on a periodic basis as determined by rules and regulations". Additions to these statutes goes one step further to allow the board of nursing to accept nationally accredited schools of nursing, and if these schools files evidence of accreditation the board may grant approval not to exceed 10 years. If the schools of nursing hold approval based on national accreditation they are also responsible to comply with all other requirements as determined by rule and regulation. Allowing the Board to review and accept school accreditation by a nationally recognized nursing accreditation agency will reduce the duplication of the same process for the nursing schools for approval and renewal of their approval. The Board supports the change in the number of years of approval from 5 to 10 years as several accreditation agencies give the accreditation for 10 years.

65-1136 clarifies that a LPN who had one-year clinical experience and has performed intravenous fluid therapy prior to July 1, 1995 and has successfully passed an examination may perform a limited scope of IV therapy. The date was the only change to this regulation.

In summary, HB 2313 contains a number of changes that clarifies or updates current statutory language. The Board has responded to the needs of the nursing community while considering the safety issues of the public. I ask that the committee pass HB 2313 out favorably.

Thank you and I will stand for questions at this time.

Attachment 1-2

Position Paper Related to Use of Terms *Approval* and *Accreditation*

The right to practice a profession or discipline is protected by the U.S. Constitution. The Constitution also states that a state may regulate a profession or occupation that affects general welfare. Nursing is a profession that makes an impact on general welfare and is, therefore, subject to regulation by the state. Language in state nurse practice acts and rules and regulations, however, has not been consistent in differentiating between mandated, legal processes and voluntary, quality-assurance processes, as related to the regulation of nursing education programs. A review of the nurse practice acts and rules and regulations of the 61 Member Boards of the National Council of State Boards of Nursing (NCSBN) indicates that most state boards of nursing use the term *approval* to describe oversight of nursing education programs. Some boards use the term *accreditation*, and a few boards use both terms interchangeably. The purpose of this position paper is to differentiate between the terms *approval* and *accreditation* as they describe a state regulatory body's role and responsibility in nursing education programs.

The term *approval* is defined as "official or formal consent, confirmation or sanction" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *approval* is defined as "official recognition of nursing education programs which meet standards established by the board of nursing" (NCSBN, 1994, p. 2). Implied in approval is permission to carry out an act, in this case, the operation of a nursing education program. In the regulatory arena, approval refers to mandatory and legal recognition of a nursing program to begin and/or continue to operate. Graduation from an approved program is necessary for a student to be eligible to take the NCLEX® examination for registered nurses or licensed practical/vocational nurses.

Approval also requires compliance with essential educational standards to protect both the students who are enrolled in the program and the public who will receive nursing care from the graduates of the program. Participation by regulatory bodies in the approval process is congruent with their legal responsibility.

The term *accreditation* is defined as "recognition of an institution of learning as maintaining prescribed standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *accreditation* is defined as "the official authorization or status granted by an agency other than a state board of nursing" (NCSBN, 1994, p. 2). Inherent in the accreditation process is evaluation by peers (Bogue & Saunders, 1992).

Whereas approval is a mandatory process related to permission for an education program to begin and continue operating by meeting essential educational standards, accreditation is generally considered a voluntary process that focuses on program excellence. In addition, approval processes (initial and continuing) are generally carried out by governmental agencies while accreditation is conducted by peers.

Both approval and accreditation are important components in the successful operation of nursing education programs designed to protect the public and provide appropriate educational experiences for future nurses. Thus, it is important that boards of nursing review their state Nurse Practice Acts and Rules and Regulations to ensure that terminology is consistent with the inherent differences between the terms *approval* and *accreditation*.

References

1. American Heritage Dictionary. (1993). Houghton Mifflin Co.: Boston.
2. Bogue, E.G. & Saunders, R.L. (1992). The evidence for quality: Strengthening the tests for academic and administrative effectiveness. San Francisco: Jossey-Bass Publications.
3. National Council of State Boards of Nursing. (1994). Model Administrative Rules. Chicago: NCSBN.

Attachment 1-3

KSNA
KANSAS STATE NURSES ASSOCIATION
the Voice of Nursing in Kansas

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Emma Doherty, M.A.
President

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Executive Director

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March 7, 2001

H.B. 2313 NURSE PRACTICE ACT CHANGES

Senator Wagle and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of the KANSAS STATE NURSES ASSOCIATION (KSNA), the professional organization for registered nurses.

KSNA supports the updates and changes recommended by the Board of Nursing to the nurse practice act and the amendments adopted by the House Committee..

- The changes proposed in KSA 65-1115 (RN), 65-1116 (LPN) *License sections* more accurately reflect the process that the agency goes through in determining the appropriateness of the qualifications of applicants for licensure.

- On page 8 of the bill there is new language proposed in KSA 65-1119 (g) (and again on page 11 new (d) for ARNP programs) that will permit the Board to recognize national accreditation of schools of nursing in lieu of Board of Nursing program review, and this should reduce the duplication that programs now experience when participating in the BON approval/renewal process. The time frame for approval is being expanded from 5 years to 10 years, and this too will reduce the agency's workload, while still ensuring quality programs for nursing preparation.

- We are very proud of the fact that all of the RN programs in Kansas have been accredited by either the National League for Nursing (NLN) or the Commission on Collegiate Nursing Education (CCNE). We are one of the few states where 100% of our RN programs have received voluntary recognition by one of the two nationally recognized nursing education accrediting agencies.

- The House Committee amendments update the grandfathering provisions that assisted LPN's who had been administering IV's prior to the act (several years ago) and were allowed to take the competency test. These sections did need to be retained, and the updated wording accomplishes that.

Thank you for considering these proposed changes. On behalf of the nursing profession, we respectfully ask for your support.

Thank you.

Senate Public Health & Welfare Committee
Meeting Date March 7, 2001
Attachment 2-1

STATE OF KANSAS

JAMES A. BARNETT
SENATOR, 17TH DISTRICT
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TOPEKA, KANSAS 66612-1504
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TOPEKA

SENATE CHAMBER

COUNTIES
CHASE, COFFEY, GEARY,
LYON, MARION, MORRIS,
OSAGE AND WABAUNSEE

COMMITTEE ASSIGNMENTS
VICE CHAIR: PUBLIC HEALTH AND WELFARE
MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND
INSURANCE

TESTIMONY

Senate Concurrent Resolution 1609

Madam Chairman and fellow Senators, thank you for this opportunity to testify in support of Senate Concurrent Resolution 1609.

I come before you today both as a physician and state Senator to express my concern regarding the high cost of prescription drugs. During my early years of practice, the cost of medicines were of course a concern. During the last decade or so, the costs have escalated markedly to the point that this is a serious problem for my patients and our nation. This problem does not impact just a few or those who have been less fortunate. A growing number of my patients are struggling with the high cost of prescription drugs and are unable to afford both medicine and other necessities in life.

Please understand that I am thankful and grateful for the new medications and treatment modalities that we have to prolong and maintain quality of life. As a physician, I daily enjoy the benefit of treating my patients with better medicine. At the same time, I recognize and believe that the current system is out of control and unbalanced. Earlier, I would encourage my patients to buy medicines in Mexico whenever possible. They could purchase their drugs for 1/4 to 1/3 on the dollar. Now, I am sad to say I am signing prescriptions for my patients to obtain their medicines in Canada at nearly ½ the cost of medicine available in the United States. This hurts me to do so, because this impacts our local pharmacists. They are the ones who are members of our community, pay taxes, and are responsible citizens. They are the ones I call in the middle of the night for help. However, I am faced with the situation where my patients have no other choice but to seek alternatives for the high cost of their medications.

I believe the situation is out of hand. I personally believe that the motive for profit has taken control of drug therapy in America. I bring today some examples of why I feel this way.

At the same time, we have seen an unprecedented effort at marketing and advertising directly to patients. I commonly receive requests from patients regarding medicines that I do not believe are always necessary or in the best interests of treatment. This also drives up the overall cost of medical care.

I know that research and development is an extremely important aspect of the pharmaceutical industry. However, I am concerned equally regarding the amount of money that is spent on marketing and advertising. I have tried to use the safest figures I could obtain to represent the industry's effort at research and development. However, I share additional data that suggests that more may be spent on marketing and advertising than on research and development. This needs further discussion and exploration. As a physician, I am often told and as well often read that the efforts at marketing and advertising are for both physician and patient education. These examples that I bring to you today do not represent the kind of education that I want or need. As a physician, I do not want this stuff. I would much rather my patients have more affordable medication.

I ask that you join me in furthering the dialogue in sending a strong message to Washington, D.C. that we are asking for help. Most of my patients are too proud to tell me that they are struggling. Many are elderly and live on fixed incomes. They survived the Great Depression and they survived World War II. Rather than sharing their burden, they sometimes go without medicine. My way of knowing that they are unable to take their medicine shows up in an uncontrolled blood pressure, or for instance, more protein spilled in their urine. That saddens me. They do not have their hands out. I am not asking for them to put their hands out. This is not a cry for Washington to provide another entitlement for the citizens of the United States. We need balance and control, moderation of marketing, and sensitivity to the needs of our citizens.

Jim Barnett

Senator Jim Barnett

JAB/gkp

Attachment 3-2

NOVARTIS

David W
Sales Representative

Novartis Pharmaceuticals Corporation
Ciba Sales
722 N. Michigan Street
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V-Mail 800 656 5660, #12674

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THANK YOU,
[illegible]

Novartis Pharmaceuticals Corporation

Cordially invites you to participate in the upcoming Clinical Forum entitled

"Postprandial Glucose Metabolism and Type II Diabetes: New Clinical Evidence, New Therapeutic Approaches"

March 3, 2001

Hyatt Regency Crown Center

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Program Agenda

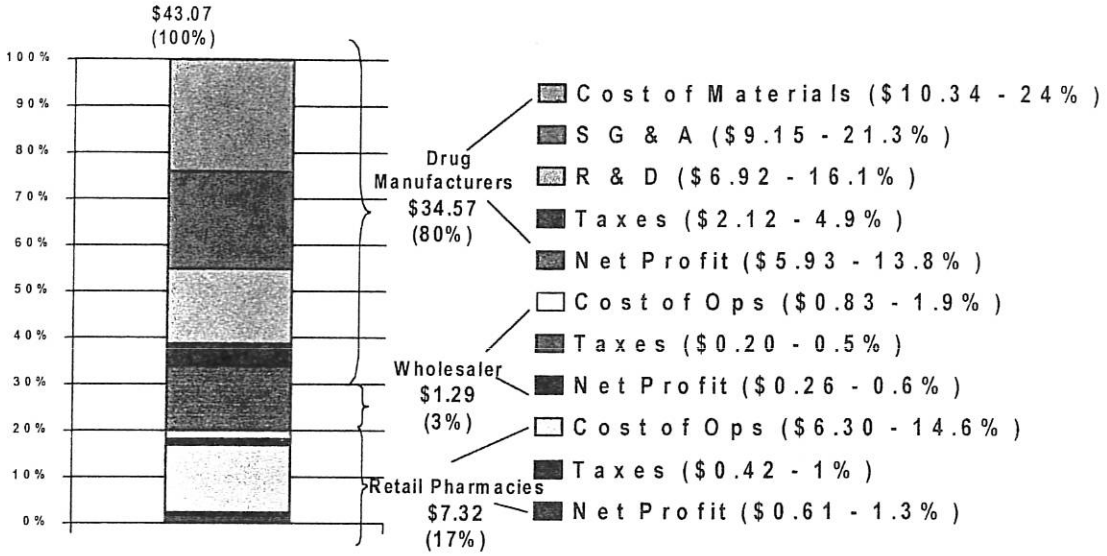
9:00 AM	-	10:00 AM	Registration and Continental Breakfast	
10:00 AM	-	10:10 AM	Introduction and Discussion of Meeting Objectives	
10:10 AM	-	11:00 AM	**Which Comes First, B-cell Dysfunction or Insulin Resistance?** *Samuel Dagogo-Jack, MD* *University of Mississippi Medical Center*	
11:00 AM	-	11:20 AM	Discussion	
11:20 AM	-	11:40 AM	Break	
11:40 AM	-	12:30 PM	Lunch and Lecture **Drug Therapy in Controlling Postprandial Glucose Levels** *Samuel Dagogo-Jack, MD*	
12:30 PM	-	12:45 PM	Discussion	
12:45 PM	-	1:15 PM	Overview-Novartis Product Pipeline and Key Clinical Trials Tom Fellers, RPh	
1:15 PM	-	1:45 PM	Overview of Afternoon Objectives/Break	
1:45 PM	-	2:45 PM	Consultant Roundtable Session Presentation of Product Messages	Group 1 Group 2
2:45 PM	-	3:45 PM	Consultant Roundtable Session Presentation of Product Messages	Group 2 Group 1
3:45 PM	-	4:00 PM	Report Back to General Session Room to Hand-In Questionnaires and Complete Final Paperwork	

To confirm your reservation
please complete the attached registration form by ***FEBRUARY 22, 2001.***

Attachment 3.3

Did you know?

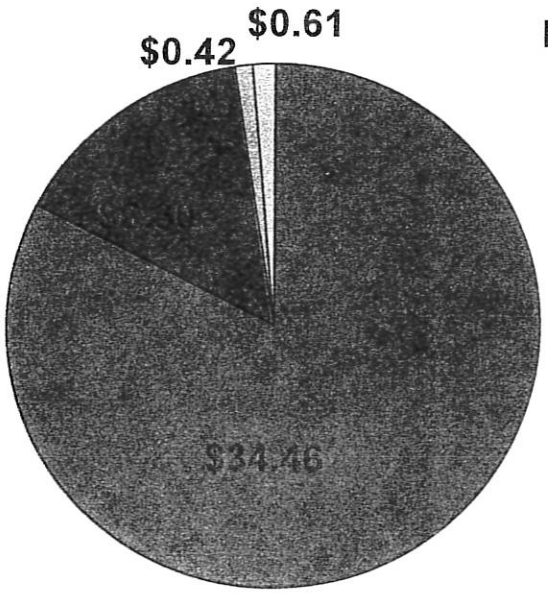
Prescription Cost Components



Source: IMS HEALTH, Hoover's Company Information, PhRMA, Retail Census, U.S. Bureau of the Census; average prescription price $43.06, 3rd quarter 1999.

Or Stated Another Way

1999 Average Price of Prescription $43.07



Prescription Cost Breakdown

- Amount Paid to Manufacturer and Wholesaler ($34.46)
- Pharmacy Operational Costs ($6.30)
- Pharmacy Taxes ($0.42)
- Pharmacy Net Profit ($0.61)

Attachment 3-4

Physician's Weekly® POINT/ COUNTERPOINT
May 22, 2000 • Vol. XVII, No. 20

Should drug companies' tax break for M.D. gifts continue?

Judy Bello
Executive Vice President for Policy and Strategic Affairs, Pharmaceutical Research and Manufacturers of America

YES Promoting new products is very important for patients. It makes no sense for the pharmaceutical industry to spend enormous sums to discover drugs if they remain a secret.

Loss of this tax deduction could cut sponsorship of CME sessions and other events that appropriately alert prescribers to available new options.

By bipartisan majorities in both houses, Congress enacted the FDA Modernization Act, designed to streamline the approval process. Congress' motivation was to get safe and effective new drugs to patients more rapidly.

Rep. Pete Stark
(D-Calif.); Sponsor, H.R. 4089

NO The reason I have introduced a bill to end this business expense deduction is that the pharmaceutical companies don't need it and *JAMA* found that gifts to physicians have a negative impact on prescribing practices.

These drug companies already get huge tax breaks for research and development though they complain constantly it's not enough.

Meanwhile, they spent more than $11 billion last year on golf shirts and other gifts for physicians. A recent article in *JAMA* estimated these freebies cost between $8,000 and $13,000 per doctor per year.

The same motivation drives the pharmaceutical industry.

Today's drugs are high-tech products. And to use them appropriately, there must be an efficient exchange of information between manufacturers and prescribers at an appropriate level of sophistication.

In addition to providing that opportunity, promotional CME events and other similar enterprises offer forums for educational interaction between the industry and prescribers.

That means new data can be collected and new experiences shared. The reporting of adverse events is only one example of the sort of valuable information that can come from such a dialogue.

These are educational opportunities for physicians, who are among the busiest people in our society. This is an efficient way to reach them.

A lot is at stake here: the costly and, of course, risky process of research and development, the potential advantage to patients, and the need for the industry to have an ongoing dialogue with physicians.

Preserving the tax deduction for expenses of CME sessions and other educational events with physicians is important to the industry, to doctors, and, most importantly, to patients.

Physicians don't need their opinions being swayed by fancy gifts, especially when it's been found that these gifts lead to distorted, inappropriate, over-prescribing of drugs.

Moreover, drug companies spend about twice as much on promotion and marketing as they do on R&D. U.S. consumers would be far better off if, instead, the $11 billion wasted on promotions went toward finding cures for chronic diseases.

But drug companies are resistant to every move by Congress to rein them in.

I have more confidence in the nation's doctors than I do in the pharmaceutical companies. Doctors don't run glossy, full-page consumer ads extolling their practices and then charge more to fund them.

Prescription drugs cost 50% more in this country than they do in Canada. The pharmaceutical companies charge what a captive market will bear. As a result, the drug industry reaps billions in profits every year.

They should use these exorbitant profits for R&D of lifesaving medical discoveries-not for gifts. And that's exactly what H.R. 4089, "The Save Money for Prescription Drug Research Act of 2000," will allow them to do.

Attachment 3-6

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Testimony for Senate Health and Welfare Committee March 6, 2001

Madame Chairman and members of the committee. I sincerely admire and appreciate your public service. I appreciate also this opportunity to testify before you.

My name is Don Hill. I am the owner of two retail community pharmacies in Emporia, I have been a practicing community pharmacist for thirty years. I am here to encourage your support for Senate Concurrent Resolution 1609 and share some of my perspective on the problem the Resolution addresses.

My experience to a large extent parallels Dr. Barnett's and I feel strongly that escalating prescription prices is a critical national problem and this problem is the most severe in more rural states including Kansas.

I would like to illustrate several aspects of my concern relating to the problem of the high and rising costs of medicine. On a weekly basis I download manufacturer's price updates from a service provider. Generally I perform this task on Friday and I am sharing with you today the manufacture's price increases from last Friday. This is a pretty typical list. Many increases are in the 4 to 5% range, a few are lower and some are significantly higher. May I stress that this is the second or third price increase for most of these items in the last 12 months. Next Friday we will get another update and our patients/customers will once again be at the pharmaceutical manufacturers mercy. I hope you can understand the frustration of health care providers who see drug cost inflation competing with them for the opportunity for more adequate reimbursement levels. While preparing for this testimony I confirmed that on August 1, 1984 (nearly 17 years ago) I was assigned by SRS a Medicaid dispensing fee of $4.56 per prescription . Today my dispensing fee is $4.50! The amount of some of the most recent manufacturer's increase in a single prescription is greater than my professional dispensing fee.

Senate Health Meeting Date March 7, 2001
Attachment 4-1

I would like to refer you to the supplemental information provided with my testimony to illustrate the need for passage of Senate Concurrent Resolution 1609. First, I am providing you a copy of a portion of the front page of last weekend's edition of USA Today. You will notice a graphic at the bottom of the page illustrating "Out-of-pocket drug cost" declines. It looks pretty good, but it is very misleading. In one way or another Americans pay for all of their prescription drug costs, and they pay widely varying amounts. The best deals go to federal government entities, large labor unions and other entities which can leverage their size and power to extract better discounts and rebates from the manufactures. The worst deals go to individuals, elderly, working poor, small business and small government entities. In my opinion pharmaceutical manufactures enjoy a near monopoly status in the United States and charge all the market will bear for their products. Those who are dealt the most severe consequences of the "out of control" escalation of prescription prices are those who must pay for their prescriptions out-of-pocket. The percentage of this population may be 25% or lower in Kansas' few urban areas however, in Emporia the percentage is 40% and I can assure you that in many rural areas 60% or more of the population pays for their prescriptions out-of-pocket.

Express Scripts is a large national Pharmacy Benefit Management company which annually compiles their Top Ten Developments or Trends in Pharmacy. One of those developments this year is "Rising Costs Drive Concern About Access and Affordability to the Top of the American Political Agenda. I am providing you a copy of their observations.

Senate Concurrent Resolution 1609 refers to research and development costs and marketing costs. I would call your attention to another Top Development in Pharmacy, "Direct-to-Consumer Advertising Proves Its Power....." I would like to illuminate the product Prilosec because I think it illustrates the best and the worst of the situation we face today. Prilosec is a wonderful product. It was a "breakthrough" drug when it was approved, representing a major therapeutic advance from which millions of people worldwide who suffer from acid reflux disease have benefitted greatly. The drug has saved lives and contributed to the quality of life for countless individuals. That is the good news! The bad news is that Prilosec's manufacturer has spent hundreds of millions in direct to consumer advertising in the last 3 years alone, while at the same time investing what they will presumably claim additional hundreds of millions in developing a new drug, Nexium. I invite you to read the company's press release, it is enlightening.

It is convenient that Nexium is coming on the market, because guess what....the patent for Prilosec has expired and that drug will be available generically later this year. I will reserve my final judgement until objective analysis is available later, but I do have several predictions. I predict that Nexium will prove to have little, if any, significant therapeutic benefit over Prilosec and the proton pump inhibitors on the market today. I predict that the manufacturer will spend hundreds of millions of dollars trying to convince prescribers, payers, and consumers that Nexium is superior to the product they spent $100 million in the last year alone promoting but which they no longer maintain exclusive patent rights to sell. I predict the burden for all of this research and development and marketing expense will be born by the consumers of Nexium and other products from this manufacturer. I predict this burden will be born disproportionately by consumers in the United States, and further so those consumers who buy the prescriptions out-of-pocket like a large number of Kansans.

Every day I see patients who literally despair over the cost of a prescription. I see patients who I know are not compliant with their physician's orders so they can save prescription expense. I see first hand the dire consequences of this non-compliance. I see young parents, I know will have their household budget wrecked for weeks or even months, when faced with the high cost of medicine for an acutely ill child.

We do have a looming crisis in the accessability and affordability of health care in MAY Kansas. Public policy has the potential to positively impact this problem. You not believe there is much you can do but your heightened awareness and the passage of this Resolution is a start. I urge your support of it's passage and your continued involvement in these issues.

Attachment 4-3

(1)

EDIT REPORT for Price Updates - REASON CODES : E = Unable to update drug, B = Drug not in your file, U = Updated price successfull,

REASON	CODE	NAME	PACK	NDC	NEW NDC	CLASS	OLD COST	AWP	MAC	DIR	THERAPY	GENERIC
U	XALA	XALATAN SOL 0.005%	2	00012-8303-04	- -	6	47.73	51.30	0.00	41.04	523600	C130209824
U	SANTYL	SANTYL OIN 250U/GM	15	00044-5270-02	50484-0527-15	6	0.00	29.95	0.00	24.96	843600	C000901121
U	SANTYL1	SANTYL OIN 250U/GM	15	50484-0527-15	- -	6	29.95	29.95	0.00	24.96	843600	C000901121
U	SANTY	SANTYL OIN 250U/GM	30	00044-5270-03	50484-0527-30	6	0.00	56.94	0.00	47.45	843600	C000901121
U	SANTY1	SANTYL OIN 250U/GM	30	50484-0527-30	- -	6	56.94	56.94	0.00	47.45	843600	C000901121
U	ELOC.1150	ELOCON OIN 0.1%	15	00085-0370-01	- -	6	21.13	21.55	0.00	0.00	840600	C003919237
U	DIPRAP15CR	DIPROLENE AF CRE 0.05%	15	00085-0517-01	- -	6	32.99	33.65	0.00	0.00	840600	P000850575
U	DIPR0.05	DIPROLENE AF CRE 0.05%	50	00085-0517-04	- -	6	73.76	75.24	0.00	0.00	840600	P000850575
U	ELOC.115CR	ELOCON CRE 0.1%	15	00085-0567-01	- -	6	21.13	21.55	0.00	0.00	840600	C003919237
U	ELOC45	ELOCON CRE 0.1%	45	00085-0567-02	- -	6	38.71	39.48	0.00	0.00	840600	C003919237
U	DIPRLO	DIPROLENE OIN 0.05%	15	00085-0575-02	- -	6	32.99	33.65	0.00	0.00	840600	P000850575
U	ELOCLO	ELOCON LOT 0.1%	30	00085-0854-01	- -	6	22.92	23.38	0.00	0.00	840600	C003919237
U	DIPRLOT.05	DIPROLENE LOT 0.05%	60	00085-0962-02	- -	6	74.58	76.07	0.00	0.00	840600	P000850575
U	CARD30	CARDIZEM TAB 30MG	100	00088-1771-47	- -	6	52.80	54.91	0.00	0.00	240400	D033286225
U	CARD60	CARDIZEM TAB 60MG	100	00088-1772-47	- -	6	82.86	86.17	0.00	0.00	240400	D033286225
U	CARDSR60	CARDIZEM CAP 60MG SR	100	00088-1777-47	- -	6	97.20	101.09	0.00	0.00	240400	D033286225
U	CARDSR90	CARDIZEM CAP 90MG SR	100	00088-1778-47	- -	6	111.06	115.50	0.00	0.00	240400	D033286225
U	CARDSR120	CARDIZEM CAP 120MG S	100	00088-1779-47	- -	6	144.78	150.57	0.00	0.00	240400	D033286225
U	CARD90	CARDIZEM TAB 90MG	100	00088-1791-47	- -	6	116.52	121.19	0.00	0.00	240400	D033286225
U	CARDCD120	CARDIZEM CD CAP 120MG/2	90	00088-1795-42	- -	6	115.20	119.81	0.00	0.00	240400	D033286225
U	CARDCD180	CARDIZEM CD CAP 180MG/2	90	00088-1796-42	- -	6	139.02	144.58	0.00	0.00	240400	D033286225
U	CARDCD240	CARDIZEM CD CAP 240MG/2	90	00088-1797-42	- -	6	197.22	205.11	0.00	0.00	240400	D033286225
U	CARDCD300	CARDIZEM CD CAP 300MG/2	90	00088-1798-42	- -	6	255.60	265.92	0.00	0.00	240400	D033286225
U	CARD360	CARDIZEM CD CAP 360MG/2	90	00088-1799-42	- -	6	278.04	289.16	0.00	0.00	240400	D033286225
U	NYST1	NYSTATIN TAB 500000U	100	00093-0983-01	- -	6	64.39	68.08	0.00	50.75	081204	C001400619
U	CARB4	CARB/LEVO TAB 10-100M	100	00228-2538-10	- -	6	58.59	70.85	0.00	0.00	289200	P000060647
U	CARB2	CARB/LEVO TAB 25-100M	100	00228-2539-10	- -	6	64.74	80.00	0.00	0.00	289200	P000060647
U	T3	APAP/CODEINE TAB 300-30M	1000	00228-3020-99	- -	3	239.00	284.30	0.00	0.00	280808	P000450510
U	TAMO101	TAMOXIFEN TAB 10MG	60	00555-0446-09	- -	6	109.57	113.95	0.00	0.00	100000	C054965241
U	TAMO20	TAMOXIFEN TAB 20MG	30	00555-0904-01	- -	6	109.57	113.95	0.00	0.00	100000	C054965241
U	MIGQ	MIGQUIN CAP	100	00603-4664-21	- -	6	42.90	42.90	0.00	0.00	280892	P000860120
U	EPIP.32IJ	EPIPEN INJ 0.3MG	1	49502-0500-01	- -	6	42.48	45.50	0.00	0.00	121200	C000055312
U	EPIPJR.152	EPIPEN-JR INJ 0.15MG	1	49502-0501-01	- -	6	42.48	45.50	0.00	0.00	121200	C000055312
U	SANTYL1	SANTYL OIN 250U/GM	15	50484-0527-15	- -	6	29.95	29.95	0.00	0.00	843600	C000901121
U	SANTY1	SANTYL OIN 250U/GM	30	50484-0527-30	- -	6	56.94	56.94	0.00	0.00	843600	C000901121
U	ORTHOEST.1	ORTHO-EST TAB 0.625MG	100	54248-0101-01	- -	6	40.06	44.68	0.00	0.00	681604	C007280377
U	XALA	XALATAN SOL 0.005%	2	00013-8303-04	- -	6	51.30	56.05	0.00	40.04	523600	C130209824
U	ARAL500	ARALEN TAB 500MG	25	00024-0084-01	- -	6	117.10	126.47	0.00	0.00	882000	C000050635
U	DANO200	DANOCRINE CAP 200MG	60	00024-0305-60	- -	6	251.82	271.97	0.00	0.00	680800	C017230885
U	DEME50	DEMEROL TAB 50MG	100	00024-0335-04	- -	2	88.17	90.72	0.00	0.00	280808	D000052135
U	HISTHC	HISTUSSIN HC SYP	480	00024-0860-16	- -	3	52.24	54.16	0.00	0.00	430800	P005581300
U	KAYE	KAYEXALATE POW	453	00024-1075-01	- -	6	200.33	216.36	0.00	0.00	401800	C009380795
U	NEOS2.5	NEO-SYNEPHRI SOL 2.5% OP	15	00024-1358-01	- -	6	24.37	26.32	0.00	0.00	523200	C000061767
U	NESY1050S	NEO-SYNEPHRI SOL 10% OP	5	00024-1359-01	- -	6	23.29	25.15	0.00	0.00	523200	C000061767
U	PEDC	PEDIACOF SYP	480	00024-1509-06	- -	5	53.72	58.02	0.00	0.00	480800	P000241509
U	PHIS150LQ	PHISOHEX LIQ 3%	148	00024-1535-02	- -	6	14.77	15.95	0.00	0.00	840416	C000070304
U	PHIS480LQ	PHISOHEX LIQ 3%	480	00024-1535-06	- -	6	28.52	30.80	0.00	0.00	840416	C000070304
U	PLAQ200	PLAQUENIL TAB 200MG	100	00024-1582-10	- -	6	146.69	158.42	0.00	0.00	882000	C000747364
U	TALWNX	TALWIN NX TAB	100	00024-1951-04	- -	4	112.67	121.68	0.00	0.00	280812	P000241951
U	MONI3200VS	MONISTAT 3 SUP 200MG	3	00062-5437-01	- -	6	32.09	32.09	0.00	0.00	842408	C022632877
U	FLAR	FLAREX SUS 0.1% OP	5	00065-0096-05	- -	6	24.38	25.38	0.00	0.00	520800	C000301057
U	PILO45GE	PILOPINE HS GEL 4% OP	4	00065-0215-35	- -	6	35.75	37.56	0.00	0.00	522000	C000054717
U	BETOS.255	BETOPTIC-S SUS 0.25% O	5	00065-0246-05	- -	6	28.19	29.63	0.00	0.00	523600	C033659198
U	BETO	BETOPTIC-S SUS 0.25% O	10	00065-0246-10	- -	6	52.69	55.31	0.00	0.00	523600	C033659198
U	PATAOS5	PATANOL SOL 0.1% OP	5	00065-0271-05	- -	6	60.38	62.44	0.00	0.00	520200	C142462766
U	AZOPT	AZOPT SUS 1% OP	10	00065-0275-10	- -	6	48.44	51.94	0.00	0.00	521000	C138890627
U	EMADI.055	EMADINE SOL 0.05% O	5	00065-0285-05	- -	6	41					

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Attachment 9-4

U	A	ALOMIDE	SOL 0.1% OP	10	00065-0345-10	-	-	6	53.75	57.00	0.00	0.00	520200	C063610093
U	CYCL.15	CYCLOGYL	SOL 1% OP	5	00065-0396-05	-	-	6	19.50	20.13	0.00	0.00	522400	C005870291
U	CYCL115DR	CYCLOGYL	SOL 1% OP	15	00065-0396-15	-	-	6	33.25	34.25	0.00	0.00	522400	C005870291
U	CYCL25	CYCLOGYL	SOL 2% OP	5	00065-0397-05	-	-	6	23.56	24.25	0.00	0.00	522400	C005870291
U	EYES	EYE STREAM	SOL OP	120	00065-0530-04	-	-	6	15.31	15.75	0.00	0.00	523600	P000650530
U	VEXO1%5	VEXOL	SUS 1% OP	5	00065-0626-06	-	-	6	24.06	25.25	0.00	0.00	520800	C049697383
U	MAXI00	MAXITROL	OIN 0.1% OP	3	00065-0631-36	-	-	6	46.00	48.25	0.00	0.00	520800	P000650630
U	TOBR50S	TOBREX	SOL 0.3% OP	5	00065-0643-05	-	-	6	33.44	35.44	0.00	0.00	520404	C049842071
U	TOBR.300	TOBREX	OIN 0.3% OP	3	00065-0644-35	-	-	6	35.63	38.75	0.00	0.00	520404	C049842071
U	TOBRSU	TOBRADEX	SUS OP	5	00065-0647-05	-	-	6	38.25	41.31	0.00	0.00	520800	P000650647
U	TOBR	TOBRADEX	SUS OP	10	00065-0647-10	-	-	6	72.88	78.75	0.00	0.00	520800	P000650647
U	TOBRSU2.5	TOBRADEX	SUS OP	2	00065-0647-25	-	-	6	19.31	20.63	0.00	0.00	520800	P000650647
U	TOBRUNG	TOBRADEX	OIN OP	3	00065-0648-35	-	-	6	41.50	44.81	0.00	0.00	520800	P000650647
U	CILO.35	CILOXAN	SOL 0.3% OP	5	00065-0656-05	-	-	6	33.44	34.94	0.00	0.00	520412	C086393320
U	CILO.32.5	CILOXAN	SOL 0.3% OP	2	00065-0656-25	-	-	6	18.56	19.13	0.00	0.00	520412	C086393320
U	IOPID	IOPIDINE	SOL 0.5% OP	5	00065-0665-05	-	-	6	53.94	57.19	0.00	0.00	523600	C073218798
U	CIPR1T	CIPRO HC	SUS OTIC	10	00065-8531-10	-	-	6	65.63	68.69	0.00	0.00	520412	P999993513
U	LEXX551	LEXXEL	TAB 5-5MG	30	00186-0001-31	-	-	6	39.54	41.12	0.00	0.00	240400	P999996282
U	XYLOC.5%	XYLOCAINE	INJ 0.5%	50	00186-0135-01	-	-	6	4.43	4.42	0.00	0.00	720000	C000073789
U	XYLOC1%EPI	XYLO/EPI	INJ 1%	50	00186-0150-01	-	-	6	5.44	5.42	0.00	0.00	720000	P000931530
U	XYLOC1%10	XYLOCAINE	INJ 1%	50	00186-0275-12	-	-	6	1.99	1.99	0.00	0.00	720000	C000073789
U	XYLO230JE	XYLOCAINE	GEL 2%	30	00186-0330-01	-	-	6	17.75	17.74	0.00	0.00	840800	C000073789
U	XYLO4100SO	XYLOCAINE	SOL 2% VISC	100	00186-0360-01	-	-	6	18.76	18.73	0.00	0.00	521600	C000073789
U	PLEN2.5	PLENDIL	TAB 2.5MG C	30	00186-0450-31	-	-	6	30.96	32.20	0.00	0.00	240800	C072509763
U	PLEN51	PLENDIL	TAB 5MG CR	100	00186-0451-58	-	-	6	103.20	107.33	0.00	0.00	240800	C072509763
U	PLEN101	PLENDIL	TAB 10MG CR	100	00186-0452-58	-	-	6	185.44	192.85	0.00	0.00	240800	C072509763
U	TONO4001	TONOCARD	TAB 400MG	100	00186-0707-68	-	-	6	91.70	95.38	0.00	0.00	240400	C035891931
U	RHIN32	RHINOCORT	SUS AQUA	5	00186-1070-06	-	-	6	48.00	50.40	0.00	0.00	520800	C051333223
U	TOPR50	TOPROL XL	TAB 50MG	100	00186-1090-05	-	-	6	60.62	62.75	0.00	0.00	240400	C098418474
U	TOPR100	TOPROL XL	TAB 100MG	100	00186-1092-05	-	-	6	91.09	94.28	0.00	0.00	240400	C098418474
U	TOPR200	TOPROL XL	TAB 200MG	100	00186-1094-05	-	-	6	182.16	188.53	0.00	0.00	240400	C098418474
U	EMLA5	EMLA	KIT TEGADER	1	00186-1515-01	-	-	6	8.53	8.42	0.00	0.00	940800	P001861515
U	NOLV20	NOLVADEX	TAB 20MG	30	00310-0604-30	-	-	6	109.57	113.35	0.00	0.00	100000	C054965241
U	CASO50	CASODEX	TAB 50MG	30	00310-0705-30	-	-	6	357.93	372.25	0.00	0.00	100000	C090357065
U	DICY10URL	DICYCLOMINE	CAP 10MG	100	00677-0341-01	-	-	6	17.48	26.37	0.00	0.00	120908	C000067925
U	FERRSULELI	FERROUS SULF	ELX 220/5ML	480	00677-0527-33	-	-	6	5.81	6.87	0.00	0.00	200404	C007720787
U	TRIA0.12	TRIAMCINOLON	CRE 0.1%	454	00677-0747-44	-	-	6	20.83	26.39	0.00	0.00	840600	C000076255
U	AMAN100G	AMANTADINE	CAP 100MG	100	00677-1128-01	-	-	6	37.40	36.58	0.00	0.00	081800	C000665667
U	LEVO0.07	LEVOTHYROXIN	TAB 0.075MG	100	00677-1650-01	-	-	6	15.57	21.65	0.00	0.00	683604	C000055038
U	ISCA115	ISOPTO CARP	SOL 1% OP	15	00998-0203-15	-	-	6	20.38	21.00	0.00	0.00	522000	C000054717
U	ISCA130	ISOPTO CARP	SOL 1% OP	30	00998-0203-30	-	-	6	31.56	32.50	0.00	0.00	522000	C000054717
U	ISCA215	ISOPTO CARP	SOL 2% OP	15	00998-0204-15	-	-	6	20.75	21.38	0.00	0.00	522000	C000054717
U	ISCA230	ISOPTO CARP	SOL 2% OP	30	00998-0204-30	-	-	6	32.06	33.00	0.00	0.00	522000	C000054717
U	ISCA415	ISOPTO CARP	SOL 4% OP	15	00998-0206-15	-	-	6	21.88	22.56	0.00	0.00	522000	C000054717
U	ISCA430	ISOPTO CARP	SOL 4% OP	30	00998-0206-30	-	-	6	34.00	35.00	0.00	0.00	522000	C000054717
U	ISCAB3	ISO CARBACHO	SOL 3% OP	15	00998-0225-15	-	-	6	32.50	34.44	0.00	0.00	522000	C000051832
U	GLAU210OS	GLAUCON	SOL 2% OP	10	00998-0250-10	-	-	6	31.56	32.50	0.00	0.00	522400	C000055312
U	ISAT1 5	ISO ATROPINE	SOL 1% OP	5	00998-0303-05	-	-	6	15.50	16.00	0.00	0.00	522400	C000055481
U	ADSOR	ADSORBONAC	SOL 2% OP	15	00998-0504-15	-	-	6	17.75	18.31	0.00	0.00	523600	C007647145
U	ADSOR5	ADSORBONAC	SOL 5% OP	15	00998-0505-15	-	-	6	20.63	21.25	0.00	0.00	523600	C007647145
U	MAXI.10S	MAXIDEX	SUS 0.1% OP	5	00998-0615-05	-	-	6	29.38	30.69	0.00	0.00	520800	C000050822
U	MAXI50S	MAXITROL	SUS 0.1% OP	5	00998-0630-06	-	-	6	42.38	44.38	0.00	0.00	520800	P000650630
U	ECON150S	ECONOPRED PL	SUS 1% OP	5	00998-0637-05	-	-	6	26.50	28.13	0.00	0.00	520800	C000052211
U	MENOMUNE	MENOMUNE	INJ A/C/Y/W	1	49281-0489-01	-	-	6	75.00	77.25	0.00	60.00	801200	P999999987

Records read = 497 - Last Drug [ ] - # Updated = 109

Attachment 4.5

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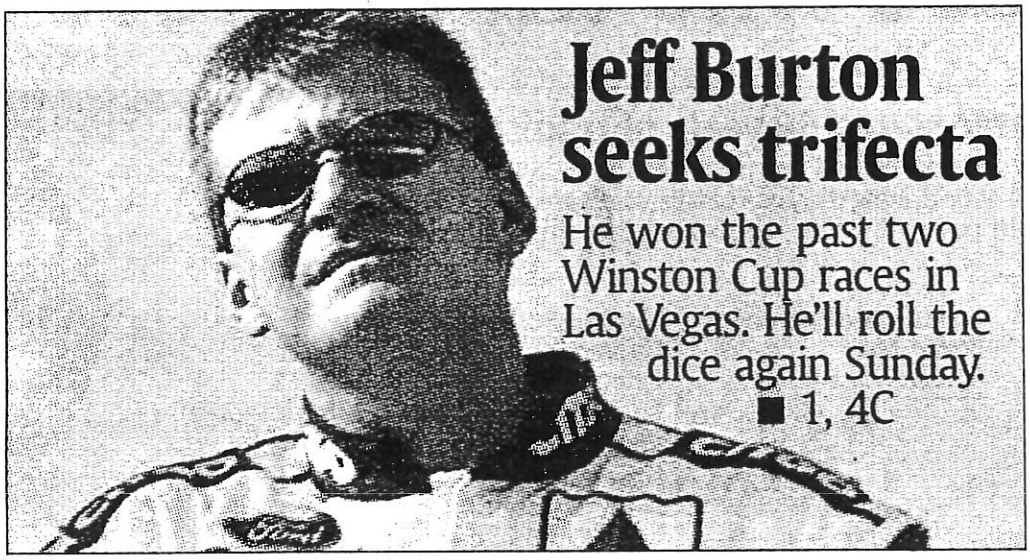
THE

LATE SPORTS



Jeff Burton seeks trifecta

He won the past two Winston Cup races in Las Vegas. He'll roll the dice again Sunday.
■ 1, 4C

By Terry Renna, AP

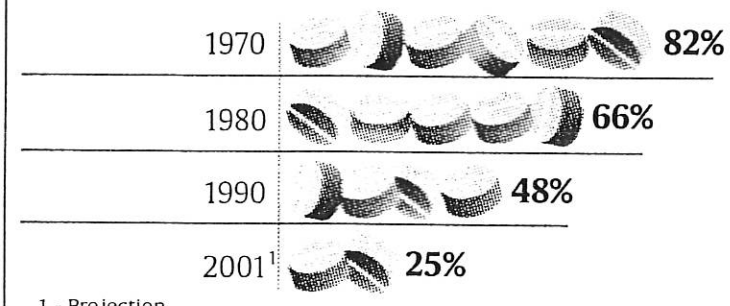
Fri/Sat/Sun, March 2–4, 2001

By John O. Buckley

USA TODAY Snapshots®

Out-of-pocket drug costs drop

Americans will pay for just a fourth of the cost of their prescription drugs out of their own pockets this year. Most are paid for by insurance or state and federal programs. Percentage paid out-of-pocket through the years:



1 - Projection
Source: Health Care Financing Administration

By Keith Simmons, USA TODAY

Tax break

reaching radar of ESPN's *SportsCenter*, there basketball phenomenon of enduring in tance. The Central Intercollegiate Athletic A ciation — whose 12 Division II, historically colleges and universities have an average e ment of about 2,700 — is conducting its annual tournament in Raleigh, N.C.

More than a basketball tournament, this party is part family reunion, part celebrati dition that survived Jim Crow, the civil righ als of the 1960s and, in an odd twist, the ef cial integration. It's a place where friends, fellowship are the main draw.

FBI agents

Order results from spy case

By Kevin Johnson
USA TODAY

WASHINGTON — Hundreds of FBI agents with access to sensitive intelligence information will face more polygraph tests under an order by FBI Director Louis Freeh and Attorney

last week Robert H cused of over the sen's arr vulnerabi counter-i cluding th ing reluc polygrap access to

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EXPRESS SCRIPTS
Charting the Future of Pharmacy

2000: Top Developments on the Pharmaceutical Landscape

Rising Costs Drive Concern About Access and Affordability to the Top of the American Political Agenda.

The cost of prescription drugs and affordability of healthcare captured the attention of lawmakers across America. Proposals for a prescription benefit plan for seniors have proliferated in Congress, but consensus has proved elusive. Some believe coverage should be universal, while others think eligibility should be limited to lower-income seniors. Some prefer a drug benefit offered through private-sector insurers; others argue that a prescription benefit should be added to Medicare.

At the state level, initiatives were advanced on several fronts, including efforts to statutorily restrict the price of drugs and to expand access to pharmaceuticals for low-income seniors through state-based subsidy programs. The Maine Legislature nearly enacted a price-control bill designed to increase access to prescription drugs for the uninsured. A more scaled-back drug discount program was eventually approved, whic is being legally challenged by manufacturers. Eleven additional states passed legislation to establish or expand senior pharmaceutical assistance programs.

What difference will the final form of a Medicare drug benefit make to pharmacy benefi sponsors? By far, seniors consume more prescription drugs than any other segment c the population. If a drug benefit is offered through a government program, plan sponsors could see their costs reduced. On the other hand, if governmental pressure forces pharmaceutical manufacturers to lower retail prices, private plans may find their ability to negotiate rebates and other discounts eroded.

Attachment 4-7

EXPRESS SCRIPTS
Charting the Future of Pharmacy

2000: Top Developments on the Pharmaceutical Landscape

Direct-to-Consumer Advertising Proves Its Power to Influence Prescription Drug Consumption.

In 1999, drug companies spent $907 million in the first half of the year to advertise their products. Over the same period in 2000, they ratcheted direct-to-consumer (DTC) advertising spending up to $1.3 billion — the amount spent on DTC advertising for all of 1998. Why? Quite simply, it's a very good return on investment. When the final numbers are in, spending on DTC advertising for 2000 is expected to surpass the $2 billion mark — an amount equal to only two percent of the total annual expenditure for prescription drugs.

	Top 10 DTC products, 2000 (January through June)	Jan-June 2000 DTC spend	1999 DTC rank	Total 1999 DTC spend
1	Vioxx® (rofecoxib – Merck)	$94.6 million	N/A	N/A
2	Claritin® (loratadine – Schering)	$66.8 million	1	$137.4 millic
3 ✔	Prilosec™ (omeprazole – AstraZeneca)	$62.2 million	4	$79.5 million
4	Viagra® (sildenafil – Pfizer)	$53.5 million	3	$79.5 million
5	Xenical® (orlistat – Roche)	$50.2 million	5	$75.6 million
6	Paxil™ (paroxetine – GlaxoSmithKline)	$47.1 million	N/A	N/A
7	Celebrex™ (celecoxib – Pharmacia)	$41 million	N/A	N/A
8	Propecia® (finasteride – Merck)	$40 million	2	$99.7 million
9	Flonase® (fluticasone – Glaxo Wellcome)	$39.2 million	10	$53.5 million
10	Zyrtec® (cetirizine – Pfizer)	$38.3 million	6	$57.1 million

Drugs in the Top 10 for 1999, but not 2000: Lipitor (#7, $55.5 million), Zyban (#8, $54.8 million), Nolvadex (#9, $54.5 million).

Along with increased media coverage of new drugs and unprecedented access to drug information on the Internet, DTC advertising is a potent factor in the emergence of a growing consumerism among plan members — a force plan sponsors can ill-afford to ignore.

This shift to consumerism is significant not only in media but in content as well. Previously, print advertisements focused on the drug. Today, television advertisements focus on a disease or condition message, and only peripherally mention the drug product, in much the same manner as traditional consumer advertising. In one recent survey, 19 percent of respondents indicated that they had asked their physician for an advertised drug.[1] Remarkably, in the same study, 15 percent of respondents indicated that they would switch physicians if not given the prescription. Clearly, DTC advertising has increased the demand for prescription medications.

FDA APPROVES ASTRAZENECA'S NEXIUM™ (esomeprazole magnesium) FOR ACID REFLUX DISEASE

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New Proton Pump Inhibitor Gives Alternative Treatment Option to Millions Suffering from Frequent and Persistent Heartburn

WILMINGTON, DE (Feb. 21, 2001) — With more than 21 million Americans believed to suffer from gastroesophageal reflux disease (GERD)[1], characterized by frequent and persistent heartburn, new NEXIUM™ (esomeprazole magnesium) may represent an important treatment alternative. NEXIUM will be available by prescription in March.

AstraZeneca announced today that the U.S. Food and Drug Administration (FDA) has approved NEXIUM, a proton pump inhibitor, for heartburn and other symptoms associated with gastroesophageal reflux disease (GERD) and for the healing of erosive esophagitis, a potentially serious condition associated with GERD. The FDA also approved NEXIUM for maintenance of healing of erosive esophagitis and, in combination with amoxicillin and clarithromycin, for eradication of *Helicobacter pylori* infection in patients with duodenal ulcer disease.

"There are millions of patients who suffer needlessly from GERD symptoms, the most common of which is frequent and persistent heartburn," said Peter Kahrilas, M.D., chief, Division of Gastroenterology and Hepatology, Northwestern University Medical School and the principal investigator of a large clinical study involving the drug. "NEXIUM can provide patients with relief from their chronic heartburn symptoms, while healing damage to the esophagus. I'm particularly encouraged by the clinical studies that indicate nearly 9 out of 10 patients with erosive esophagitis were healed when treated with this drug for eight weeks."

AstraZeneca, the maker of PRILOSEC® (omeprazole), developed NEXIUM as an optical isomer, the first proton pump inhibitor (PPI) to be developed in this way. NEXIUM is derived from PRILOSEC, which is a mixture of two molecules with identical molecular structure but different 3-dimensional orientations in space - that is the two molecules are mirror images of each other. NEXIUM is one of these two molecules.

Both NEXIUM, a new prescription product, and PRILOSEC block the final step of acid production in the stomach by inhibiting the acid-producing cells known as parietal cells. PRILOSEC, the first and most prescribed PPI on the market, has been available in the U.S. since 1989. The total dollar value in 2000 of the U.S. PPI market was an estimated $8.3 billion.

The wholesaler acquisition cost (WAC) for NEXIUM is $3.33/capsule for either a NEXIUM

NEXIUM capsules to wholesalers. The actual acquisition cost for individual pharmacies and patients may vary.

NEXIUM 40 mg or 20 mg is indicated for the short-term (4 to 8-weeks) treatment of diagnosed erosive esophagitis (EE). The healing rates of NEXIUM 40 mg and NEXIUM 20 mg were evaluated against PRILOSEC 20 mg (the approved dose for acid-related diseases) in patients with diagnosed EE in four multi-center, double-blind, randomized studies.

NEXIUM is the first PPI to be approved by the FDA, using another PPI as an active control in its pivotal, clinical trials. Results from these trials showed that NEXIUM 40 mg and 20 mg provided excellent healing rates (89.9% to 94.1%) and resolution of heartburn symptoms in erosive esophagitis patients. * Similar to Prilosec

In clinical trials, the safety profile of NEXIUM was similar to that of PRILOSEC. While NEXIUM is generally well tolerated, it is not for everybody. The most frequently occurring side effects were headache (5.5 for NEXIUM 20 mg, 5.0 for NEXIUM 40 mg, and 3.8 for PRILOSEC 20 mg) and diarrhea. Nausea, flatulence, abdominal pain, constipation and dry mouth occurred at similar rates among patients taking NEXIUM or PRILOSEC.

Biaxin® (clarithromycin), should not be used in pregnant women except in circumstances where no alternative therapy is appropriate. Biaxin is marketed by Abbott Laboratories. Amoxicillin is contraindicated in patients with a history of allergic reaction to any of the penicillins.

AstraZeneca **(NYSE:AZN)** is a major international healthcare business engaged in the research, development, manufacture and marketing of ethical (prescription) pharmaceuticals and the supply of healthcare services. It is one of the top five pharmaceutical companies in the world with healthcare sales of $15.8 billion and leading positions in sales of gastrointestinal, oncology, anesthesia (including pain management), cardiovascular, central nervous system (CNS) and respiratory products. In the United States, AstraZeneca is a $7.9 billion healthcare business with more than 10,000 employees.

For more information, please visit www.astrazeneca-us.com. For more information or a copy of the full prescribing information for PRILOSEC or NEXIUM, contact Jim Coyne at 1-800-942-0424, ext. 1656, or via e-mail at jim.coyne@astrazeneca.com or reference the World Wide Web at www.acidcontrol.com.

This press release contains forward-looking statements with respect to AstraZeneca's business. By their nature, forward-looking statements and forecasts involve risks and uncertainties. For a discussion of those risks and uncertainties, please see the company's Annual Report/Form 20-F for 1999.

1. GERD in America, 1997: A Two Year Follow-up Study, Louis Harris and Associates, Inc.

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Additional Background for Editors:

ABOUT GASTROESOPHAGEAL REFLUX DISEASE (GERD)

As many as 25 million adults experience heartburn on a daily basis. Although heartburn is the most common symptom of GERD, the condition is also often marked by other symptoms - such as a sour taste in the mouth or difficulty swallowing - related to the

Attachment 4-10

backing up of harsh stomach acid into the esophagus.

When this acid reflux damages the lining of the esophagus, it may lead to a potentially more serious condition called erosive esophagitis that can lead to narrowing or ulceration of the esophagus.

Click here for a picture of NEXIUM™ (esomeprazole magnesium) 40 mg and 20 mg 30-count capsule bottles.

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Attachment 4-11

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Robert R. (Bob) Williams, M.S., C.A.E.
Executive Director

TESTIMONY

Senate Concurrent Resolution No. 1609
Senate Public Health and Welfare Committee
March 7, 2001

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee regarding Senate Concurrent Resolution No. 1609.

The cost of prescription medication has been an issue of concern for the Kansas Pharmacists Association for many years and we have testified to that fact in the Kansas Legislature on numerous occasions. Community pharmacists often receive complaints and concerns from their patients regarding the high cost of prescription medication. Unfortunately, pharmacists are frequently blamed for increases in the cost of prescription medication. Pharmacists have no control over the cost of prescription medication. In attempts to control the cost of prescription drug programs, reimbursement to community pharmacists by third party payers is frequently reduced resulting in the need for pharmacies to increase volume to dangerously high levels to stay in business or to simply close their doors. For example, as a result in increased costs to the Kansas Medicaid drug program, reimbursement to pharmacists was reduced by SRS last year.

Senate Public Health & Welfare Committee
Meeting Date March 7, 2001
Attachment 5-1

The increased cost in prescription medication appears to be a trend that will continue. There has been no indication that drug prices will be declining. The trend will also continue due to the fact that more and more diseases are being treated by drug therapy. There are numerous studies which indicate that the treatment of diseases with prescription medication is more cost effective than traditional forms of treatment. Unfortunately, many aspects of our health care system have not kept up with this move toward the treatment of diseases with medication and away from traditional methods. SCR 1609 is certainly a move in the direction of rethinking traditional forms of treatment.

KPhA applauds Senator Barnett's objective in drafting SCR 1609, encouraging Congress to address the issue of high cost prescriptions and the need for assistance in paying for prescription medication. There are numerous discussions in Congress regarding the cost of prescription medication and KPhA has been contacted by several members of the Kansas Congressional Delegation regarding those issues. It is KPhA's opinion that our members in Congress would welcome the support of the Kansas Legislature in its efforts to deal with these complicated issues.

We encourage the Senate Public Health and Welfare Committee to recommend favorably SCR 1609.

Thank you.

Attachment 5-2

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Nancy G. Zogleman
Senior Manager
State Government Relations

Statement of Nancy Zogleman
Pfizer, Inc.
Senate Public Health & Welfare Committee
Senate Concurrent Resolution 1609
March 7, 2001

Madam Chair and members:

Thank you for the opportunity to confer with the Committee regarding SCR 1609, a resolution to Congress on the cost of prescription pharmaceuticals. I am a Kansas resident and a former aide to the Senate President. It is a pleasure to once again participate in legislative process in my home state.

SCR 1609 is a well-intended effort to call attention to a national problem of inadequate drug coverage. Pharmaceutical products, like much of health care, has become very expensive. Without private insurance or government assistance, many Americans have a difficult time paying for the services or medicines they need. This problem has been recognized by past and current U.S. Presidents and, we hope, will be addressed by the Congress this year. Those of you who may have watched President Bush's address to the Congress a few days ago will remember the bi-partisan ovation he received for his initiative on prescription drugs. The pharmaceutical industry supports federal initiatives and we support the efforts of SCR 1609 to encourage Congress to address this issue.

We are concerned, however, with some of the information in the Whereas clauses. Attached, are balloon amendments which we believe may clarify these provisions and document the suggested changes. Allow me to walk you through the attachments and the suggested amendments.

First, while there are 39 million Medicare eligibles in the U.S., not all are without drug coverage and not all are on fixed incomes. Therefore, you may wish to change the original version. See attachment.

Senate Public Health & Welfare Committee
Meeting Date March 7, 2001
Attachment 6-1

Second, the Resolution accurately states that the U.S. has averaged 12.2% increases in drug costs, it would be useful for your Senate and House colleagues to know what portions of that increase are attributable to price increases, patient utilization and new products. As you know from personal experience, today's pharmaceutical industry has produced life saving and enhancing products for numerous diseases and ailments, which, heretofore, were untreatable or treated with less success. See attachment.

Third, this change would strike the paragraph dealing with direct to consumer advertising. While there may be some other way to deal with this paragraph, we think some of your colleagues may not want to create the impression that they oppose patient education. The federal law permits and regulates such advertising. It is highly regarded by your constituents and accepted by the AMA. It is the long standing view of our industry that the physician is the proper authority to diagnosis and treat his or her patient. See attachments.

Fourth, in lines 34 and 35, we might suggest a change to strike "in excess of 50%" and to illustrate the phrase "preferred buyers." As you can see, the principal beneficiaries of discount pricing are federal and state governments.

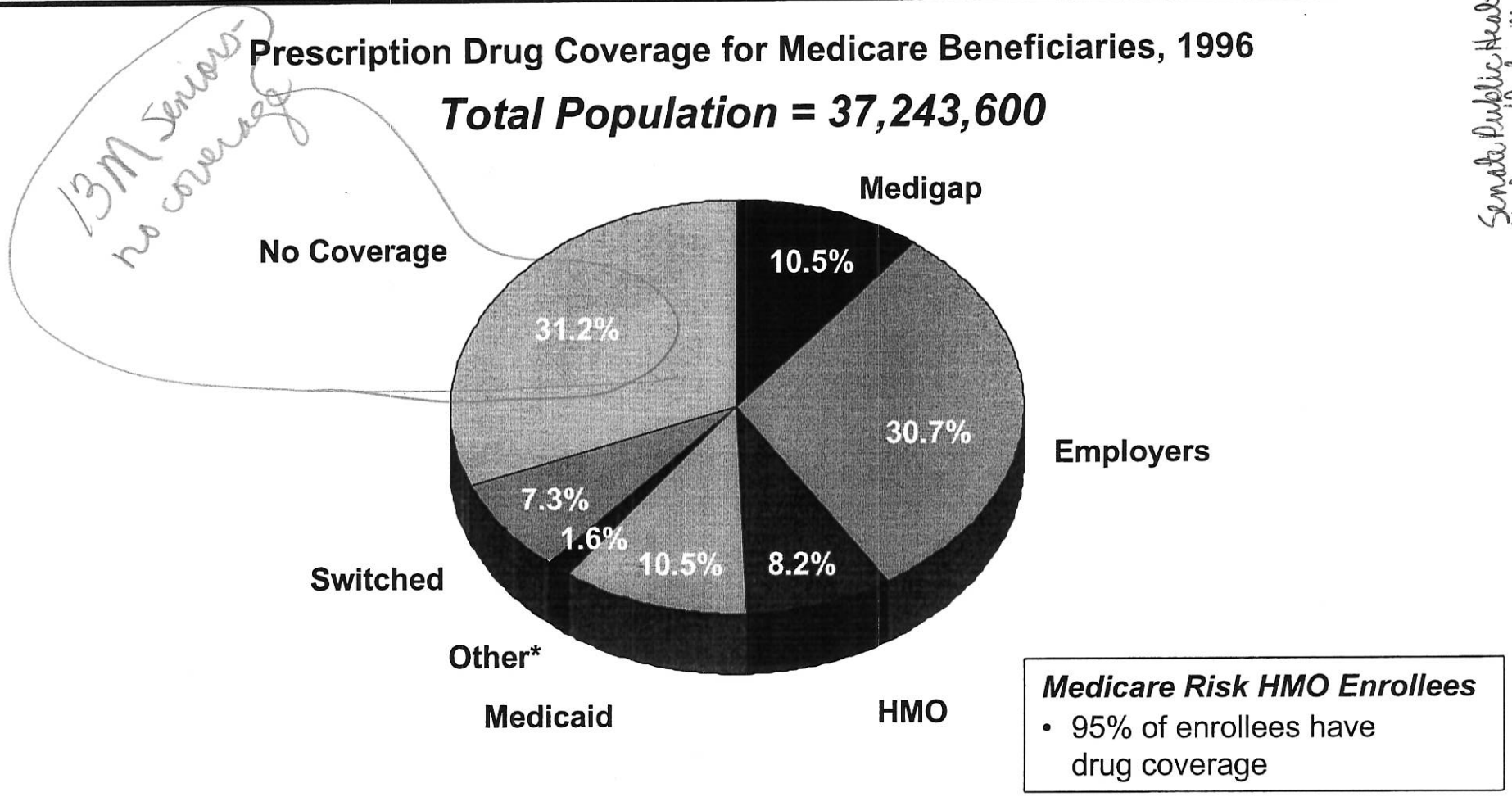
Fifth, the paragraph beginning on line 38 concerns the costs of research and development of drugs and notes that the drug manufacturing industry spent more than four times what other industries spend on research. It also states that most of this cost is paid by "individual" Americans. In fact, most prescription drug costs are paid by insurance, both public and private. Moreover, this paragraph suggests that drug prices should be controlled in the U.S. as they are in some other countries. Once again, we think many of you may be troubled by the notion of the federal or state government imposing price controls on health care, whether it be prescription drugs or provider reimbursements.

Finally, in line 43, the paragraph appears to be critical of mail order pharmacy and internet pharmacy. Both are legal practices. Both are valued by your consumers. And both help consumers buy their medicines at better prices.

Thank you for considering our thoughts and these suggested changes. I trust that you will find them helpful and that they will gather the support of your colleagues to SCR 1609.

Attachment 6-2

About 69% of all Medicare-eligible beneficiaries have some form of coverage, with employers being the largest single group of payers



* Other category includes other public programs including the Veterans Administration, Department of Defense & State Pharmaceutical Assistance Programs & nonrisk HMOs.

Source: Poisal JA, Chulis GS. *Health Affairs*. March/April 2000; 248-256.

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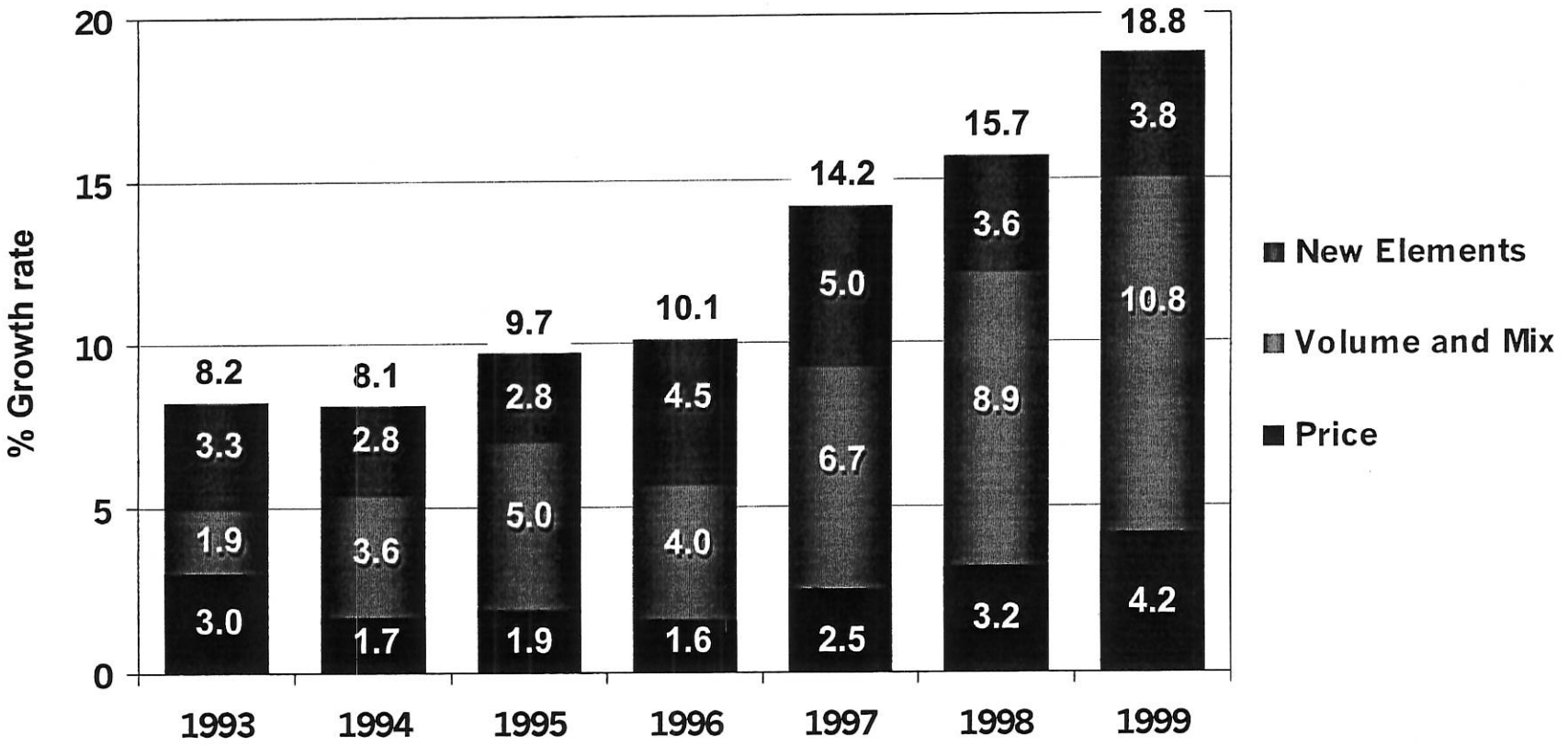
Meeting Date March 7, 2001
Attachment 7-1

Although prescription drug prices have increased, they are a small contributor to overall drug expenditure increases

Attachment 7.2

Price as Component of Prescription Drug Expenditure Growth

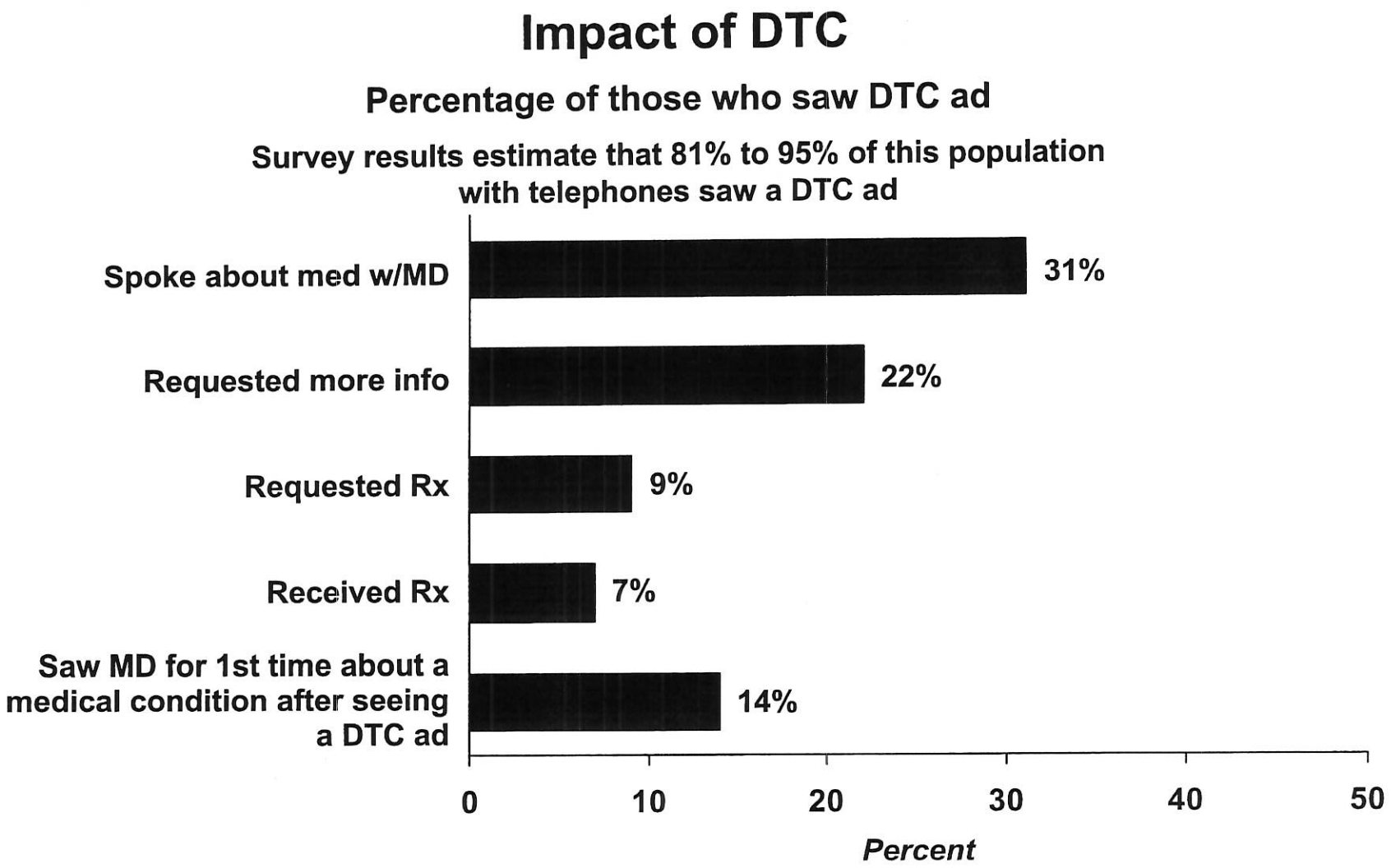


Note: Prior to 1993, market includes only retail pharmacy and nonfederal hospital distribution channels. From 1993 to 1999, market includes six audited channels: retail pharmacies, nonfederal hospitals, staff-model HMOs, clinics, long-term care and federal facilities. Growth rates reflect percent change in sales dollars for specified calendar year versus previous calendar year.

Source: *Pharmaceutical Pricing Update,* Plymouth Meeting, PA: IMS Health; March 2000;7-3.

People exposed to DTC advertising become proactive regarding their health, including drug usage

Attachment 7-3



Source: 1999 National Survey of Consumer Reactions to Direct-to-Consumer Advertising. *Prevention Magazine* (sample=1,205 consumers, 18+), 1999.

H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs

(1) Our AMA considers acceptable those product-specific direct-to-consumer advertisements (DTCA) that follow the guidelines for such advertisements that were developed by the AMA, in consultation with the FDA, in 1993. These guidelines also apply to DTC A of FDA approved medical devices, and are as follows: (a) The advertisement should be disease-specific and enhance consumer education; (b) The ad should convey a clear, accurate and responsible health education message (i.e., information on the prevention or treatment of a disease, disorder, or condition); (c) In all cases, the ad should refer patients to their physicians for more information; (d) The ad should not encourage self-diagnosis and self-treatment, but should identify the consumer population at risk; (e). Discussion of the use of the drug product for the disease, disorder, or condition should exhibit fair balance; (f) Warnings, precautions, and potential adverse reactions associated with the drug product should be clearly explained so as to facilitate communication between physician and patient; (g) No comparative claims can be made for the product. In the interest of fair balance, alternative non-drug management options for the disease, disorder, or condition can be included; (h) The brief summary information should be presented in language that can be understood by the consumer; (i) The advertisement must comply with applicable FDA rules, regulations, policies and guidelines as provided by their Division of Drug Marketing, Advertising and Communications; (j). The ad should be part of a manufacturer's education program that would include collateral materials to educate both physician and consumer; and (k) The manufacturer should not run concurrent incentive programs for physician prescribing and pharmacist dispensing.

(2) Our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.

(3) Our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical industry to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

(4) Our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content, an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

(5) Our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTCA and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion.

(6) Our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical industry to make policy changes regarding DTCA, as necessary. (BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509,and Reaffirmation, I-99)