Approved: May 1, 2002
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 12:10 a.m. on February 28, 2002 in Room 123-S of the Capitol.

All members were present except: Senator David Adkins - excused

Committee staff present:
Alan Conroy, Chief Fiscal Analyst, Kansas Legislative Research Department
Deb Hollon, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman

Conferees appearing before the committee:
Dr. Robert Day, Director of Medical Policy/Medicaid, Health Care Policy, Department of Social and Rehabilitation Services
Senator James Barnett
Bob Williams, Executive Director, Kansas Pharmacists Association
Joyce Volmut, Executive Director, Kansas Association for the Medically Underserved
Sally Finney, Executive Director, Kansas Public Health Association, Inc.
Marjorie Powell, Assistant General Counsel, Pharmaceutical Research and Manufacturers of America, Washington, D.C.
Jo Ann Howley, Concerned Citizen
Elizabeth Adams, Executive Director, NAMI Kansas
Dr. Stephen Feinstein, Ph.D., Chairman, Kansas Mental Health Coalition
Bryce Miller, President, NAMI Topeka
Barbara Bohm, Director, Spirit Three
Sharon Copeland, Concerned Citizen
Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
Jane Adams, Executive Director, Keys for Networking, Inc. (Written Testimony)
Senator Anthony Hensley
Jim Snyder, President, Kansas Council of Silver Haired Legislators
Dr. Earnest Pogge, Coordinator of the AARP Kansas Legislative Task Force

Others attending: See attached list

Bill Introductions

Senator Jordan moved, with a second by Senator Jackson, to introduce a bill concerning retirement; relating to certain school retirants (1rs2254). Motion carried on a voice vote.

Senator Jordan moved, with a second by Senator Jackson, to introduce a bill concerning children's health insurance benefits; relating to eligibility requirements (1rs2281). Motion carried on a voice vote.

Senator Schodorf moved, with a second by Senator Kerr, to introduce a bill concerning supplemental appropriations for the Judicial Branch (1rs2280). Motion carried on a voice vote.

Chairman Morris called the Committee's attention to discussion of:

SB 422--Reimbursement by the department of social and rehabilitation services for certain drugs

Dr. Robert Day, Director of Medical Policy/Medicaid, Department of Social and Rehabilitation Services, spoke to the Committee regarding **SB 422** and explained a proposed amendment. Committee questions and discussion followed.

Senator Barone moved, with a second by Senator Kerr, to amend **SB 422** with the proposed Department of Social and Rehabilitation Services language (Attachment 1). Motion carried on a voice vote.

Senator Barone moved, with a second by Senator Kerr, to recommend **Substitute for SB 422** favorably for passage as amended. Motion carried on a roll call vote.

Chairman Morris opened the public hearing on:

SB 603--Drug coverage

Staff briefed the Committee on the bill.

Dr. Robert Day, Director of Medical Policy/Medicaid, Department of Social and Rehabilitation Services, presented information regarding **SB 603** (Attachment 2). Dr. Day explained that **SB 603** would enable the Secretary of the Department of Social and Rehabilitation Services to negotiate with drug manufacturers and labelers for discount prices or rebates for prescription drugs deeper than those achieved through Federally mandated rebate practices. In testimony, Dr. Day noted that without more management activity around the Medicaid program, it would be difficult to sustain projected growth. He also mentioned the need to establish management tools that will help to assure the most effective use of Medicaid dollars and **SB 603** could provide SRS with one such tool to enable them to ensure best pricing for prescription drugs and managing prescription drugs has now become the most costly component of the Department's prescription drug budget.

Senator James Barnett testified in support of **SB 603** (Attachment 3). Senator Barnett explained that he has practiced medicine for nearly 20 years and his treatment approach has changed and improved dramatically in part because of new drug therapies. He mentioned that he has concerns about the amount of money spent on marketing and advertising, including direct to consumer marketing that complicates his ability to provide affordable care to his patients. Senator Barnett referred to the spending of the top ten pharmaceutical companies on marketing vs. research and development and asked that it be noted that marketing is representative of 32.5 percent of sales vs. research and development that receives 12.4 percent. In concluding his testimony, Senator Barnett noted that the people of the State of Kansas are paying for these types of promotionals with hard-earned tax dollars and it is time to say no.

Bob Williams, Executive Director, Kansas Pharmacists Association, spoke in support of **SB 603** (Attachment 4). Mr. Williams mentioned that **SB 603** would allow SRS to negotiate additional drug rebates with drug manufacturers. In his testimony, Mr. Williams explained that the State of Kansas needs to follow the lead of other states in their efforts to control the cost of Medicaid prescription drugs.

Joyce Volmut, Executive Director, Kansas Association for the Medically Underserved, spoke in support of **SB 603** (Attachment 5). Ms. Volmut mentioned that their association supports the bill because it is a step in the right direction for alleviating one of the barriers clients face in completing their treatment of care. She also noted that they would also ask that the medically indigent clinics in Kansas be included in the bill.

Sally Finney, Executive Director, Kansas Public Health Association, Inc., spoke in support of **SB 603** (Attachment 6). Ms. Finney explained that the Kansas Public Health Association believes that any measure that will increase the buying power of the Kansas Medicaid program without compromising the ability of clients to receive basic care is good public health policy and this is why they support the bill. She noted that from her perspective as a public health advocate, this is a short-term solution. In closing, Ms. Finney mentioned that the only workable long-term strategy for reducing both public sector and private sector health care costs is to redirect significant resources to primary prevention efforts.

Marjorie Powell, Assistant General Counsel, Pharmaceutical Research and Manufacturers of America (PHARMA), Washington, D.C., spoke in opposition to **SB 603** (Attachment 7). Ms. Powell mentioned that PHARMA represents the innovative drug manufacturers, those companies that are researching and developing new medications and they are very concerned with issues of access. She noted that they have supported a Medicare drug benefit at the federal level, and explained that if there were to be a Medicare drug benefit, some portion of the states' Medicaid drug line item would be picked up entirely by the

federal government because Medicare is the first payer. Ms. Powell also mentioned that they have concerns when a prior authorization program is tied to rebates as a mandatory program that is grounded in cost considerations as opposed to medical or scientific bases or management of the Medicaid program. She urged the Committee to look at what is happening in other states. Ms. Powell addressed the costs in sales and marketing being higher than in research and development costs and explained that those sales and marketing numbers include all of the samples that manufacturers provide to physician and the information that is provided to physicians about a new medication. Committee questions and discussion followed.

Jo Ann Howley, concerned citizen, spoke in opposition to **SB 603** (Attachment 8). Ms. Howley mentioned that her son was diagnosed with paranoid schizophrenia and that he was hospitalized almost continuously for fifteen years. She noted in her testimony that due to the proposed legislation, her son may be prescribed a cheaper medication and not the current medication which allows him to live successfully outside the confines of the hospital. She questioned the cost of long term hospitalization to the $600.00 a month for his medication.

Elizabeth Adams, Executive Director, NAMI Kansas, spoke in opposition to **SB 603** (Attachment 9). Ms. Adams mentioned that NAMI's premise is that people in need should have access to the right treatment, including the right medication, at the right time for that individual's successful recovery of life. She noted that for many people with schizophrenia, their first exposure to antipsychotic medication may have life-long implications for compliance with treatment. If they must fail first on older drugs or face bureaucratic hurdles that seem insurmountable to get treatment, they may lose their best opportunity for intervention and recovery.

Dr. Stephen Feinstein, Chairman, Kansas Mental Health Coalition, spoke in opposition to **SB 603** (Attachment 10). Dr. Feinstein explained that the Kansas Mental Health Coalition believes that **SB 603** is both fiscally unwise and unethical in its treatment of Kansans who are poor and mentally ill. He mentioned that the bill is fiscally unwise because it does not take into account the well-documented reductions in the cost of treatment that result when sick people have timely access to the most effective medications. Dr. Feinstein noted that selectively denying treatment just does not reflect the democratic system or the value, as a nation, placed on human life.

Bryce Miller, President, NAMI Topeka, spoke in opposition to **SB 603** (Attachment 11). Mr. Miller explained that **SB 603** contains no consumer input and no consumer safeguards in the selection and use of the formulary and he finds the bill flawed. He noted that things must not return to the "prior authorization" days of a decade ago.

Barbara Bohm, Spirit Three, spoke in opposition to **SB 603** (Attachment 12). Ms. Bohm presented her own concerns and experiences to the Committee as stated in her written testimony.

Sharon Copeland, concerned citizen, spoke in opposition to **SB 603** (Attachment 13). Ms. Copeland expressed concern that as a member of the National Alliance for Mental Illness Kansas, a Registered Nurse and mother of a son with mental illness, that it would be very detrimental to the treatment of this disease and a set back in treatment if the bill is passed. She noted that the newer medications are more expensive, but if they keep those with mental illness out of institutions, jails, off of drugs and alcohol, and alive, it can actually be a cost saver for the State of Kansas.

Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas, Inc., spoke in opposition to **SB 603** (Attachment 14). Mr. Klotz explained that people with mental illness need some kind of protection under this type of attempt to save money for the state. They are interested in keeping cost down. Community mental health centers of which there are 29 across the state have become the major provider of mental health services and they do rely heavily on Medicaid. Mr. Klotz mentioned that is written testimony gives reasons why the mentally ill need protection.

Written testimony was received from Jane Adams, Ph.D, Executive Director, Keys for Networking, Inc., in opposition to **SB 603** (Attachment 15).

Committee questions and discussion followed after the various conferee testimony and the Chairman thanked the conferees for their appearance before the Committee. There being no further conferees to come before the Committee, the Chairman closed the public hearing on **SB 603**.

Chairman Morris opened the public hearing on:

SCR 1621--Urging Congress to enact prescription drug coverage under medicare

Staff briefed the Committee on the bill.

Senator Anthony Hensley spoke in support of **SCR 1621** and distributed background information for consideration as follows relating to **SB 589**:

- State of Kansas Department on Aging Report on the 2000 Survey of Kansas Seniors (Attachment 16)
- Rescuing the Kansas Senior Pharmacy Assistance Program (Attachment 17)
- Kansas Intergovernmental Transfer Program, Budget Division Estimates (Attachment 18)

Senator Hensley mentioned that **SB 589** is a proposal to expand Kansas pharmacy assistance program to cover approximately 35,000 Kansans as opposed to the current program which covers approximately 1,000 Kansans. He also explained that **SCR 1621** is a very critical issue for a number of senior Kansans across the state which would establish a prescription drug relief program through Medicare and hopefully in the near future that would become a reality.

Chairman Morris mentioned that he will schedule **SB 589** for a hearing the week of March 11, 2002.

Jim Snyder, President, Kansas Council of Silverhaired Legislators, spoke in support of **SCR 1621** (Attachment 19). Mr. Snyder mentioned that **SCR 1621** provides for a request of the Congress of the United States to provide monies in the Medicare Portion of Social Security funds to help in the purchase of prescription drugs by senior citizens.

Dr. Ernest Pogge, Coordinator of the AARP Kansas Legislative Task Force, spoke in support of **SCR 1621** (Attachment 20). Dr. Pogge mentioned that enacting a meaningful Medicare drug benefit this year is a top priority for AARP and their members; therefore, AARP supports **SCR 1621**.

Written testimony was received from Bob Williams, Executive Director, Kansas Pharmacists Association, in support of **SCR 1621** (Attachment 21).

Chairman Morris thanked the conferees for appearing before the Committee. There being no further conferees to come before the Committee, the Chairman closed the public hearing on **SCR 1621**.

Senator Feleciano moved, with a second by Senator Jordan, to recommend **SCR 1621** favorably for passage. Motion carried on a roll call vote.

The meeting was adjourned at 1:50 p.m. The next meeting is scheduled for March 5, 2002.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE 2-28-02

NAME	REPRESENTING
Trudy Racine	SRS
Eric Kutsby	AARP
Ernie Pogge	AARP
Jesse Romero	Center for Policy alternatives
Lyn M. Wilson	American Heart Ass'n.
Stephanie Sharp	Amer. Cancer Society
	Pat Hubbell Assoc.
Barbara Belcher	Merck
PAUL POISTER	PhRMA
Joyce Dorent	KAMC
Elizabeth Adams	NAMI-KS
Stephen Feinstein	Kansas Mental Health Coalition
Sharon Copeland	NAMI-KS
Jo Ann Hawley	self
Barbara Bohm	NAMI-KS, SCICK
Chris Collins	KMS
Carolyn Middendorf	Ks St Ds Assn
Chris Beal	Lilly
Scott Brown	Lilly
Nancy Zogleman	Pfizer
	Kearney Law / KAC
Kelly Tinsley	Ks. Public Health Assn.
John Peterson	Ks Govt Consulting

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE February 28, 2002

NAME	REPRESENTING
DICK KNOSPEL	ABBOTT LABORATORIES
CAROL A. CURTIS	AstraZeneca
Kate Kulesher	Wyeth
Myrta Myers	Johnson & Johnson
Pat Hubbell	Pharma
Marjorie Powell	PhRMA
[illegible]	Eleazer Smith Klein
Jim Snyder	Council - Silver Haired Legis
Ted Roberts	" " "
Craig Kobe	KCDD
Laura Howard	SRS
Bryce Miller	NAMI
Robert Day	SRS
Tammara Capps	Purdue
Tom Rickmon	AVENTIS
Paul M. Hoth	Assoc. of CMHCs of KS, Inc.
Mike Hammond	Assoc. of CMHCs of KS
Bob Williams	KS. Pharmacists Assoc
Jason Moore	Hutchinson Pharmacy Student (KU)
PETER STERN	KS. PHARMACY SERVICE CORP.
Bob Alderson	KS. PHARMACISTS ASSOC.
Don Hill	MEDICINE SHOPPE PHARMACY, EMPORIA KS

SENATE BILL No. 422
By Committee on Ways and Means
1-23

AN ACT concerning reimbursement by the department of social and rehabilitation services for certain drugs; relating to the medicaid pharmacy programs; changing certain rules and regulations requirements; amending K.S.A. 39-7,120 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. ***(a) Except where a prescriber has personally written "dispense as written" or "D.A.W.," or has signed the prescriber's name on the "dispense as written" signature line in accordance with K.S.A. 2001 Supp. 65-1637, the department of social and rehabilitation services may limit reimbursement for a prescription under the medicaid program to the multisource generic equivalent drug.***

(b) No pharmacist participating in the medical assistance program shall be required to dispense a prescription-only drug that will not be reimbursed by the medical assistance program.

~~(a) A practitioner may prescribe prescription-only drugs in accordance with this section that, in the professional judgment of the practitioner and within the lawful scope of the practitioner's practice, the practitioner considers appropriate for the diagnosis and treatment of a patient. The department of social and rehabilitation services may maintain a drug formulary under the medicaid program. However, such formulary shall not restrict a physician's ability to treat a patient with a drug that has been approved and designated as safe and effective by the federal food and drug administration act. The department may limit reimbursement for a prescription-only drug upon the recommendation of the drug utilization review committee and upon a finding that the drug is unsafe or is being prescribed contrary to the federally approved guidelines. Drugs used for cosmetic purposes, fertility drugs, anorexic drugs, nonlegend (over the counter) drugs, and drugs for which there is no federal financial participation shall be exempt from the provisions of this section, except that the department is authorized to include drugs from these categories for reimbursement based upon recommendations of the drug utilization review committee which may include prior authorization requirements to control use.~~

~~(b) Nothing in this section shall limit the authority of the department to reimburse~~

Senate Ways and Means
2-28-02
Attachment 1

~~for multisource prescription-only drugs in accordance with state and federal law, including state maximum allowable cost and federal upper limit requirements of the health care financing administration.~~

~~(c) The provisions in this section apply only to medicaid enrolled pharmacists engaged in dispensing prescriptions, drugs and medicines to medicaid patients. Except as provided in this section, it shall be unlawful for any pharmacist, assistant pharmacist or pharmacist intern who dispenses prescriptions, drugs and medicines to substitute an article different from the one ordered, or deviate in any manner from the requirements of an order or prescription without the approval of the prescriber.~~

~~(1) When a pharmacist receives a written prescription on which the prescriber has personally written in handwriting ''dispense as written'' or ''D.A.W.'', or an oral prescription in which the prescriber has expressly indicated that the prescription is to be dispensed as communicated, the pharmacist shall dispense the brand name legend drug as prescribed.~~

~~(2) When a pharmacist receives a written prescription on which the prescriber has not personally written in handwriting ''dispense as written'' or ''D.A.W.'', or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug that is rated equivalent (AB-rated) by the food and drug administration and in the pharmacist's professional judgment, is safely interchangeable with the prescribed drug, then the pharmacist, after disclosing the substitution to the purchaser, shall dispense the generic drug, unless the purchaser objects. A pharmacist may also substitute pursuant to the oral instructions of the prescriber. A pharmacist shall notify the purchaser if the pharmacist is dispensing a drug other than the brand name drug prescribed.~~

~~(3) A pharmacist dispensing a drug under the provisions of (c)(2) shall not dispense a drug of a higher retail price than that of the brand name drug prescribed. If more than one safely interchangeable generic drug is available in a pharmacist's stock, then the pharmacist shall dispense the least expensive alternative.~~

~~(4) Nothing in this section requires a pharmacist to substitute a generic drug~~

~~if the substitution will make the transaction ineligible for medicaid reimbursement.~~

~~(5) When a pharmacist dispenses a brand name legend drug and, at that time, a less expensive generically equivalent drug is also available in the pharmacist's stock, the pharmacist shall disclose to the purchaser that a generic drug is available.~~

~~(6) This section does not apply when a pharmacist is dispensing a prescribed drug to persons covered under a managed health care plan that maintains a mandatory or closed drug formulary.~~

Sec. 2. K.S.A. 39-7,120 is hereby amended to read as follows: 39-7,120. *(a) Except as provided in subparagraph (b),* the department of social and rehabilitation services shall not restrict patient access to prescription-only drugs pursuant to a program of prior authorization or a restrictive formulary except by rules and regulations adopted in accordance with K.S.A. 77-415 *et seq.* Prior to the promulgation of any such rules and regulations, the department shall submit such proposed rules and regulations to the medicaid drug utilization review board *during an open meeting* for written comment. *The department may implement permanent prior authorization 30 days after receipt of comments by the drug utilization review board.*

(b) The department may impose temporary prior authorization on any prescription only drug for a period of no more than 120 days without the adoption of rules and regulations as required in subparagraph (a) of this section. Such prior authorization shall first be presented to the drug utilization review board and placed on the agenda of the board for public oral and written comment at the next regularly scheduled meeting. Notice of such prior authorization and any approval criteria shall be provided in writing to those persons who have requested notice of drug utilization review board meetings, drug manufacturers of the products affected by the prior authorization and recognized physician and pharmacist associations in Kansas. Following the public comment, the board shall make a recommendation whether to temporarily place prior authorization on a prescription only drug which may include suggested approval criteria. The department may impose the prior authorization on such drug, including approval criteria, 30 days after receipt of comments by the drug utilization review board. Written notice of the temporary prior authorization

shall be provided by the department to the joint committee on rules and regulations.

Sec. 3. K.S.A. 39-7,120 is hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
Topeka, Kansas 66612-1570

for additional information, contact:

Operations
Diane Duffy, Deputy Secretary

Office of Budget
J.G. Scott, Director

Office of Planning and Policy Coordination
Trudy Racine, Director

phone: 785.296.3271 ***fax:*** 785.296.4685

Senate Ways and Means Committee
February 28, 2002

Senate Bill 603

Health Care Policy
Robert Day, Ph.D
Director of Medical Policy/Medicaid

Senate Ways and Means
2-28-02
Attachment 2

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee
February 28, 2002

Chairman Morris and members of the committee, I am Robert Day, Director of Medical Policy/Medicaid in the Health Care Policy Division of SRS. Thank you for the opportunity to discuss Senate Bill 603, a bill that would enable the Secretary to negotiate with drug manufacturers and labelers for discount prices or rebates for prescription drugs deeper than those achieved through Federally mandated rebate practices (OBRA '90).

As you are aware, without more management activity around the Medicaid program, it will be difficult to sustain projected growth. We need to establish management tools that will help to assure the most effective use of Medicaid dollars. This bill could provide us with one such tool by enabling us to ensure best pricing for prescription drugs. Having this tool could be one of a number of possible ways to manage prescription drugs, what has now become the most costly component of the prescription drug budget.

Other states have instituted such a supplemental rebate program to enhance pharmaceutical savings. California has used this tool for more than 12 years. Its strategy, similar to the one outlined in SB 603, is to place on a prior authorization list any drug for which a manufacturer will not agree to provide a supplemental rebate. Florida has taken this a step farther by specifying that drug manufacturers offer a supplemental rebate 6-10% above the average federal rebate (15.1%), or risk having their drugs added to the prior authorization list.

Requiring prior authorization for a drug can substantially reduce sales for that drug. For example, when added to Florida's prior authorization list, one brand name anti-migraine drug fell from 60% to 6% of the market share in that state, while a preferred anti-migraine drug climbed to 89% of market share from only 16%. Using this cost manager, Florida alone anticipates a fiscal year's savings of more than $100 million.

Those who oppose supplemental rebate programs have argued that these plans limit the availability of drugs to consumers and violate federal law. We are not interested in any plan that would compromise patient care, and we firmly believe that the implementation of this Senate Bill 603 could be done in a way so as not to compromise patient care. Instead, this program must encourage doctors to use preferred drugs, but not prevent patients from accessing any non-preferred drugs. The creation of a formulary committee, composed of health care providers, could ensure that beneficiaries have appropriate access to medications determined to meet the standard of medical necessity. This committee would analyze, based on cost, safety, and efficacy data, which drugs and drug classes should be placed on the Medicaid formulary

While there have been a number of legal challenges to the creation of a preferred formulary that

involves supplemental rebates, to the best of our knowledge, the litigation has not resulted in termination of these programs.

States are benefitting fiscally from employing the supplemental rebate program. We believe that pharmaceutical cost savings in Kansas would mirror those experienced in these states. Based on experience of a similar program in Florida, it is estimated Kansas could eventually receive up to an additional 5% in drug rebates for this program or approximately $10 million if this bill were passed. To process the additional rebates, an additional three staff would have to be added to the MMIS management staff and the MMIS program would have to be modified. These costs, totaling $620,000 in the first year and $120,000 in the subsequent year could be paid from the rebate proceeds and federal funds.

I stand ready to answer any questions you might have.

STATE OF KANSAS

JAMES A. BARNETT
SENATOR, 17TH DISTRICT
HOME ADDRESS: 1400 LINCOLN
EMPORIA, KS 66801
OFFICE: STATE CAPITOL BUILDING—136-N
TOPEKA, KANSAS 66612-1504
785 296-7384
1-800-432-3924

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 for SB 603

Prescription Drug Costs

Chairman Morris and distinguished members of the Senate Ways and Means Committee, thank you for the opportunity to come before you today to discuss prescription drug costs for the state of Kansas. First of all, let me speak in support of the benefits Kansans and all Americans receive from advances in prescription drug therapy. I have practiced medicine for nearly 20 years. My treatment approach has changed and improved dramatically in part because of new drug therapies. I can do a better job of controlling diabetes, treating hypertension, and lowering cholesterol than ever before. As well, the development of proton pump inhibitors such as Prilosec have resulted in the closest thing to what patients will describe as a miracle drug during my years of practice. At the same time, drug prices have grown dramatically and far ahead of the rate of inflation.

- Prescription drug pricing.
- Competitive pricing.
- Current formulary practice.
- Assume litigation.
- Potential savings.
- Future relief for Kansans.

In closing, I again want to express my gratitude to the pharmaceutical companies of America. I, like many other physicians, are greatly appreciative of the opportunity to use their product.

However, I join many other physicians who know that the time for better control of drug costs has long passed. Like others, I have concerns about the amount of money spent on marketing and advertising, including direct to consumer marketing that complicates our ability to provide affordable care to our patients. I refer you to the spending of the top 10 pharmaceutical companies on marketing vs. research and development and ask that you note that marketing is representative of 32.5% of sales vs. research and development that receives 12.4%. I am tired of being offered money in my pocket to use the products of pharmaceutical companies. I have attached letters of invitation to attend meetings. One

Senate Ways and Means
2-28-02
Attachment 3

is from Eli Lilly that offers me $1,500.00 to attend a meeting. Another offers $1,000.00, and yet another has a number of telephone conferences that I can place to receive $100.00 per call. Most bothersome of all was a flyer that I received on my desk called "Fuel and Facts." This was received last summer when the price of gasoline was nearing $2.00. I was invited to meet at a local Texaco station and while my car was filled with gas, listen to the benefits of Claritin. This deeply disturbed me. I declined on all of these offers. The people of the state of Kansas, however, are paying for these types of promotionals with their hard-earned tax dollars. It is time to say no, and it is time to ask for a better price.

Thank you.

Signed:

Senator Jim Barnett

Lowering Prescription Drug Prices for States and Uninsured Residents

The Problem:

Spiraling prescription drug costs have hit states hard in two ways: (1) drug costs are busting state Medicaid budgets and burdening other state health coverage programs, and (2) uninsured state residents, especially seniors, are unable to afford the medicines they need.

Background on Drug Pricing:

If the retail cost for a particular dosage and quantity of a brand name prescription drug is $100, on average:

- An uninsured resident pays $100 for that prescription
- Medicaid and large HMOs pay $65
- Federally-qualified health centers pay $54 (called the "340B" price)
- The federal government (largely, the U.S. Departments of Defense and Veterans Affairs) pays $46 or less.

Drug manufacturers make a healthy profit on all of these prices.

Drug manufacturers sell the exact same pharmaceuticals to different purchasers at widely varying prices (see the box for an illustration). Uninsured Americans pay the highest prices, except in the state of Maine which has a program to substantially lower drug prices for the uninsured. State Medicaid programs pay a price fixed by federal law, except in the states of California and Florida, which negotiate greater discounts directly from drug companies.

What States Can Do:

First, states can negotiate lower Medicaid drug prices, as California and Florida do

Federal law permits states to negotiate supplemental Medicaid rebates from drug companies above and beyond the federally-designated rebates. In the illustration above, a state that negotiates a discount from the federally-designated Medicaid price to the "340B" price ($65 to $54) would save 17% of the cost. California has negotiated supplemental drug rebates for more than a decade. In 2001, Florida became the second state to enact legislation for supplemental Medicaid rebates, which was projected to save the state $200 million per year.

Second, states can negotiate lower prices for the uninsured, as Maine does

Uninsured residents pay excessive prices for prescription drugs. In many cases, these high prices have the effect of denying residents access to medically necessary care, thereby threatening their health and safety. States can provide uninsured residents with substantially reduced drug prices. Under federal law, a state pharmaceutical assistance program can pay less for drugs than the federally-designated Medicaid price. By setting up a program similar to the one in Maine, states can negotiate drug prices for the uninsured similar to or lower than the "340B" price. In the illustration above, a $100 price currently paid by the uninsured would be lowered to $54, a savings of 46%.

Center for Policy Alternatives ◆ 1875 Connecticut Avenue NW, Suite 710 ◆ Washington, DC 20009
(202) 387-6030 FAX (202) 387-8529 ◆ info@cfpa.org ◆ www.stateaction.org

The United States District Court of the District of Columbia upheld the legality of Maine's prescription drug discount program in a ruling on Monday. Pharmaceutical Research and Manufacturers of America (PhRMA) had challenged the Healthy Maine Prescription (HMP) program, arguing that it violated Section 1115 Medicaid demonstration program standards.

HMP, in operation since June 1, 2001, is authorized through a Section 1115 Medicaid demonstration waiver approved by the federal government on January 18, 2001. The program provides discounts on prescription drugs to persons with incomes of up to 300% of the poverty level who are not eligible for Medicaid. The price beneficiaries pay for a prescription is equal to the Medicaid payment rate for a prescription less 14%. Maine requires pharmaceutical manufacturers to pay rebates for drugs prescribed under HMP in accordance with the Medicaid rebate schedule. The state disburses the rebate funds to retail pharmacies to cover the cost of the subsidy and program administration. (Pharmacists receive a fixed subsidy totaling 18%.) Since July 2001, Maine has paid pharmacists an additional two percent--or about $1 per prescription--in state-only (unmatched) funds.

PhRMA asked for a summary judgment invalidating HMP and enjoining the Secretary of the Department of Human Services from approving any other programs that include any of the features of HMP. They argued that Maine's program unlawfully required rebates from drug manufacturers even though it made no state payments under the state's Medicaid plan, failed to provide medical assistance in accordance with legal requirements, and required beneficiary co-payments exceeding nominal limits. The arguments made in this case mirror those considered by the United States Circuit Court of the District of Columbia when it struck down Vermont's pharmacy discount plan on June 8, 2001. In the Vermont case, the Circuit Court said that payments made to pharmacies were not "state payments" because they were funded entirely by manufacturer rebates.

In yesterday's ruling, the District Court found that Maine's two-percent payment fits the meaning of state payment. The Circuit Court's decision on Vermont had defined payments as "state or federal funds appropriated for Medicaid expenditures". The District Court said that "since Maine's two-percent payments are in addition to and separate from the 18-percent subsidy provided by the manufacturer rebates, the court also concludes that Maine's HMP funds are not from fully reimbursed manufacturer rebates."

PhRMA's filing argued that Maine's state-only expenditures should not have been approved as "payments" because they were not made under the state Medicaid plan. On this matter, the court ruled that deference should be given to the Secretary of DHHS and his demonstration project authority. The opinion said "Medicaid treats payments made in demonstration projects as though they were expenditures under the State plan 'to the extent...prescribed by the Secretary' ". On the issue of co-payments, the District Court ruled that PhRMA does not have standing to challenge because none of its members are affected by these rules.

If PhRMA appeals this decision, the appeal will be heard by the United States Circuit Court, the same court that ruled on the Vermont program.

agreed to fund disease-management programs for acutely ill Medicaid recipients in exchange for getting all their drugs on the preferred list. The programs, run through hospitals, provide one-on-one counseling with patients, with the goal of lessening emergency room visits or excessive drug prescriptions.

Though Pfizer and Bristol-Myers have worked with the new program, they remain members of PhRMA and support the group's lawsuit.

Two months ago, Jackson Memorial Hospital in Miami announced it would participate in the Pfizer program, eventually enrolling about 4,000 local Medicaid patients who have asthma, diabetes, hypertension or heart failure. About 200 are enrolled thus far, according to the state Agency for Health Care Administration. Pfizer funds the program, though it is staffed by the hospital.

In its lawsuit, PhRMA contends that by encouraging doctors to prescribe only certain drugs the state prohibits access to nonpreferred drugs in violation of federal law.

U.S. District Court Judge William Stafford said the preferred drug list did not prohibit access to nonpreferred drugs, it only created a "prior authorization program" expressly permitted by the federal Medicaid law.

JOURNAL-CODE: MI

LOAD-DATE: January 4, 2002

Bernie Horn, Policy Director
Center for Policy Alternatives
202-956-5135, bhorn@cfpa.org

———— Headers ————
Return-Path: <bhorn@cfpa.org>
Received: from rly-xb02.mx.aol.com (rly-xb02.mail.aol.com [172.20.105.103]) by air-xb04.mail.aol.com (v82.22) with ESMTP id MAILINXB45-0108172622; Tue, 08 Jan 2002 17:26:22 -0500
Received: from email.cfpa.org (pc153.cfpa.org [216.50.19.153]) by rly-xb02.mx.aol.com (v83.18) with ESMTP id MAILRELAYINXB29-0108172604; Tue, 08 Jan 2002 17:26:04 -0500
Received: by pc153.cfpa.org with Internet Mail Service (5.5.2653.19)
id <C2LNY3F4>; Tue, 8 Jan 2002 17:23:05 -0500
Received: from 216 (pc198.cfpa.org [216.50.19.198]) by email.cfpa.org with SMTP (Microsoft Exchange Internet Mail Service Version 5.5.2653.13)
id C2LNY3FT; Tue, 8 Jan 2002 17:23:02 -0500
From: "Bernie Horn" <bhorn@cfpa.org>
To: "Tracie Pough" <tpough@cfpa.org>, "Jesse Romero" <jromero@cfpa.org>
Cc: <kwilfore@cfpa.org>, <lcattaneo@cfpa.org>
Subject: Florida Rx plan upheld by U.S. District Court
Date: Tue, 8 Jan 2002 17:25:06 -0500

BAKER
&
HOSTETLER LLP
COUNSELLORS AT LAW

303 EAST 17TH AVENUE • SUITE 1100 • DENVER, COLORADO 80203-1264 • (303) 861-0600 • FAX (303) 861-7805
WRITER'S DIRECT DIAL NUMBER (303) 764-4101

January 28, 2002

Members of the Joint Budget Committee
Colorado State Capitol
200 East Colfax
Denver, Colorado 80203

Re: Medicaid Cost Reduction Proposals

Dear Members:

The law firm of Baker & Hostetler LLP represents RxPlus Pharmacies, Inc. RxPlus is an association representing almost 200 individual retail pharmacists located throughout the State of Colorado.

We understand that the General Assembly and the Joint Budget Committee may consider several innovative proposals designed to address the pharmaceutical component of increasing Medicaid costs. The first proposal involves "prior authorization" legislation similar to that passed in other states. Such statutes require drug manufacturers to provide rebates in exchange for inclusion on a list of preferred Medicaid drugs. The second proposal consists of voluntary negotiation between the Colorado Department of Health Care Policy and Finance and drug manufactures to obtain a more favorable price, often referred to as the 340B price, for Medicaid recipients.

During the past two years, the states of Maine, Florida and Michigan have passed "prior authorization" legislation in an effort to curb Medicaid pharmaceutical costs. The savings are substantial. The Michigan statute is to take effect February 1, 2002. Michigan expects to save $42 million from the program which will cover 1.6 million residents who receive their drug benefits through Medicaid and other state-funded programs.[1] Florida expects to save at least $100 million in the current fiscal year. [2]

Every time a state has passed such legislation, suit was filed to block the statute. Each time the suit was filed by the same plaintiff, the Pharmaceutical Research and Manufacturers of America, a Washington based trade group known as PhRMA. As described in detail below, in every case, the innovative efforts of state legislators to address spiraling Medicaid costs have been found to be constitutional and in compliance with federal law. RxPlus believes that similar programs instituted in Colorado would be well supported by a growing body of case law.

"Prior authorization" statutes are explicitly permitted under federal law.

The federal Medicaid statute specifically permits "prior authorization" statutes under state laws. Payment for covered outpatient drugs is covered in 42 USC 1396r-8. Rebate Agreements are authorized under that statute and "prior authorization" programs are specifically permitted by 42 USC 1396r-8(d)(5) which provides:

> (5) Requirements of prior authorization programs
>
> A State plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6) of this section) only if the system providing for such approval -
>
> (A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and
>
> (B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

In every legal challenge by PhRMA, the Courts have held that the state plans are permitted under law. In addition, the courts have found every constitutional argument advanced by PhRMA to be lacking and without foundation.

Maine's Prior Authorization Statute Upheld.

In May 2000, the Governor of Maine signed into law an "Act to Establish Fair Pricing for Prescriptions Drugs" 2000 ME. Legis. Chap. 786. That statute established the "Maine Rx Program." In addition to the establishment of a preferred drug list and a "prior authorization" requirement, the Act directed the Commissioner of Maine's Department of Health Services to negotiate rebate agreements with manufacturers. PhRMA challenged the constitutionality of the Act in *Pharmaceutical Research and Manufacturers of America v. Kevin Concannon*, 249 F.3^{d} 66 (1st Cir. 2001).

PhRMA alleged that the Maine Rx Program contained several federal constitutional defects. PhRMA alleged that the act violated the dormant commerce clause. PhRMA also argued pre-emption under the supremacy clause and that the Act violated provisions of the Federal Medicaid Program.

The District Court initially entered a preliminary order enjoining application of the Maine Rx Program. On Appeal, the United States Court of Appeals for the First Circuit dismissed the injunction, finding no constitutional invalidity. Among other provisions, the Act directed the Commissioner of the Maine Department of Human Services to use its "best efforts to obtain an initial rebate calculated under the Medicaid program..." Me.Rev.Stat. Ann. Tit.22, Section 2681(4)(B). The Court dismissed PhRMA's arguments that this provision of the Act was an unconstitutional exercise of power. The Court noted that the "Act is not 'regulating' prices, but merely 'negotiating' rebates." *Pharmaceutical Research, supra*, at page 81

Maine's statute contained both a prior authorization component and a direction to the state department to negotiate a more favorable rate. The Court found both components consistent with federal law and constitutional standards. The Maine program is now providing substantial savings for the state and its taxpayers. Despite that reported decision, PhRMA's practice is to file suit in every instance.

Florida's Prior Authorization Statute Upheld.

PhRMA brought suit to enjoin the Florida "prior authorization" statute. On December 28, 2001, the United States District Court for the Northern District of Florida entered its Order denying the preliminary injunction requested by the PhRMA. The plaintiff sought to enjoin the application of the statute the Florida legislature passed in 2001 amending its law to create a prior authorization statute, Sections 409.91195 and 409.912(37) of the Florida statutes.

The Florida statute creates a list of preferred drugs. To get on the list, manufacturers must offer the State a 10% supplemental rebate on top of the federal rebate, which averages 15.1%. In the event the drug is not on the list, doctors must obtain prior verbal authorization before a prescription can be filled.

The United States District Court specifically addressed the question posed by PhRMA, which alleged that a creation of a state Medicaid formulary was in violation of the Federal Medicaid Law. The Court held that Florida's prior authorization statute "did not authorize the creation of a 'formulary,' as that term is used in the Federal Medicaid law but, instead, allowed the establishment of a 'preferred drug list' and a 'prior authorization program' expressly permitted by the Federal Medicaid law."

Michigan's Prior Authorization Statute Upheld.

In November, 2001, PhRMA filed suit after the passage of Michigan's "prior authorization" statute. In that case, the federal court referred a single state issue to a state court for resolution. The Ingham County Circuit Court Judge ruled that the unorthodox manner of implementing the Michigan law, whereby several legislators were given a veto over the policy, violated the Michigan constitution, *Pharmaceutical Research and Manufactures of America v.*

Michigan Department of Community Health, Case Number 01-94627-AZ in the 30th Circuit Court for the County of Ingham, State of Michigan.

The State of Michigan appealed that decision and on January 17, 2002, the Court of Appeals for the State of Michigan in Docket Number 238862 overturned the injunction, without comment. Several matters remain before the Court, but the state expects to implement the ambitious plan on February 1, 2001.

A Colorado "prior authorization" statute , consistent with Federal law would withstand challenge.

Every reported decision which deals with the merits of a "prior authorization" statute supports the validity of a carefully drafted statute under the federal Medicaid law. Notwithstanding the numerous challenges by the pharmaceutical industry, each time a court has examined the innovative state legislation, a prior authorization statute drafted in accordance with the Medicaid guidelines, has been found to be legal, constitutional and valid.

340B Price Negotiation

Drug manufactures sell the exact same pharmaceuticals to different purchasers at widely varying prices. Often an uninsured consumer will pay the highest price. Through rebate methods, other classes of consumers obtain a different price for the same product. By way of example, using the uninsured consumer as a benchmark for a product cost of $100.00, the Medicaid price for the same drug would be approximately $65.00. The federally qualified health centers price (the 340B class of trade contract) would be approximately $54.00. The federal government price (VA Hospitals, etc.) would be $46.00 or less.

Federal law would permit the Colorado Department of Healthcare Policy and Finance to negotiate with drug companies so that the Colorado Medicaid Program would obtain the 340B rate enjoyed by federally qualified healthcare centers. Negotiation by the state and a drug manufacturer is a purely voluntary effort and can be undertaken by the Department at any time. However, even the specific legislative direction to the state department to negotiate a more favorable rate in Maine's statute has been upheld, *Pharmaceutical Research, supra.*

Conclusion

Should the Colorado General Assembly enact legislation establishing a "prior authorization" system consistent with federal Medicaid statutes or directing the Colorado Department of Health Care Policy and finance to negotiate a more favorable price from drug manufacturers, a legal challenge may be filed by the pharmaceutical industry. However in every case to date, courts around the country, without exception, upheld the statute. The efforts of drug

manufacturers have not frustrated the innovative programs of state legislatures to try to get a handle on the spiraling costs of pharmaceutical products.

If I can provide any additional information or copies of any of the statutes or decisions referred to in this letter, please do not hesitate to call.

Yours very truly,

Michael F. Feeley

MFF:dms

cc: Mr. M. Kinney, President
RX Plus Pharmacies

---

[1] Russell Gold, *Michigan Court Lifts Judge's Injunction On Plan to Cut Prescription-Drug Costs*, Wall St. J. January 18, 2002

[2] Russell Gold, *Federal Judge Lets Stand Florida Law Seeking Rebates From Drug Makers*, Wall St. J. January 3, 2002

Americans Without Prescription Drug Insurance Pay Much Higher Prices Than Citizens of Other Countries For the Same Drugs

Rank	Prescription Drug	Use	Canadian Price	U.S. Prices Paid By Uninsured	% U.S. Price Exceeds Canadian Price
1	Prilosec	Heartburn/Ulcer	$ 1.47	$ 3.31	125%
2	Prozac	Depression	$ 1.07	$ 2.27	112%
3	Lipitor	High cholesterol	$ 1.34	$ 2.54	90%
4	Prevacid	Ulcer	$ 1.34	$ 3.13	134%
5	Epogen	Anemia	$ 21.44	$ 23.40	9%
6	Zocor	High cholesterol	$ 1.47	$ 3.18	116%
7	Zoloft	Depression	$ 1.07	$ 1.98	85%
8	Zyprexa	Mood disorder	$ 3.39	$ 5.27	55%
9	Claritin	Allergies	$ 1.11	$ 1.96	77%
10	Paxil	Depression	$ 1.13	$ 2.22	88%

Spending of the Top Ten Pharmaceutical Companies On Marketing Versus Research and Development* (in millions of dollars)

Company	Rank	Total Sales	Marketing & Admin. Costs	Marketing as % of Sales	Research & Develop. Costs	R & D as % of Sales
Merck & Co.	1	$ 32,714	$ 5,200	15.9%	$ 2,068	6.3%
Johnson & Johnson	2	$ 27,471	$ 10,503	38.2%	$ 2,600	9.5%
Bristol-Meyer Squibb	3	$ 20,222	$ 4,578	22.6%	$ 1,843	9.1%
Pfizer	4	$ 16,204	$ 6,351	39.2%	$ 2,776	17.1%
American Home Products	5	$ 13,550	$ 5,040	37.2%	$ 1,740	12.8%
Abbott Laboratories	6	$ 13,178	$ 2,857	21.7%	$ 1,194	9.1%
Warner-Lambert Co.	7	$ 12,929	$ 5,959	46.1%	$ 1,259	9.7%
Eli Lilly and Co.	8	$ 10,003	$ 2,758	27.6%	$ 1,784	17.8%
Schering-Plough Corp.	9	$ 9,176	$ 3,434	37.4%	$ 1,191	13.0%
Pharmacia Corp.	10	$ 7,253	$ 2,800	38.6%	$ 1,434	19.6%
TOTALS:		$ 162,700	$ 49,479	32.5%	$ 17,889	12.4%

*All data from the companies' Annual Reports; company ranking according to Fortune 500 , April 2000

Eli Lilly and Company
Lilly Corporate Center
Indianapolis, Indiana 46285
U.S.A.

Phone 317 276 2000

April 9, 2001

James Barnett MD
1400 Lincoln St
Emporia, KS 66801

Dear Dr. Barnett:

On behalf of Eli Lilly and Company, I am pleased to invite you to participate in the EVISTA Strategy and Consultant Conference, June 8-10, 2001. This meeting will take place at the Regent Beverly Wilshire, a Four Seasons Hotel in Beverly Hills, California. For 70 years it has been a landmark at Wilshire Boulevard and Rodeo Drive.

This conference, for key clinicians who specialize in the treatment of postmenopausal women, will present current data related to the prevention and treatment of osteoporosis. In addition to the didactic presentations on Sunday, we will break into small groups for a more detailed discussion based on the data presented on Saturday. A preliminary agenda is enclosed. Your input during all aspects of the meeting is essential and highly valued.

In return for your participation in the Strategy and Consultant Conference, you will be paid a $1,500.00 honorarium. This will be provided to you following the meeting for your time and services. **Please understand that you must attend the entire weekend program to be eligible for honorarium payment. There will be no exceptions to this requirement. You may depart Beverly Hills on flights after 2:00 p.m. on Sunday, June 10th.**

As an honored guest of Eli Lilly and Company, you are invited to attend a welcome reception Friday evening at 7:00 p.m. The meeting will begin Saturday at 8:00 a.m. and end at approximately 2:00 p.m. An exciting evening of dinner and entertainment is planned on Saturday evening. The meeting will conclude on Sunday by noon.

Due to AMA guidelines and regulations, we are unable to pay for your guest's travel expenses, however, your guest is invited to attend all entertainment events, compliments of Eli Lilly and Company. Once you fax in your personal travel form to Rachael Bosley at Virtual Meeting Strategies, Lilly Travel will contact you within 7 business days to book your airfare. We will also be happy to help coordinate guest air arrangements. In order to expedite this process, please include credit card information on your registration form to secure payment for your guest. Please understand that the earlier you return your registration form, the better your chances are for getting the most convenient flight for you and your guest. Booking airfare early will also help you save money on your guest's airfare.

In order to conduct accurate market research, a pre-selected list of physicians has been invited to participate in the EVISTA Strategy and Consultant Conference. We ask that you refrain from further extending your invitation to other practitioners so that we can maintain the integrity of the research. Your help in this matter is greatly appreciated. Space for this program is limited and will be filled on a first come, first served basis.

We hope that your schedule will allow you to participate. Please complete the attached registration form, indicating your ability to attend, and fax to Rachael Bosley at (317) 805-6650 by Friday, April 20, 2001. We look forward to your attendance.

If you have any questions, please contact Rachael Bosley, Event Coordinator, at (317) 805-6600 ext. 238.

Sincerely,

K. Shaw Lamberson M.D.

K. Shaw Lamberson, MD
Clinical Research Physician
Eli Lilly and Company

Are All Antihypertensives the Same? BENICAR™ SPEAKER TRAINING

La Quinta Resort, Palm Springs, CA
November 2-4, 2001

Friday, November 2, 2001

6:30 p.m. – 10:00 p.m. Check-In & Dinner Reception

Saturday, November 3, 2001

8:00 a.m. – 8:20 a.m.	Sankyo Welcome & Introductions
8:20 a.m. – 9:00 a.m.	Benicar™ Clinical Overview
9:00 a.m. – 10:00 a.m.	Are All Antihypertensives the Same?
10:00 a.m. – 10:20 a.m.	Mid-Morning Break
10:20 a.m. – 11:20 a.m.	The Impact of Renin-Angiotensin System Inhibition on Cardio-vascular Disease
11:20 a.m. – 12:00 p.m.	Panel Q&A
12:00 p.m. – 1:00 p.m.	Lunch
1:00 p.m.	Afternoon Activities

Sunday, November 4, 2001

8:00 a.m. – 8:20 a.m.	Recap
8:20 a.m. – 9:20 a.m.	The Impact of Renin-Angiotensin System Inhibition on Renal Disease
9:20 a.m. – 9:40 a.m.	Panel Q&A
9:40 a.m. – 10:00 a.m.	Mid-Morning Break
10:00 a.m. – 12:00 p.m.	Breakout Sessions
12:00 p.m.	Wrap and Departures

JAB citalopram HBr™

$1000 w/ Dr.

785-820-0405 call Chris

785-493-8223 to know if interested - need today. Jo

Are All Antihypertensives the Same? BE

TRAVEL & ACCOMMODATIO

Meeting Site: LA QUINTA RESORT
Palm Springs, California

Meeting Dat

ATTENDEE INFORMATI

Please check one: ❑ Participant ❑ Sankyo Pharma Staff

FIRST NAME: _____ LAST NAME: _____ SUFFIX: _____

SPECIALTY: _____ ME/STATE LICENSE# _____ SSN or Tax ID #: _____

MAILING ADDRESS: (all correspondence will be sent to this address — NO P.O. BOXES)

PHONE: Office: _____ Home: _____

Fax: _____ E-mail _____

GUEST FIRST NAME: _____

LAST NAME: _____

TRANSPORTATION INFORMATION:

Do you require air transportation? (one round-trip coach ticket will be offered)

❑ YES, seating preference: ❑ Aisle ❑ Window

Preferred departure airport: _____

HOTEL INFORMATION:

Room and tax will be covered for the nights of **November 2 and 3, 2001.**

Choice of **ONE** Saturday afternoon activity or afternoon free.

SPA: ❑ Self ❑ Guest

AFTERNOON
ON OWN: ❑ Self ❑ Guest

GOLF: ❑ Self ❑ Guest

Will you require rental clubs?

❑ YES ❑ NO ❑ Right/Left MEN'S ❑ Right/Left WOMEN'S

******PLEASE FAX COMPLETED FORM TO SCS HEALTHCARE MARKETING, INC. @ 201-891-8656******

DATE RECEIVED: _____ DATE ENTERED: _____ CONFIRMATION LETTER SENT: _____ TRAVEL CONFIRMED: _____

PROACTIVE HEALTHCARE COMMUNICATIONS, INC.

National Telephone Conference
$100 Value Participation Item

JAMES A BARNETT, PCP
1301 W 12th Street Suite 202
Emporia, KS 66801

Dear Dr. BARNETT

On behalf of Janssen Pharmaceutica, I would like to invite you to join a select group of your colleagues in an **Interactive Telephone Conference** program regarding:

Recent Advances in Screening, Diagnosis and Treatment of Alzheimer's Disease.

Each program will feature a lecture by a nationally recognized thought leader who will present a clinical overview of Alzheimer's Disease and review recent advances in screening, diagnosis and treatment. The lecturer will be interested in sharing clinical insights with you and your colleagues and will respond to questions. Following the lecture, there will be an interactive discussion on the clinical parameters and therapeutic options for managing patients with AD. The series of programs are scheduled for:

Monday through Thursday evenings in February and March of 2002.

The entire program will last about 1 hour and you can participate in one of these sessions either from your office or your home.

For your participation in a telephone conference and in compliance with the AMA guidelines for promotional endeavors of this nature, you may choose from items related to medical education and patient care valued at $100.

Space is limited. Please call 800-635-8730 and ask for program # 92 as soon as possible to make your reservation. We look forward to having you join us.

Sincerely,

Peter M. Lawrence

Peter M. Lawrence
President

JAB
Brian from CBCK
RE: teleconferences available
1) cardiac vasc therapy
get $100 cert
2) Type 2 diabetes
get $100 cert
3) air monitoring gluc + lactone
get $100 cert + $150
call 1-800-552-5487

3-14

Dr Barnett-
Hope you can
Stop by and
grab a free
tank of gas!

FUEL & FACTS

The Claritin/Nasonex Team will be at
TEXACO GAS STATION – Highway 50 & Graphic Arts

TODAY

THURSDAY, JUNE 28
11:30 AM – 1 PM

STOP IN AND GET A FULL TANK OF GAS! While the tank is filling, we will present the results of Claritin/Nasonex Clinical Studies.

Drop in TODAY, with an empty tank, and fill up on facts and fuel!

Compliments of

Claritin®
10 mg TABLETS (loratadine)

Anita Mora Gaye Rinehart

Kansas Pharmacists Association
Kansas Society of Health-System Pharmacists
Kansas Employee Pharmacists Council
1020 SW Fairlawn Rd.
Topeka KS 66604
Phone 785-228-2327 ✦ Fax 785-228-9147 ✦ www.kansaspharmacy.org
Robert (Bob) R. Williams, MS, CAE, Executive Director

TESTIMONY

SB 603
Senate Ways and Means Committee
February 28, 2002

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 SB 603. KPhA supports SB 603.

SB 603 would allow SRS to negotiate additional drug rebates with drug manufacturers. Drug manufacturers not willing to negotiate with SRS will run the risk of not having their drugs placed on a list of "preferred drugs". SB 603 also establishes a "formulary committee" to develop a formulary listing of covered drugs by the state Medicaid program. The formulary committee's recommendation would be submitted to the Drug Utilization Review Board (DUR) for review and policy recommendations. SB 603 does not require non-participating drug manufacturer's drugs be placed on prior approval, it simply authorizes SRS to consider doing so. As the bill indicates, all prior approvals must meet the requirements of 42 U.S.C. section 1396r-8(d)(5). Additionally, prior approval must go through a formulary committee AND the DUR Board, allowing for ample checks and balances.

As State Governments throughout the United States struggle to keep up with the spiraling cost of prescription medications, many states are considering similar legislation. Much of the attention has been focused on Florida, Michigan and Maine, who have implemented similar programs. All were challenged by the Pharmaceutical Research and Manufacturers Association (PhRMA) .

Senate Ways and Means
2-28-02
Attachment 4

The Florida and Maine programs were implemented by statute, the Michigan program by regulation. In all cases, PhRMA claimed the programs broke a federal rule that all prescription drugs (with few exceptions) be available to Medicaid recipients. The federal judge in Florida disagreed indicating the Florida list of preferred drugs steered doctors and patients toward certain preferred drugs, but didn't prevent access to non-preferred drugs. (See attached January 3, 2002 Wall Street Journal article).

The original Florida proposal required physicians to contact the Medicaid fiscal agent to get the prior approval on non-formulary drugs. That process has changed and pharmacists are now permitted to make prior-approval calls for non-formulary drugs. The Florida program allows drug manufacturers to agree to additional rebates OR a program that provides equivalent cost savings in order to have their drugs NOT included on the prior-authorization list. Some companies have already entered into such arrangements. For example, Pfizer is providing a program using case management for seriously ill Medicaid recipients in institutional settings. It is KPhA's understanding they have guaranteed the state $33 million in savings over a 2 year period using the program. If the savings are not realized, Pfizer is obligated to pay the difference.

In Michigan an injunction was issued preventing implementation of the program. That injunction has been reversed. While the program is still in court, the State of Michigan has proceeded with implementation of the program February 1. (See attached information from Michigan Department of Community Health.)

The Maine prescription rebate program was also sued by PhRMA and an injunction issued in October 2000. That injunction was overturned by an appeals court in May, 2001. Like Florida, the court found that the Maine law does not conflict with the Medicaid statute (see

attached "The Green Sheet" article). It is also our understanding that a similar law has passed in Washington State, although I have no specifics regarding their program.

In an effort to illustrate what Medicaid and the Kansas Legislature is up against, attached to my testimony is a report prepared by Families USA (a national, nonprofit organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans, based in Washington DC) regarding prescription drug prices for the elderly. This report tracks price increases from January 2000–January 2001 for the 50 drugs most commonly used by the elderly. According to the report, of the 50 drugs most commonly used by the elderly, one-sixth (8 out of 50) rose less than the rate of inflation. Three-quarters (38 out of 50) rose 1.5 or more times than the rate of inflation and one-third (18 out of 50) rose three or more times the rate of inflation. Furthermore, from January 1996 to January 2001, the prices of the prescription drugs most frequently used by older Americans rose, on average, 22.2 percent. The report also lists the annual cost per year of drug therapy, the number of price changes per drug, and increases in generic drug prices.

The State of Kansas needs to follow the lead of other states in their efforts to control the cost of Medicaid prescription drug programs. SB 603 addresses the "cost drivers" for double digit inflation in drug prices, namely the prices set by drug companies. One of the recommendations of Governors attending the 2002 National Governors Association winter meeting is to increase the discounts that drug manufacturers must provide to state Medicaid programs. KPhA encourages your support of SB 603.

Thank you.

Judge Allows Drug Rebates In Florida Law

By RUSSELL GOLD
Staff Reporter of THE WALL STREET JOURNAL

A federal judge in Tallahassee let stand a Florida law that seeks rebates from drug makers in exchange for inclusion on a list of preferred Medicaid drugs.

The ruling, a major setback for the pharmaceutical industry, is likely to prompt other states to follow the lead of Florida, which passed the law in an effort to restrain its sharply rising drug spending. Already, Michigan has implemented a program partly modeled on Florida's.

"As the legal hurdles melt away, I think more and more states will pay attention" to Florida, said Greg Vadner, the Missouri Medicaid director and vice chairman of the National Association of State Medicaid Directors. "The precedent appears to be leaning our way," he said, referring to Friday's ruling.

The Pharmaceutical Research and Manufacturers of America, a Washington-based trade group known as PhRMA, had brought the suit to block the Florida initiative. PhRMA, which represents the nation's brand-name prescription drug manufacturers, is planning to appeal the case to the Eleventh U.S. Circuit Court of Appeals in Atlanta.

At stake is a portion of the $25 billion states spend on prescription drugs each year through Medicaid, a joint federal-state program to provide health care to the poor and disabled.

Faced with tight budgets and double-digit inflation in pharmaceutical costs, states have been looking for ways to control expenditures. In turn, this has prompted PhRMA to use statehouse lobbying and an aggressive legal strategy to quell such efforts.

In May, Florida lawmakers approved an innovative effort to slow Medicaid spending increases by creating a list of preferred drugs. To get on the list, manufacturers had to offer the state a 10% supplemental rebate on top of a federal rebate, which averages 15.1%. If a drug isn't on the list, doctors must get verbal authorization from a phone bank of pharmacists and pharmacy technicians before the prescription can be filled.

This added inconvenience discourages doctors from prescribing drugs not on the list and shifts patients toward the preferred drugs. For example, after the preferred list went into effect, the market share for Imitrex, GlaxoSmithKline PLC's popular antimigraine drug that isn't on the list, dropped to 6% from 60%. The share of Merck & Co.'s Maxalt, an antimigraine drug that is on the list, rose to 89% from 16%, according to a consultant hired by PhRMA. As a result of the supplemental rebates, the state expects to save at least $100 million this fiscal year.

Pfizer Inc. and Bristol-Myers Squibb Co., both based in New York, cut deals with Florida to get all of their drugs on the list without discounts. Instead, they created programs to improve the health of chronically ill patients and guaranteed cost savings to the state. Despite this favored status, the companies, both of which are members of PhRMA, say they support the goals of the lawsuit.

PhRMA filed the suit in August in U.S. District Court in northern Florida, claiming the state's law broke a federal rule that all prescription drugs be available to Medicaid recipients unless the drug offers no clinically meaningful benefit. The court disagreed, finding that Florida's list steered doctors and patients toward certain preferred drugs, but didn't prevent access to nonpreferred drugs, which would be illegal under federal law.

Jan Faiks, PhRMA's assistant general counsel, said in a statement that she disagreed with the judge's ruling and worried that the Florida law would strip Medicaid recipients of access to needed drugs and "could seriously harm the health of these patients."

Mark Striker, a pharmaceutical analyst at Salomon Smith Barney in New York, says the case was an important part of the "pharmaceutical industry's attempt to slow state momentum" to obtain price discounts. In another closely watched case, PhRMA is suing to block a similar preferred drug list in Michigan. Details of the Michigan program were finalized last month. That case is filed in state district court in Lansing, Mich. A hearing is set for later this month.

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING

LANSING, MICHIGAN 48913

JAMES K. HAVEMAN, JR., Director

February 11, 2002

Dear Provider/Prescriber:

On February 1, 2002, the Michigan Department of Community Health began the implementation of the expanded prior authorization program for pharmaceuticals without denial of drugs that will require prior authorization. The week of February 1 – 8 was designated as a testing period and a time for prescribers to fax in or call in prior authorization requests. This pre-implementation prior authorization period will be extended to February 24, 2002. Thus, prior authorization will not be required to fill prescriptions until at least February 25, 2002. On February 25, 2002, the department will begin phasing in specific drug classes requiring prior authorization to dispense. The phase in will continue through March 18, 2002. The classes of drugs and dates of implementation of the prior authorization requirement are enclosed.

Prior authorization may be requested for any of the drugs that will require prior authorization at any time during this phase in by calling the First Health Services Corporation's [FHSC] Clinical Call Center at 1-877-864-9014 or by faxing your request to FHSC at 1-888-603-7696 or 1-800-250-6950. A fax form is enclosed and may be duplicated for your use. The form identifies the information that will be required to grant prior authorization.

FHSC will prioritize prior authorization requests according to the phase in date for the therapeutic class of drug requested. Requests for drugs in the February 25, 2002 phase in will be addressed prior to requests for drugs from later phase in dates.

Also enclosed is a list of drugs that do not require prior authorization in most cases. We urge providers to prescribe from this list and only call for prior authorization when clinically necessary.

Please note, drugs that required prior authorization before February 1, 2002 will continue to require prior authorization, and all related edits will remain in force. The department does not cover refills until 75 percent of the previous prescription has been used.

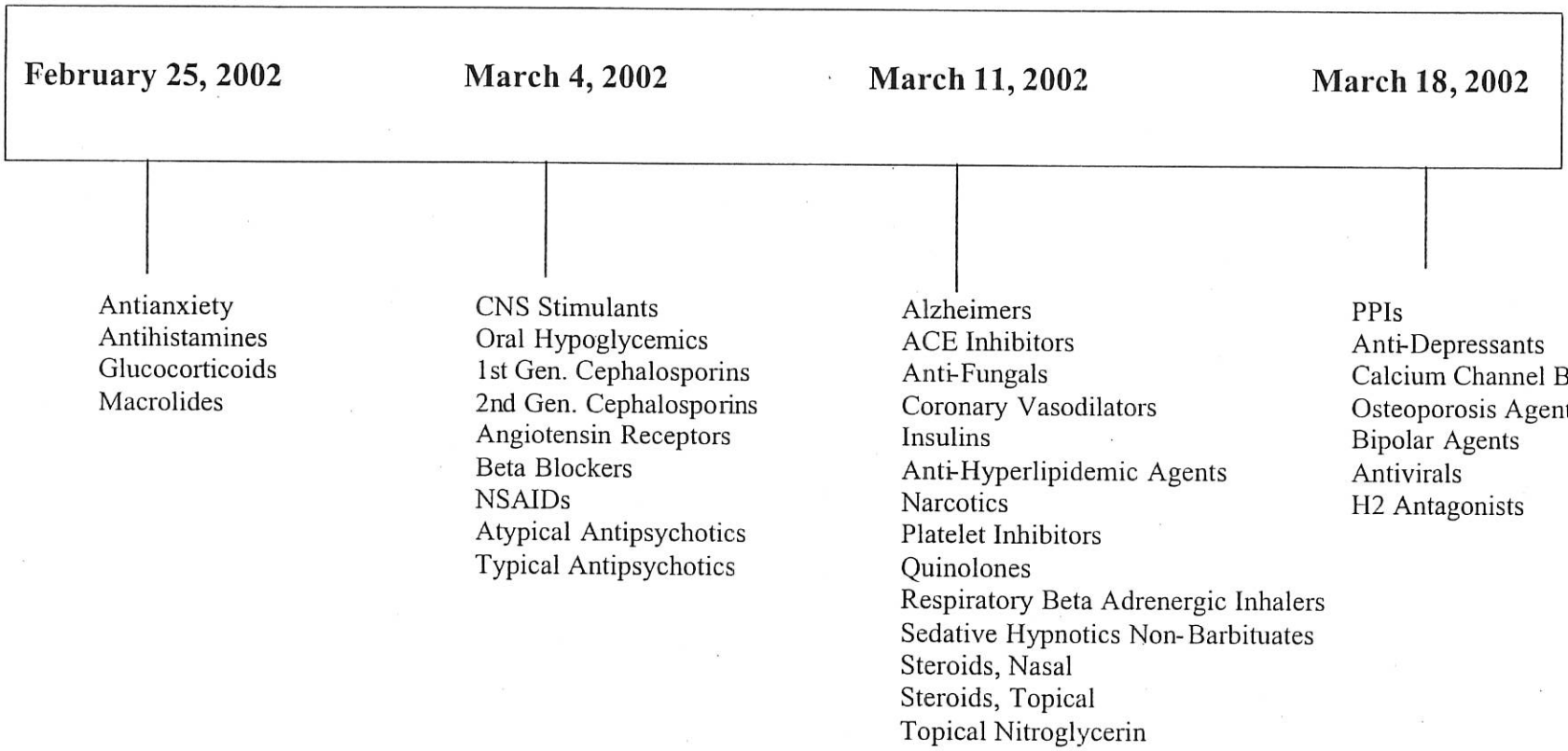
For general questions regarding this program, providers should contact the FHSC Technical Call Center at 1-877-624-5204.

Cordially,

James K. Haveman, Jr.

Michigan Department of Community Health

Timeline For Therapeutic Class Phase In of the Implementation of the Expanded Prior Authorization
February-March 2002



KAMU

Kansas Association for Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 www.ink.org/public/kamu

February 28, 2002
SB 603
Committee on Public Health and Welfare

My name is Joyce Volmut, I am the executive director of the Kansas Association for the Medically Underserved, an association of primary care clinics, Federally Qualified Health Centers, Health Departments and rural health clinics who provide primary care services to Kansas medically underserved and the uninsured.

Our Association supports SB 603 because it is a step in the right direction for alleviating one of the barriers clients face in completing their treatment of care. In addition to provisions, we would ask also that the medically indigent clinics in Kansas also be included in this bill. All of these programs are enrolled with the Secretary of Health and Environment as points of entry for increasing access and serve as a medical home to the uninsured, underinsured. The majority of clinics also serve Medicaid. We would also recommend that Medicaid/Medicare Dual Eligible clients also be included as a group of individuals where prescription costs are negotiated and medication services provided to those individuals who qualify.

In a review of data collected from our member clinics, pharmacy costs remain high. In 2000, member clinics reported pharmacy expenses of over 1 million dollars. This did not include other pharmaceutical services that were provided through samples or through the pharmaceutical manufacturing companies discounted drug services for individual qualifying patients. Clinic patients totaled over 101,000 individuals last year. This was a 34% increase from the previous year. Over 70,000 or 70% of those provided services were uninsured. This represents about 1/3 of the total uninsured in Kansas.

Once again we are appreciative of your interest in meeting the needs of the most vulnerable Kansas people – though budgetary in nature, we fully understand health care costs must be contained. Efforts set forth in this bill however, begin to tackle at least one of the issues, but not at the cost of the individual or family in need.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.
AFFILIATED WITH THE AMERICAN PUBLIC HEALTH ASSOCIATION
215 SE 8TH AVENUE
TOPEKA KANSAS 66603-3906
PHONE: 785-233-3103 FAX: 785-233-3439
E-MAIL: kpha@networksplus.net
WEB SITE: HTTP://KPHA.MYASSOCIATION.COM

Testimony presented to Senate Ways and Means
by Sally Finney, Executive Director
on February 28, 2002

Chairman Morris and members of the Committee, I thank you for giving me the opportunity to appear before you today on behalf of the members of the Kansas Public Health Association to ask you to support Senate Bill 603.

KPHA is an individual membership organization whose mission is to promote sound public health programs and policies in Kansas. We believe that any measure that will increase the buying power of the Kansas Medicaid program without compromising the ability of clients to receive basic care is good public health policy. That is why we support SB 603.

This legislation simply asks that pharmaceutical companies give the State of Kansas the same price breaks they give to the federal government. In the short-term, the cost savings will help the program to deal with the state's current financial difficulties so that Kansas Medicaid may continue to serve as many clients as possible without disruption of services. As a public health advocate, I must emphasize, however, that this is a **short-term solution**. There is a proven, long-term solution to this problem.

Preventing infectious disease, chronic disease and injury saves money and saves lives. The only workable long-term strategy for reducing both public sector and private sector health care costs is to redirect significant resources to primary prevention efforts.

That being said, we recognize the importance of addressing the current Medicaid drug budget situation and ask your support of SB 603.

Senate Ways and Means
2-28-02
Attachment 6

Statement PhRMA

Statement of the Pharmaceutical Research and Manufacturers of America (PhRMA)
Opposing
Kansas Senate Bill 603

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading research-based pharmaceutical and biotechnology companies, which invent medicines to make life not only longer but better. Right now, more than 40,000 pharmaceutical company researchers are working on more than 1,000 new medicines to help reduce the human and economic toll of such diseases as cancer, Alzheimer's AIDS and many others. This year PhRMA companies will invest over $30 billion to discover and develop new medications that allow patients to lead longer, happier, healthier and more productive lives.

SB 603 proposes to give the Secretary of the Department of Social and Rehabilitation Services the authority to seek supplemental rebates for the Medicaid program and rebates or discounts for any other state program that pay for prescription drugs. SB 603 would also require prescription drug manufacturers to negotiate and pay supplemental Medicaid rebates and rebates or discounts for drugs used in any other state program.

SB 603 would also authorize the Secretary to impose prior authorization for any prescription drugs from any manufacturer if the manufacturer and the Secretary of the SRS fail to agree to the terms of a supplemental Medicaid rebate or a discount or rebate for the prescription drug discount program and the discounts or rebates are not as favorable as the prices under 42 USC Sec. 256b. PhRMA opposes SB 603 because it imposes price controls and holds Medicaid and other patients hostage by potentially denying them access to the most appropriate prescription drug.

Prior authorization restricts the access of Medicaid patients to needed prescription drugs. Medicaid patients, like all other patients, should have timely access to all drugs approved by the Food and Drug Administration. Congress intended prior authorization programs to prevent unnecessary utilization, not to prevent physicians from prescribing medications in accordance with their medical judgment.

Newer drugs save lives and costs. Research demonstrates that use of newer drugs increases life expectancy, improves quality of life, and can mean lower health care spending overall.

Restricting access to effective medications may cause patients to suffer medically and, additionally, require more costly treatments in the long run. Government prior authorization systems can result in the denial of the most appropriate drug therapy, ultimately increasing the use of other more expensive services such as hospitalization. Accordingly, prior authorization can cause overall health care spending to grow. Moreover, these programs can

Senate Ways and Means
2-28-02
Attachment 7

lead to unrecoverable costs to the patients in time and health.

The effect of prior authorization is to interfere with the physician-patient relationship. Prior authorization systems, because they are often time-consuming and cumbersome, may discourage doctors from prescribing the most appropriate therapies.

Prior authorization programs are not cost free. A prior authorization process does not come without its own costs. Physician time involved in seeking prior authorization is time away from treating patients. The state must hire and provide equipment and space for the individuals who review physician requests for prior authorization. States should consider the administrative costs, as well as the costs of additional physician visits, emergency room visits and hospitalizations that are likely to result from patients not receiving the most optimal prescription drug for their individual needs.

Prior authorization requirements. The federal Medicaid law permits prior authorization only in specific instances. These are the only instances in which drugs may be limited or restricted under the Medicaid program. Under federal law drugs may be prior authorized: 1) To ensure the drug is prescribed for "medically accepted indications;" 2) When the drug is non-prescription or used for a condition not covered by Medicaid, i.e., weight loss, baldness, and other limited classifications listed in the statute; 3) When the drug's manufacturer has not signed a federal rebate agreement; and, 4) When a drug is excluded from the formulary. Cost is not a consideration in these factors. The only possible element under which cost might be a factor would normally be under the formulary exclusions listed in the Medicaid statute. However, the formulary exclusion provisions in the federal statute (Sec. 1927(d)(4)(c)) *only* allow exclusions of drug treatments "if the excluded drug *does not have a significant, clinically meaningful* therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment." Therefore, cost cannot be a factor in any limitations placed upon drug consideration in a Medicaid-implemented formulary. The provisions of SB 603 would not comply with these federal Medicaid requirements.

The payment of additional rebates or discounts or the provision of disease management programs is not a consideration for imposing prior authorization under the federal Medicaid statute. The provisions of SB 603 would hold Medicaid patients hostage to the Department's determination of acceptable Medicaid rebate terms rather than providing them access to quality health care and necessary prescription drugs.

Supplemental Rebates Are Price Controls

By implementing supplemental rebates, other health care purchasers such as managed care plans, private plans and patients without drug coverage may be forced to pay higher costs. Recent studies have shown that dramatic changes in one part of the market almost always affect other parts. For example, a June 1997 GAO study found that Federal efforts to lower Medicaid drug prices put "upward pressure" on Federal Supply Schedule prices. Such cost increases may also lead to more restrictive drug coverage by insurers or the elimination of coverage altogether, again putting patients at risk. Although the initial result of SB 603 may be to decrease the state's drug costs, the end result may be an overall increase in health care dollars spent by all citizens.

Because of the "best-price" guarantee mandated under the federal Medicaid statute, if

a manufacturer provides supplemental rebates to a particular state Medicaid program or any other state program, this additional discount would establish a NEW, lower "best-price" that in turn must be provided to ALL state Medicaid programs, unless approved by the Centers for Medicare and Medicaid Services (CMS) as a state pharmacy assistance program excluded from the "best-price" calculations. In addition, the state program must continue to comply with the remaining provisions of the Medicaid law. For example, only specific circumstances, such as inappropriate use or abuse, constitute acceptable reasons to limit patients' access to medications. Patient access guidelines may not be determined solely on the basis of cost or the Medicaid rebates amount

In some states pharmaceuticals are provided as part of a Medicaid managed care drug benefit. In these instances, the managed care entity administering the drug benefit independently negotiates discounts or rebates with manufacturers. Therefore, these medications dispensed under the managed care program are excluded from the fee-for-services rebate requirements under the Medicaid statute.

Under the Medicaid fee-for-service pharmacy program, a contracting PBM can administer the Medicaid drug program and serve as a fiscal agent to collect rebates according to the federal Medicaid statute. Since rebates are already paid on these products under Medicaid law, the PBM cannot negotiate for additional discounts on these same prescriptions without violating the federal statute.

Supplemental Rebates Are A Tax on the Pharmaceutical Industry

According to 1998 data, the pharmaceutical industry contributed to Kansas a total of $95,529,976 in state and local taxes. The pharmaceutical industry also contributes $26,878,486 in Medicaid rebates. Supplemental rebates would amount to an additional tax on the industry.

For these primary reasons, PhRMA opposes SB 603 and urges Kansas legislators to reject this bill.

SENATE WAYS AND MEANS
Submitted by Jo Ann Howley
February 28, 2002

In 1981 my son, Mitch, was 14 years old. We saw him struggling with his life at that point in time and finally had him see a psychiatrist who diagnosed him with paranoid schizophrenia. We were devastated and at first tried to care for him and keep him out of the hospital, but when he threatened to kill me (his mother) and his younger sister, I had no choice but to hospitalize him at Topeka State.

Mitch was hospitalized almost continuously for 15 years. He was treated with heavy doses of thorazine which subdued him, but did nothing to improve the quality of his life or allow him to live successfully outside the confines of the hospital.

In 1995, we (the staff and I) finally convinced him to try Clozaril. Since that time, his life has changed dramatically. He lives in a group home in Emporia and attends psychosocial classes everyday. He is kind and loving. He no longer hears voices telling him to hurt those around him and he no longer experiences having visual hallucinations. We are so grateful for this new medication. I talked yesterday with the pharmacist who fills his prescription for Clozaril each month. The cost is about $600 a month, but Mitch is on Medicaid and it is only necessary for him to pay the co-pay so it is affordable for him. His income is only $535 a month.

I am appalled to think that due to this proposed legislation, my son may be prescribed a cheaper medication--such as Thorazine. We need to not only consider the heartbreak of our having to see our son decompose, but realize the cost considerations that we are actually making here. What cost is long term hospitalization compared to the $600 a month for this medication?

I ask you to carefully consider your decision on this matter and to please vote "No" on SB 603.

Thank you.

Senate Ways and Means
2-28-02
Attachment 8

Senate Ways and Means Committee
Testimony on Senate Bill 603
Submitted by: Elizabeth Adams, Executive Director, NAMI Kansas

Thank you Chairman Morris and Senators for hearing me. I represent the Kansas families affected by mental illness and individuals suffering with biological disorders of the brain. Our premise is that people in need should have access to the right treatment, including the right medication, at the right time for that individual's successful recovery of life.

Neuroscience, the treatment and understanding of the brain, is virtually a new science. The 90s were called "The Decade of the Brain," due to the vast growth of research and understanding in those years. Historically, individuals with mental illness were often treated in ways we would now deem abusive, including the terrible side effects of earliest medications. Persistent tardive dyskinesia (TD), for example, is one of those side effects. TD is characterized by purposeless movements of the head, neck, trunk and extremities. It often begins with wormlike movements of the tongue, grimacing, chewing and lip smacking, as well as, sudden involuntary writhing movements.

According to Dr. Steven Hyman, Director of The National Institute for Mental Health, due in part to such side effects, statistically, most individuals with schizophrenia will discontinue use of these older medications after one to two years without medical supervision. He says, "One of the most common reasons for psychiatric readmissions, which may number in the dozens for many individuals, is the repeated discontinuation of medication after leaving the hospital. The need for frequent hospitalizations has obvious implications for employment, school and social functioning, as well as substantial costs involved for inpatient treatment via what has been referred to as a 'revolving door.'"

Fortunately, the newest research has produced a category of medicines called atypical antipsychotics. According to the many individuals I have worked with, the "healing properties," if you would, of this new class of medications has quelled symptoms, restored functionality, and "given back the lives" of consumers taking them. They are more expensive than the earlier drugs.

Kansas, by statute, has declared that no individual should be denied access to the medication that will promote his or her most effective and right treatment at the right time. Other states with restrictive drug formularies have shown that costs actually escalated rather than declined due to greater medical, inpatient psychiatric care and corrections costs.

To repeal Kansas law to force citizens to take older, cheaper, less effective medications for life-threatening diseases is unethical. It is not cost effective. Prior authorization and other cloaked denial to access mechanisms affect individuals severely. For many people with schizophrenia, their first exposure to antipsychotic medication may have lifelong implications for compliance with treatment. If they must "fail-first" on older drugs or face bureaucratic hurdles that seem insurmountable to get treatment, they may lose their best opportunity for intervention and recovery. We oppose Senate Bill 603.

Senate Ways and Means
2-28-02
Attachment 9

Testimony

Re
SB 603 – An ACT concerning prescription drug discounts and rebates

Kansas Senate Committee
On
Ways and Means

February 28, 2002

Presented by
Stephen H. Feinstein, Ph.D., Chairman
Kansas Mental Health Coalition

Chairman Morris and members of the Ways and Means Committee I am Dr. Stephen Feinstein, Chairman of the Kansas Mental Health Coalition. The Coalition is composed of advocacy organizations, mental health service providers, community hospitals, associations representing health care professionals, and private individuals who have a stake in mental health issues. I appreciate the opportunity to speak to you today about Senate Bill 603, which would create a formulary listing of the drugs covered by the state Medicaid program and require prior authorization for drugs not in the formulary.

The Kansas Mental Health Coalition believes that SB 603 is both fiscally unwise and unethical in its treatment of Kansans who are poor and mentally ill. It is fiscally unwise because it does not take into account the well-documented reductions in the cost of treatment that result when sick people have timely access to the most effective medications. Requiring sick people to *fail-first* or to work their way through a series of time-consuming steps is NOT TIMELY. For people with severe and persistent mental illness the availability of each new generation of psychotropic medication produces better and faster recovery from symptoms. Each brings with it new cost issues, but we always find that those costs are offset by shorter and less frequent hospitalizations and a reduction in the need for other interventions. This was dramatically illustrated by the impact of the expensive new atypical antipsychotic medications that made it possible to successfully move lifelong patients out of our state hospitals and into their communities. In lieu of these medications Mental Health Reform could not have been successful. Clearly the cost up front was worth the result.

When the next generation of psychotropic medications becomes available they will probably be faster acting, more effective and better tolerated than the current generation. As with every other new product that comes on the market, the consumer will be charged for the industry's cost of development. We can expect that the medication will not be cheaper, but we can also expect that it will further reduce the demand for expensive services. The Kansas Mental Health Coalition hopes that the public policy adopted by this legislature continues to be open access to the best available medication and negotiation for the best price.

Creating a formulary that is based, in part, upon cost is also fiscally unwise because it does not take into account the well documented cost increases that result when a state denies access, caps access or delays access to the most effective medications. All of these actions result in increased frequency, severity, and duration of symptoms and that translates into more hospital days, more nursing home days, more physician interventions, more mental health clinic hours, more court and criminal justice hours, and more reliance on the welfare system. In fact, a study of 47 states' Medicaid programs found that while restrictive formularies reduced pharmaceutical expenses, the saving was completely offset by increased expenses for other treatments.

We do support the concept of price negotiation designed to obtain favorable rates for large-scale purchasers like our state Medicaid program. Nonetheless, we also believe that such rates must not be obtained by creating a two tiered system of medical care, i.e., One level that provides unlimited access to medication for people of means and another that

requires poor people to use less effective medications while they work their way through a bureaucratic maze that may never provide what they need. We know that the members of this committee would find it repugnant to tell a loved one who has a debilitating and potentially fatal disease that he or she must use a less effective medication that is in the state Medicaid formulary while waiting for permission to use a medication that is known to be more effective. If this happened you might well think that just as *justice delayed is justice denied* so too *treatment delayed is treatment denied.* Selectively denying treatment just does not reflect our democratic system or the value, we as a nation, place on human life.

We hope that you will not support the creation of the Medicaid formulary proposed in SB 603. Thank you for hearing our concerns. We look forward to answering any question you may have.

Testimony to The Senate Ways and Means Committee
By: Bryce Miller, Topeka, Kansas
Community Mental Health Advocate

RE: SB 603 – An act concerning prescription drug discounts and rebates

My name is Bryce Miller, Topeka and I would like to thank you for the opportunity to speak briefly today regarding SB 603. This bill concerns prescription drug discounts and rebates.

I am a retired state employee having retired in 1993 after working 19 years as a management analyst for the Kansas Department of Human Resources. Having been misdiagnosed and treated, 1964-74, for clinical depression, with various medications, often time with little success, I was finally properly diagnosed in 1974 as suffering from bipolar illness and was placed on lithium therapy, which was a real improvement over previous treatment.

One conclusion I reached following my 1964-74 tumultuous period that as a consumer I was going to educate myself above mental illnesses and their treatment. Never again was I as a consumer taking any medication without knowing about it and potential side effects. "In other words, nothing about us without us."

I still remember the day, many years ago, when Robert Harden escorted Dr. Karl Menninger into a 5th floor hearing room in this capitol building to discuss mental illnesses and the need for proper treatment. Dr. Karl started out his remarks by stating "Any of us in this hearing room can be inflicted with a mental illness, at any time, including state senators!" Needless to say there was a long pause in the proceedings.

During my 26 years as a consumer advocate I served as a consumer member on the Governors Mental Health Services Planning Council (1990-98) during the early days of mental health reform.

I served from 1992-98 as a member of the Board of Directors for the National Alliance on Mental Illness, Arlington, Virginia, representing the NAMI Consumer Council.

As an advocate and the retire representative on the State of Kansas Employee Health Care Commission, I have been involved in the past several years in the struggle to secure mental health insurance parity, first for state employees and later for the citizens of Kansas.

I would like to congratulate those legislators who supported mental health insurance parity last year.

You may remember the opponents said parity would increase costs at least 8 to 10% per year.

I'm pleased to report that yesterday during the State of Kansas Employees Health Care Commission the following information about parity was released regarding State of Kansas employees parity:

a. Regarding Premier Blue, mental health parity produced a slight increase of .14% of total 1+MD plan crests for the plan year 1999 compared to plan year 1998.
b. Regarding Kansas Choice, mental health parity produced a slight increase of .05% of total managed indemnity plan crests for the plan year 2000 compared to plan year 2001, based on claims data available.

Things do not always turn out as predicted!

Because SB 603 contains no consumer input and no consumer safeguards in the selection and use of the formulary, I find this bill flawed. We must not return to the "prior authorization" days of a decade age. Much time was spent by doctors securing prior authorization for medications that often were not appropriate. We advocates worked too hard a decade ago to get rid of "prior authorization." We must not "turn back the clock." Therefore, I request you vote against SB 603.

Senate Ways and Means
2-28-02
Attachment 11

Testimony on SB603 by Barbara Bohm ,P.O.Box 373, Americus, KS 66635

I was perturbed when I learned the State of Kansas , in an erroneous belief that this proposed policy will save the taxpayers of Kansas an significant amount of money, is thinking of considering the cost of medicine needed to help one stay sane over what the doctor thinks will likely be most successful. In other words, to force the doctor to try and stabilize the individual first using only the older, cheaper medicines, and, ONLY after that failed, try a perhaps more expensive medicine which studies might well show far more likely to be successful for a particular diagnosis. But there are "hidden" costs to these delays. First and foremost, many medication changes are done in a hospital setting, where the individual can be more closely watched. For most medicine changes, this will take about two weeks. But my last hospital stay, which involved a complete medicine change, lasted from Thanksgiving of 1989 to early spring of 1990- April I think. What was saved by putting me on cheap medicine like lithium didn't make a dent in that about 4 month hospital stay in Topeka State Hospital at taxpayer expense. What is more, I had two week hospital stays every year or so for 10 years prior to that. One such breakdown cost me my job at Brown's Ferry Nuclear Plant where I worked for 2 years as a nuclear engineer.

Yes, I have a Master's in Nuclear Engineering. Both on my high school ACT and later after being found to be manic/depressive, when I took my GRE, I placed in the top 1% in scores in the U.S.A.

You CAN be both mad and gifted! If you have not yet seen the movie ":A Beautiful Mind" , I strongly urge you to see it. Even though he was not manic/depressive like me, I found many of the movie Bert Nash's experiences to echo my life as well. For instance, he one reason he stopped taking his medicine was he could no longer do advanced math. Later he did take his medicine- but in the movie it said these were "atypical" medicines- read expensive. One of the first medicines I was put on was haldol. When I complained to a staff member that I could no longer read my issue of Scientific American, his comment was - "I don't read Scientific American , and I am happy!" I was unable to clarify my statement- what I really meant was -"How could I pass graduate school and get my Master's in Nuclear Engineering if I was unable to even read Scientific American?" What price tag can be placed on a wasted mind and impoverished quality of life?

Senate Ways and Means
2-28-02
Attachment 12

Testimony Against Senate Bill 603

I ask you to take careful consideration when looking at SB 603. Peoples livelihood, and lives depend on it. Speaking as a member of National Alliance for Mental Illness Kansas, as a RN and mother of a son with mental illness I can tell you it will be very detrimental to the treatment of this disease and a set back in treatment if this bill is passed.

Although Mental Illness can't be cured it can be treated effectively for many individuals and the treatment is getting better all the time as new drugs are being developed, by using the appropriate medications. Appropriate medication is a Key word, because there are so many different receptor sites in the brain affected by mental illness, and since each medication affects each person differently it is a long trial and error process to find the right mediation or combination of medications. For the person being treated this is a trying and long process, they may suffer severe side effects, get no relief from depression, continue to have delusions, paranoia, and have psychotic episodes. These problems can lead to suicide, drug and alcohol abuse, and crime of any magnitude. The doctor must make many adjustments in dosage, types of medication and combinations. This is a time consuming process.

If this bill passes doctors can't take the time to write to a committee for prior authorization too many times for free, as it is time-consuming and cumbersome. This may lead to the mental illness being treated only to get by. This can lead to the client not functioning to the best of their ability, ending up in the hospital more frequently, in jail or prison, on the streets or dead.

My son was treated for his mental illness for the first time 3 years ago. We had insurance and his doctors were able to find the right combination of medications. He is now a productive tax-paying citizen. If they had stopped at the first few trials of treatment I can assure you he would be no where close to where he is today.

Please don't let Kansas loose ground on how much has been learned about the pharmacology affect on mental illness. Yes, the newer medications are more expensive but if it keeps those with mental illness out of institutions, jails, off of drugs and alcohol, and alive it can actually be a cost saver for the state of Kansas.

Sharon Copeland

Senate Ways and Means
2-28-02
Attachment 13

Association of Community Mental Health Centers of Kansas, Inc
720 SW Jackson, Suite 203, Topeka, Kansas 66603
Telephone: 785-234-4773 / Fax: 785-234-3189
Web Site: www.acmhck.org

Kansas Senate Ways and Means Committee

Testimony on SB 603

February 28, 2002

Presented by
Paul Klotz, Executive Director
Association of Community Mental Health Centers of Kansas, Inc.

Senate Ways and Means
2-28-02
Attachment 14

Mr. Chairman and members of the Committee, I am Paul Klotz, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc. I represent the 29 licensed Community Mental Health Centers (CMHCs) in Kansas who provide community-based mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week.

The CMHCs have been and continue to be effective gatekeepers to our state mental health hospitals. In FY90, we had a total of 1,003 state mental health hospital beds. As a result of Mental Health Reform and growth in the system which has followed, we have successfully closed 627 beds, leaving us with a safety net in 2002 of 376 beds.

The network of CMHCs served just under 83,000 Kansans during FY01. During FY01, CMHCs served 12,838 adults with severe and persistent mental illness (the target population); 42,848 other adults (or non-target population); 10,860 children and adolescents with serious emotional disturbance (the target population); and 16,437 other children and adolescents. Community Mental Health Centers are required to serve individuals regardless of their ability to pay and are now the safety net for Kansans with mental illness. Our Centers are seeing populations that are increasingly presenting greater and greater needs. We are able to do that, in part, due to effective medications for the treatment of mental illness.

The Association appears before you today to express our opposition to Senate Bill 603, which we believe limits access to medications by imposing a "preferred drug list" or "restrictive drug formulary" upon prescription medicines in the State's Medicaid Program. This bill would have the effect of eliminating a patient's right to access the appropriate medicine for their condition, as well as their physician's responsibility to prescribe freely the medication that is best suited to their unique needs as a patient. We believe this legislation, if passed, would reverse progress we have made over the past ten years to improve access to effective treatment.

Mr. Chairman, not too many years ago, with your help, and that of Senators Feleciano and Kerr, we increased access to critically needed atypical antipsychotic medications. This has been an effective program and its success would not have been possible without the help of you and your colleagues. I say this because you know too well how important the issue of access to effective medication is for consumers and families who are faced with mental illness.

A "restrictive formulary" or "prior authorization" ignores several factors, which we recognize in our daily interactions in serving the mentally ill:

- The proven, long range higher costs of substituting older, cheaper medications for the newer, less potentially debilitating class of atypical medications.
- The extreme variance among newer psychotropic agents on the individual.
- Vulnerability of the mentally ill to medication changes.
- The high hospitalization costs of medication failure.
- The unintended consequences of mounting costs in other areas under state budget control such as corrections, law enforcement and welfare.

We know the newer, innovative and therapeutically unique medications to treat mental illness can both improve health and save healthcare dollars. By controlling and preventing future problems, the new medications help eliminate additional hospitalizations and more invasive and prolonged procedures.

We know there is less compliance with older medication than with the newer medications, in part due to the negative side effects. Many times, the older medications serve to further enhance what many have been known to stereotype the mentally ill.

It is important to note once again that re-hospitalization not only creates an added financial burden on the state but it immensely affects the patient's life. We know by experience (which is confirmed by research) that the newer medications have made it possible for the reduction of hospital days per year. The cost of medications, even though high, does not get close to the cost of hospitalization. This problem is also compounded by the shortage of psychiatric beds in our community and continuous reduction in the number of beds in state hospitals.

Here are some additional facts we believe will be helpful to you as you decide the course of action to take on this legislation:

- One week of hospitalization for a schizophrenic patient after a psychotic break costs as much as maintaining the same patient for one year on a newer antipsychotic medication.

- Cutting costs up-front won't guarantee savings later. In fact, savings from prescription medicine restrictions in 47 Medicaid programs nationwide were completely off-set by increased spending elsewhere in the system – particularly when it came to physician services and inpatient hospital care.

- Studies and "real-world" experience shows that unobstructed access to medication is the best way to increase treatment success and to save money.

- Mental health medicines take weeks to have an effect, unlike other medicines where outcomes are known in just hours. Restricting access to mental health medicines may leave some patients without effective treatment for months.

While we understand the aim of this legislation is to control costs, it delays appropriate treatment, costs more in the long run, and puts the health of the consumer in jeopardy.

Should you decide to vote favorably on SB 603, we then respectfully request that this Committee protect from prior authorization medications for the treatment of mental illness. Medications for the treatment of mental illness, cancer and AIDS have been exempted in states such as Florida, Oregon and Washington.

Mr. Chairman, thank you for the opportunity to testify before you today.

Keys for Networking, Inc.

The Kansas Parent Information and Resource Center

The State Organization of the Federation of Families for Children's Mental Health

February 28, 2002

To: Members of the Senate Ways and Means Committee
From: Jane Adams, Ph.D., Executive Director

In my absence, I am providing you with written testimony opposing SB 603.

Keys For Networking, Inc. is a state parent organization for families who have children with severe emotional disabilities. Last year Keys served over 10,000 families.

As an organization serving families who have children with serious emotional disorders, we feel that SB 603 poses as a threat to families who need to access the best available medication for their children. Prescriptions drugs for the child with SED must often be tailored to suit their unique needs and readily available as the needs of the child change. Because symptoms and severity levels differ with each child, SED children cannot afford to have their medication limited to the cheapest, often oldest, drugs available. There is no one perfect medication for each illness.

A "preferred drug list" or "drug formulary" exposes the vulnerable mentally ill child to possible medication changes, or in the worst case, access to needed medication. Changes in medication or limited access could cause negative side effects resulting in school failure, hospitalization, or even worse – contact with the criminal justice system. Parents must have the reassurance that they are being provided with the most up-to-date prescription drugs available.

If, in an attempt to save the state money, SB 603 is passed we ask that you leave mental health medications exempt as they are used to treat children with SED – truly the most vulnerable citizens.

Senate Ways and Means
2-28-02
Attachment 15

Bill Graves
Governor

Connie Hubbell
Secretary of Aging

KANSAS
DEPARTMENT ON AGING

Report on the 2000 Survey of Kansas Seniors

February 1, 2001

KANSAS DEPARTMENT ON AGING
NEW ENGLAND BUILDING
503 SOUTH KANSAS
TOPEKA, KS 66603-3404
PHONE (785) 296-4986

Introduction

The last senior survey was conducted in 1997. Since that time, new senior issues regarding housing, mental wellness, nutrition programs, and seniors as caregivers have surfaced. To update our information on the status of seniors, The Area Agencies on Aging and Kansas Department on Aging pursued a new and expanded survey.

In an effort to increase the statewide and regional response rate over 1997, we increased the distribution of the survey instrument. We began with a total of 15,000 preprinted surveys with postage paid envelopes and apportioned them to each county and region based on their senior population.

The 11 AAAs distributed a total of 5,000 surveys to current service customers. Next, the AAAs and KDOA Quality Review staff distributed 10,000 surveys to community organizations and businesses that were likely to have contact with seniors. Some of the AAAs reproduced the survey in newsletters and other formats, and distributed those to seniors and community representatives in their respective counties.

The distribution netted 8,778 responses, with 4,925 forms returned via the postage paid envelopes and an additional 3,853 surveys being returned from the reproduced surveys.

The responses were keyed into a database by KDOA staff, and were analyzed to produce the statewide and regional results shown on the following pages.

Senior Survey 2000 Results

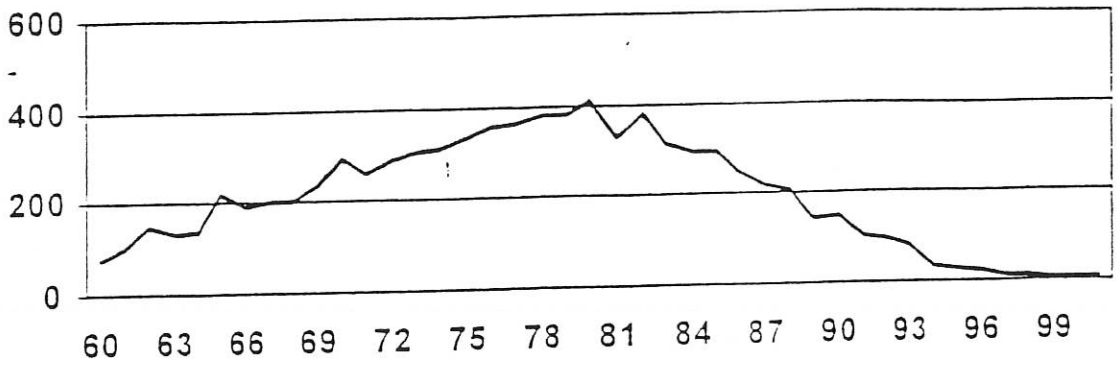
The following graph shows the total responses per AAA and the percentage of the total response for each AAA.

AAA	Total Surveys Received per AAA	Percent Received
Wyandotte-Leavenworth	241	2.75%
Central Plains	534	6.08%
Northwest Kansas	415	4.73%
Jayhawk	626	7.13%
Southeast Kansas	631	7.19%
Southwest Kansas	1,147	13.07%
East Central Kansas	123	1.40%
North Central-Flint Hills	2,082	23.72%
Northeast Kansas	311	3.54%
South Central Kansas	1,455	16.58%
Johnson County	699	7.96%
Unknown	514	5.86%
Total	8,778	100.00%

The next section contains various demographic data on the Kansas Seniors who responded to the survey.

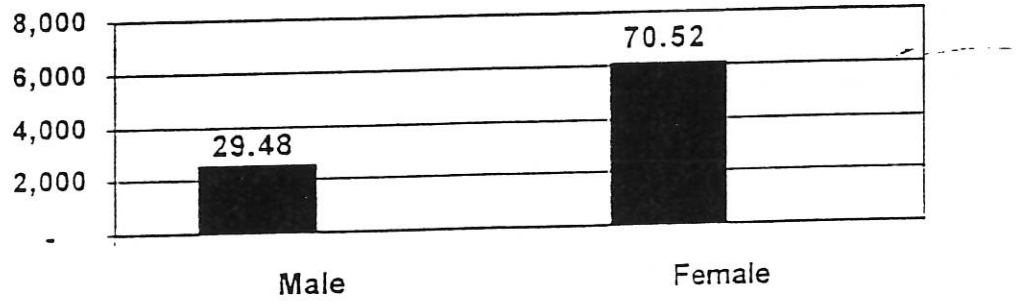
The first question in this section asked for the respondent's age. From a response of 8,315 surveys listing an age. The minimum age was sixty, and the maximum age was one hundred and one years old. The average age was 77.2 years with a standard deviation of 8.2 years. The following graph shows the break down of responses.

Age of Respondents



The next question inquired as to the gender of the respondent, and 70.52% of the respondents were women.

Gender of Respondents



The third question asked if the senior lived in a city, town. or county. The majority of Kansas seniors responded that they live in towns (56.48%).

The first question of the survey addressed the concerns of Kansas seniors. Participants were asked to identify any of the twenty-six listed concerns that they felt was a concern now, or could be in the next five years. Respondents overwhelmingly identified cost of medicine as the number one concern. The second highest concern was the cost of food. The top five concerns were rounded out with maintaining a healthy diet, maintain my personal independence, and cost of nursing home care, with over fifty percent of respondents citing each.

Ranking	Question No.	Statements	No. of Responses	Percent Responses
1	19	Cost of medicine	6,495	79.56%
2	3	Cost of food	5,306	62.71%
3	1	Maintaining a healthy diet	5,118	60.49%
4	18	Maintain my personal independence	5,070	59.92%
5	12	Cost of nursing home care	4,445	52.54%
6	7	Availability of in-home care	4,044	47.80%
7	2	Legislative voice for seniors	3,951	46.70%
8	24	Cost of hospital care	3,933	46.48%
9	16	Help with housework/cleaning	3,710	43.85%
10	22	Cost of in-home care	3,589	42.42%
11	9	Help with house/yard work	3,560	42.08%
12	5	Maintain mental wellness	3,515	41.54%
13	6	Cost of transportation	3,021	35.70%
14	26	Availability of transportation	3,010	35.57%
15	20	Telephone fraud and other fraud	2,992	35.36%
16	17	Health care choices	2,488	29.41%
17	21	Availability of hospital care	2,404	28.41%
18	10	Health insurance information	2,371	28.02%
19	15	Availability of nursing home care	2,357	27.86%
20	11	Availability of legal assistance	2,007	23.72%
21	13	Availability of disease prevention information	1,752	20.71%
22	8	Family caregiver issues	1,746	20.64%
23	25	Availability of community activities	1,731	20.46%
24	4	Help with financial planning	1,284	15.18%
25	14	Availability of part-time work	928	10.97%
26	27	Other	449	5.31%
27	23	Availability of full time employment	399	4.72%
		Total	81,675	

The second question asked respondents to identify three of the concerns selected in question one that were most important to the respondent. Again respondents

overwhelmingly identified cost of medicine as the number one concern. The rest of the top five were maintain my personal independence, cost of food, maintaining a healthy diet, and cost of nursing home care.

Ranking	Question No.	Statements	No. of Responses	Percent Responses
1	19	Cost of medicine	3,355	50.76%
2	18	Maintain my personal independence	2,082	27.42%
3	3	Cost of food	1,962	25.84%
4	1	Maintaining a healthy diet	1,871	24.64%
5	12	Cost of nursing home care	1,567	20.63%
6	7	Availability of in-home care	1,100	14.49%
7	16	Help with housework/cleaning	1,046	13.77%
8	5	Maintain mental wellness	1,042	13.72%
9	9	Help with house/yard work	1,027	13.52%
10	2	Legislative voice for seniors	940	12.38%
11	24	Cost of hospital care	916	12.06%
12	22	Cost of in-home care	683	8.99%
13	26	Availability of transportation	600	7.90%
14	6	Cost of transportation	485	6.39%
15	10	Health insurance information	442	5.82%
16	17	Health care choices	416	5.48%
17	20	Telephone fraud and other fraud	367	4.83%
18	15	Availability of nursing home care	292	3.85%
19	21	Availability of hospital care	228	3.00%
20	11	Availability of legal assistance	199	2.62%
21	8	Family caregiver issues	183	2.41%
22	27	Other	171	2.25%
23	4	Help with financial planning	157	2.07%
24	14	Availability of part-time work	156	2.05%
25	13	Availability of disease prevention information	133	1.75%
26	25	Availability of community activities	128	1.69%
27	23	Availability of full time employment	41	0.54%
		Total	22,089	

As with question one, the cost of medicine was the top concern. This continues to be a major concern of Kansas seniors and it was the second highest concern on the 1997 Senior Survey. Maintaining personal independence moved from fourth highest concern on question one to the second highest on question two. This also continues to be a concern to Kansas seniors and it was the number one concern on the 1997 Senior Survey. Cost of food was the third most important concern in the 2000 survey moving up from ninth in the 1997 survey. Maintaining a healthy diet was the fourth highest concern in this year's survey moving up from twelve in the 1997 survey.
These results indicate that Kansas seniors feel they are under increasing financial pressure to make ends meet. Another indication of this is that three of the top five most important concerns of seniors have to do with cost issues. Cost of nursing home care was the fifth highest concern, with a 20.63% response from Kansas Seniors.

The importance Kansas Seniors have placed on the top five concerns varies only slightly from one Area Agency on Aging to another. Eight of the Eleven Area Agencies on Aging have the same five issues in their top five. Wyandotte-Leavenworth AAA and Johnson County AAA had one issue each that was different, and the Northeast Kansas AAA had two other issues in their top five. Below is a summary of the top ten concerns from each AAA and percentage for each response:

Wyandotte-Leavenworth AAA		Response
1	Cost of medicine	43.66%
2	Cost of food	33.33%
3	Maintain my personal independence	28.64%
4	Maintaining a healthy diet	26.29%
5	Legislative voice for seniors	15.02%
6	Availability of in-home care	15.02%
7	Cost of nursing home care	14.55%
8	Help with housework/cleaning	13.15%
9	Maintain mental wellness	12.68%
10	Cost of hospital care	11.27%

Central Plains AAA		Response
1	Cost of medicine	54.86%
2	Cost of food	31.78%
3	Maintain my personal independence	28.54%
4	Cost of nursing home care	19.64%
5	Maintaining a healthy diet	17.61%
6	Legislative voice for seniors	13.97%
7	Maintain mental wellness	13.77%
8	Cost of hospital care	12.75%
9	Availability of in-home care	12.35%
10	Help with house/yard work	11.34%

Northwest Kansas AAA

		Response
1	Cost of medicine	58.82%
2	Cost of food	28.88%
3	Maintain my personal independence	24.87%
4	Maintaining a healthy diet	23.26%
5	Cost of nursing home care	22.19%
6	Cost of hospital care	15.78%
7	Help with housework/cleaning	14.17%
8	Maintain mental wellness	13.10%
9	Availability of in-home care	13.10%
10	Help with house/yard work	12.83%

Jayhawk AAA

		Response
1	Cost of medicine	47.96%
2	Maintain my personal independence	29.07%
3	Cost of food	23.33%
4	Maintaining a healthy diet	22.78%
5	Cost of nursing home care	22.22%
6	Maintain mental wellness	15.74%
7	Availability of in-home care	14.63%
8	Cost of hospital care	12.41%
9	Help with housework/cleaning	11.85%
10	Legislative voice for seniors	11.48%

Southeast Kansas AAA

		Response
1	Cost of medicine	50.27%
2	Maintaining a healthy diet	31.53%
3	Cost of food	31.35%
4	Maintain my personal independence	27.39%
5	Cost of nursing home care	16.04%
6	Help with housework/cleaning	16.04%
7	Availability of in-home care	13.87%
8	Maintain mental wellness	13.33%
9	Help with house/yard work	12.25%
10	Cost of hospital care	11.17%

Southwest Kansas AAA

		Response
1	Cost of medicine	47.26%
2	Maintaining a healthy diet	28.80%
3	Maintain my personal independence	25.25%
4	Cost of food	23.63%
5	Cost of nursing home care	21.81%
6	Help with house/yard work	15.92%
7	Legislative voice for seniors	14.71%
8	Maintain mental wellness	14.20%
9	Cost of hospital care	14.10%
10	Availability of in-home care	12.58%

1	Cost of medicine	55.00%
2	Maintain my personal independence	36.67%
3	Maintaining a healthy diet	25.83%
4	Cost of food	24.17%
5	Cost of nursing home care	23.33%
6	Maintain mental wellness	15.00%
7	Availability of in-home care	15.00%
8	Cost of hospital care	12.50%
9	Help with housework/cleaning	11.67%
10	Legislative voice for seniors	8.33%

North Central-Flint Hills AAA		Response
1	Cost of medicine	48.46%
2	Maintain my personal independence	27.74%
3	Maintaining a healthy diet	26.90%
4	Cost of food	22.12%
5	Cost of nursing home care	21.50%
6	Availability of in-home care	16.62%
7	Help with house/yard work	14.65%
8	Help with housework/cleaning	14.32%
9	Legislative voice for seniors	13.25%
10	Maintain mental wellness	12.86%

Northeast Kansas AAA		Response
1	Cost of medicine	46.90%
2	Maintain my personal independence	32.07%
3	Cost of food	27.24%
4	Availability of in-home care	24.48%
5	Help with housework/cleaning	24.48%
6	Cost of nursing home care	20.69%
7	Maintaining a healthy diet	18.62%
8	Maintain mental wellness	11.38%
9	Help with house/yard work	11.38%
10	Cost of hospital care	10.34%

South Central Kansas AAA		Response
1	Cost of medicine	56.08%
2	Cost of food	27.17%
3	Maintain my personal independence	24.50%
4	Maintaining a healthy diet	24.25%
5	Cost of nursing home care	23.25%
6	Help with house/yard work	14.08%
7	Maintain mental wellness	13.75%
8	Legislative voice for seniors	13.08%
9	Availability of in-home care	12.42%
10	Help with housework/cleaning	12.17%

Johnson County AAA		Response
1	Cost of medicine	52.65%
2	Maintain my personal independence	32.87%
3	Cost of food	22.59%
4	Maintaining a healthy diet	17.45%
5	Help with house/yard work	16.51%
6	Cost of nursing home care	15.26%
7	Help with housework/cleaning	14.64%
8	Maintain mental wellness	14.33%
9	Availability of in-home care	13.86%
10	Legislative voice for seniors	12.15%

AAA Unidentified		Response
1	Cost of medicine	47.99%
2	Cost of food	30.15%
3	Maintain my personal independence	23.37%
4	Maintaining a healthy diet	23.12%
5	Cost of nursing home care	21.11%
6	Maintain mental wellness	15.58%
7	Cost of hospital care	14.32%
8	Availability of in-home care	13.82%
9	Help with housework/cleaning	13.82%
10	Cost of in-home care	12.81%

By cross-indexing responses from various questions with the three most pressing concerns expressed by respondents. The following information was developed:

When comparing the responses to the second question with individuals who live alone to respondents who do not live alone, the responses are very similar. They have the same items selected for their top eleven responses and their top five are exactly the same. However, there are very small differences in the order of priorities.

When comparing the income levels of respondents against the "most important concerns" they listed on their surveys, the top five concerns were basically the same. The lowest income level included "help with housework/cleaning" on their surveys and excluded "cost of nursing home care" from their top five. The top ten "most important concerns" for each income level are shown on the following page.

16-10

Rank	Income Level less than $696	No. of Responses	Precent Response
1	Cost of medicine	627	47.90%
2	Cost of food	462	35.29%
3	Maintain my personal independence	352	26.89%
4	Maintaining a healthy diet	321	24.52%
5	Help with housework/cleaning	262	20.02%
6	Availability of in-home care	213	16.27%
7	Cost of nursing home care	176	13.45%
8	Maintain Mental Wellness	150	11.46%
9	Cost of hospital care	148	11.31%
10	Availability of transportation	142	10.85%

Rank	Income Level between $696 - $1,044	No. of Responses	Percent Response
1	Cost of medicine	1,198	54.70%
2	Cost of food	651	29.73%
3	Maintain my personal independence	584	26.67%
4	Maintaining a healthy diet	489	22.33%
5	Cost of nursing home care	413	18.86%
6	Availability of in-home care	334	15.25%
7	Help with housework/cleaning	326	14.89%
8	Help with house/yard work	318	14.52%
9	Maintain Mental Wellness	271	12.37%
10	Legislative voice for seniors	241	11.00%

Rank	Income Level more than $1,044	No. of Responses	Percent Response
1	Cost of medicine	1,462	50.03%
2	Maintain my personal independence	876	29.98%
3	Maintaining a healthy diet	740	25.33%
4	Cost of nursing home care	730	24.98%
5	Cost of food	550	18.82%
6	Maintain Mental Wellness	464	15.88%
7	Legislative voice for seniors	429	14.68%
8	Availability of in-home care	401	13.72%
9	Help with house/yard work	389	13.31%
10	Cost of hospital care	367	12.56%

Rank	Income Level I don't know	No. of Responses	Percent Response
1	Cost of medicine	214	42.63%
2	Maintaining a healthy diet	143	28.49%
3	Maintain my personal independence	129	25.70%
4	Cost of food	122	24.30%
5	Cost of nursing home care	122	24.30%
6	Help with housework/cleaning	91	18.13%
7	Help with house/yard work	87	17.33%
8	Cost of hospital care	73	14.54%
9	Maintain Mental Wellness	70	13.94%
10	Availability of in-home care	70	13.94%

The next cross-index is on minority survey responses to the "most important concerns" question. The top four concerns are similar to Section B responses shown in this report. However the next six items show some differences from prior Section B responses. The following chart lists the top ten concerns for minorities on the survey.

Rank	Minority Responses	No. of Responses	Percent Response
1	Cost of medicine	108	39.71%
2	Maintain my personal independence	80	29.41%
3	Cost of food	77	28.31%
4	Maintaining a healthy diet	67	24.63%
5	Legislative voice for seniors	42	15.44%
6	Help with house/yard work	42	15.44%
7	Help with housework/cleaning	35	12.87%
8	Availability of in-home care	34	12.50%
9	Cost of hospital care	32	11.76%
10	Availability of transportation	30	11.03%

The next cross-index is for minorities with incomes under $1,044 per month. The top four concerns are similar to section B responses shown else where in this report. However the next six items show some differences from prior Section B responses and is similar to the chart for minorities of all income levels. The following chart lists the top ten concerns for minorities with income under $1,044 (150% of the poverty level for one-person household) on the survey.

Rank	Minority Income under $1,044	No. of Responses	Percent Response
1	Cost of medicine	73	42.20%
2	Maintain my personal independence	52	30.06%
3	Cost of food	48	27.75%
4	Maintaining a healthy diet	41	23.70%
5	Legislative voice for seniors	29	16.76%
6	Help with house/yard work	28	16.18%
7	Help with housework/cleaning	23	13.29%
8	Availability of in-home care	22	12.72%
9	Availability of transportation	22	12.72%
10	Cost of hospital care	19	10.98%

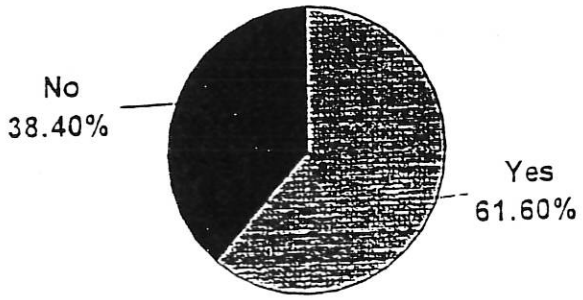
The next two charts reflect the section B "most important concerns" for urban and rural AAAs. There were 6,164 surveys identified as rural and 2,100 surveys as urban. The rural responses match the overall responses for most important concerns. The urban responses have some concerns ranked differently than the overall responses.

Rank	Rural AAAs	No. of Responses	Percent Responses
1	Cost of medicine	2,703	50.93%
2	Maintain my personal independence	1,419	26.74%
3	Maintaining a healthy diet	1,401	26.40%
4	Cost of food	1,343	25.31%
5	Cost of nursing home care	1,137	21.42%
6	Availability of in-home care	784	14.77%
7	Help with housework/cleaning	751	14.15%
8	Help with house/yard work	743	14.00%
9	Maintain Mental Wellness	708	13.34%
10	Legislative voice for seniors	660	12.44%

Rank	Urban AAAs	No. of Responses	Percent Response
1	Cost of medicine	961	50.87%
2	Maintain my personal independence	570	30.17%
3	Cost of food	499	26.42%
4	Maintaining a healthy diet	378	20.01%
5	Cost of nursing home care	346	18.32%
6	Maintain Mental Wellness	272	14.40%
7	Availability of in-home care	261	13.82%
8	Legislative voice for seniors	241	12.76%
9	Help with housework/cleaning	240	12.71%
10	Help with house/yard work	234	12.39%

The next section dealt with the ability of seniors to access services. The respondents were asked if they currently used services for seniors in their communities. Most (61.60%) reported using services currently in their communities.

I currently use services for seniors in my community:



The next question asked respondents how often do you go to a senior center for other than meals? The most responses (38.8%) indicated they never go to senior center for other than meals.

– Rescuing the Kansas Senior Pharmacy Assistance Program –

Purpose: To enhance the current prescription drug assistance program to cover substantially more eligible Kansas seniors.

Need for Change: The skyrocketing costs of health care, in particular prescription drugs, are leaving many Kansas seniors with the impossible choice of either putting food on the table, heating their homes or paying for necessary medicines. This fact is indisputable.

A recent Kansas Department on Aging survey of Kansas seniors conducted through the state's 11 area agencies on aging found that the top concern among all seniors served by the agencies was prescription drug costs.

The current prescription drug program enacted in 2000 is severely limited in scope, leaving thousands of Kansas seniors without assistance. The current program applies the interest earned from the $65 million senior trust fund toward prescription drug assistance. Approximately $1 million is used to serve roughly 1200 seniors. According to the Kansas Department on Aging, a maximum of 62,000 individuals could qualify for assistance, meeting the absolute minimum requirements of the program.

Proposal: Working within existing state resources, the proposal would simply expand the current Senior Pharmacy Assistance Program to provide prescription drug assistance to tens of thousands more Kansas seniors. The proposal would also implement a Medicaid spend-down program to provide additional pharmacy assistance to Kansas families facing catastrophic drug costs. Also, funding is set aside for the Senior Health Insurance Counseling for Kansas program.

The proposal fully utilizes the $65 million currently in the senior trust fund—existing resources — to expand the Senior Pharmacy Assistance Program on a broader scale. The proposal also secures all future transfers to the senior trust fund for prescription drug assistance.

The three-year program would:

1. Appropriate $21.575 million per year for prescription drug assistance for Kansas seniors.
   (1) $18.2 million per year dedicated to prescription drug assistance under current Senior Pharmacy Assistance Program.
   (2) $3.2 million per year to fund provisions of 2000 House Bill 2379, Medicaid Spend-down Program.
   (3) $175,000 for Senior Health Insurance Counseling for Kansas (SHICK).
2. Current eligibility requirements would remain.

Senate Ways and Means
2-28-02
Attachment 17

3. The maximum benefit would change to $600 annually. This change was made to allow more seniors to get coverage. Also, the catastrophic drug benefit created in the bill will now supplement the pharmacy assistance program. The amount is in line with the average yearly out-of-pocket expenses on prescription drugs estimated by the AARP's Public Policy Institute *(According to the AARP's Public Policy Institute, beneficiaries were projected to spend an average of $480 out-of-pocket on prescription drugs in 2000. Beneficiaries with incomes between 175% and 250% of poverty spent an average of $523 out-of-pocket.)*
4. The program would cover roughly 35,000 more eligible Kansans annually than the current program.
5. The Medicaid Spend-down Program would allow families with catastrophic prescription drug costs to deduct their drug costs from their monthly income to qualify for Medicaid coverage. There are many families whose monthly income is on the cusp of qualifying for Medicaid. However, if their monthly drug costs were deducted they could qualify for Medicaid coverage.
6. The bill secures all future transfers to the senior trust fund through the Intergovernmental Transfer Program for prescription drug assistance under the provisions outlined in Section 1.

Conclusion: The current Senior Pharmacy Assistance Program is anemic, leaving several thousand eligible Kansas seniors with no prescription drug assistance. By utilizing the entire $65 million now, the state can provide assistance to substantially more Kansas seniors. Over the three-year plan, more than 35,000 eligible Kansas seniors will receive help annually. A much more prominent step toward assuring that no Kansas senior has to choose between buying drugs and other necessities.

Senate Ways and Means
2-28-02
Attachment 18

Kansas Intergovernmental Transfer Program
Budget Division Estimate

FY 2002

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/01		0	0	65,712,927	1,456,796	923,590	9,952,155	476,077	0	78,521,545
Aug. (actual)	34,721,011	20,967,671	3,337,036	0	4,592,134	4,088,119	1,736,051	0	0	34,721,011
Nov. (actual)	15,710,608	9,487,479	1,509,947	0	2,077,855	1,849,797	785,530	0	0	15,710,608
Feb. (est.)	25,000,000	15,100,000	2,400,000	0 *	3,307,500	2,942,500	1,250,000	0	0	25,000,000
May (est.)	25,000,000	15,100,000	2,400,000	0 *	3,307,500	2,942,500	1,250,000	0	0	25,000,000
Sub-total	100,431,619	60,655,150	9,646,983	65,712,927	14,741,785	12,746,506	14,973,736	476,077	0	178,953,163
Transfers		0	0	0	0	0	0	(476,077)	476,077	0
TOTAL	100,431,619	60,655,150	9,646,983	65,712,927	14,741,785	12,746,506	14,973,736	0	476,077	178,953,163
Budgeted Expenditures		44,000,000	7,000,000	0	12,300,000	10,950,000	13,400,000	0	250,000	87,900,000
Balance Available for FY 2003		16,655,150	2,646,983	65,712,927	2,441,785	1,796,506	1,573,736	0	226,077	**91,053,163**

* Must put transfer of $476,077 from SRS HCBS Programs Fund to Aging HCBS Programs Fund in the bill.
** Must provide for Sr. Services Trust diversion language.

FY 2003

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/02		16,655,150	2,646,983	65,712,927	2,441,785	1,796,506	1,573,736	0	226,077	91,053,163
Aug. (est.)	25,000,000	15,100,000	2,400,000	0 *	3,250,000	3,000,000	1,250,000			25,000,000
Nov. (est.)	25,000,000	15,100,000	2,400,000	0 *	3,250,000	3,000,000	1,250,000			25,000,000
Sub-total	50,000,000	46,855,150	7,446,983	65,712,927	8,941,785	7,796,506	4,073,736	0	226,077	141,053,163
SSTI Transfer		15,673,944	0	(15,697,867) *	0	23,923	0	0	0	0
TOTAL		62,529,094	7,446,983	50,015,060	8,941,785	7,820,429	4,073,736	0	226,077	141,053,163
Budgeted Expenditures		62,529,094	7,446,983	0	12,300,000	10,973,923	4,073,736	0	226,077	97,549,813
Balance Available for FY 2004		0	(0)	50,015,060	(3,358,215)	(3,153,494)	(0)	0	0	**Total** 43,503,350

** Must provide for Sr. Services Trust diversion and transfer out language. Transfer out = $15,697,867.
***In both FY 2002 and FY 2003 $1.2 million is budgeted from the Senior Services Fund, balance as of11/20/01 = $3,050,486.

Kansas Intergovernmental Transfer Program
Department on Aging Estimate
FY 2002

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/01		0	0	65,712,927	1,456,796	923,590	9,952,155	476,077	0	78,521,545
Aug. (actual)	34,721,011	20,967,671	3,337,036	0	4,592,134	4,088,119	1,736,051	0	0	34,721,011
Nov. (actual)	15,710,608	9,487,479	1,509,947	0	2,077,855	1,849,797	785,530	0	0	15,710,608
Feb. (est.)	52,269,224	13,544,850	2,153,017	20,890,590	6,915,218	6,152,088	2,613,461	0	0	52,269,224
May (est.)	52,269,224	0	0	36,588,457	6,915,218	6,152,088	2,613,461	0	0	52,269,224
Sub-total	154,970,067	44,000,000	7,000,000	123,191,974	21,957,221	19,165,682	17,700,658	476,077 *	0	233,491,611
Transfers		0	0	0	0	0	0	0	0	0
TOTAL	154,970,067	44,000,000	7,000,000	123,191,974	21,957,221	19,165,682	17,700,658	476,077	0	233,491,611
Budgeted Expenditures		44,000,000	7,000,000	0	12,300,000	10,950,000	13,400,000	0	250,000	87,900,000
Balance Available for FY 2003		0	(0)	123,191,974	9,657,221	8,215,682	4,300,658	476,077	(250,000)	**145,591,611**

FY 2003

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/02		0	(0)	123,191,974	9,657,221	8,215,682	4,300,658	476,077	(250,000)	145,591,611
Aug. (est.)	41,861,003	0	0	29,302,702	5,441,930	5,023,320	2,093,050			41,861,003
Nov. (est.)	41,861,003	0	0	29,302,702	5,441,930	5,023,320	2,093,050			41,861,003
Sub-total	83,722,006	0	(0)	181,797,378	20,541,082	18,262,322	8,486,759	476,077	(250,000)	229,313,617
SSTI Transfer		0	0	0	0	0	0	0	0	0
TOTAL		0	(0)	181,797,378	20,541,082	18,262,322	8,486,759	476,077	(250,000)	229,313,617
Budgeted Expenditures		44,000,000	7,000,000	0	12,300,000	10,950,000	4,400,000	0	250,000	78,900,000
Balance Available for FY 2004		(44,000,000)	(7,000,000)	181,797,378	8,241,082	7,312,322	4,086,759	476,077	(500,000)	**Total** 150,413,617

Kansas Intergovernmental Transfer Program
Aging Revenue Estimate - Governor's Spending Plan

FY 2002

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/01		0	0	65,712,927	1,456,796	923,590	9,952,155	476,077	0	78,521,545
Aug. (actual)	34,721,011	20,967,671	3,337,036	0	4,592,134	4,088,119	1,736,051	0	0	34,721,011
Nov. (actual)	15,710,608	9,487,479	1,509,947	0	2,077,855	1,849,797	785,530	0	0	15,710,608
Feb. (est.)	52,269,224	13,544,850	2,153,017	20,890,590	6,915,218	6,152,088	2,613,461	0	0	52,269,224
May (est.)	52,269,224	0	0	36,588,457	6,915,218	6,152,088	2,613,461	0	0	52,269,224
Sub-total	154,970,067	44,000,000	7,000,000	123,191,974	21,957,221	19,165,682	17,700,658	476,077	0	233,491,611
Transfers		0	0	0	0	0	0	0	0	0
TOTAL	154,970,067	44,000,000	7,000,000	123,191,974	21,957,221	19,165,682	17,700,658	476,077	0	233,491,611
Budgeted Expenditures		44,000,000	7,000,000	0	12,300,000	10,950,000	13,400,000	0	250,000	87,900,000
Balance Available for FY 2003		0	(0)	123,191,974	9,657,221	8,215,682	4,300,658	476,077	(250,000)	**145,591,611**

FY 2003

Transfers		SRS IGT	Aging IGT	Sr. Services Trust	SRS Med Match	Age Med. Match	LTC L & G	SRS HCBS	Aging HCBS	Total
Balance as of 7/1/02		0	(0)	123,191,974	9,657,221	8,215,682	4,300,658	476,077	(250,000)	145,591,611
Aug. (est.)	41,861,003	25,284,046	4,018,656	0 *	5,441,930	5,023,320	2,093,050			41,861,003
Nov. (est.)	41,861,003	25,284,046	4,018,656	0 *	5,441,930	5,023,320	2,093,050			41,861,003
Sub-total	83,722,006	50,568,092	8,037,312	123,191,974	20,541,082	18,262,322	8,486,759	476,077	(250,000)	229,313,617
SSTI Transfer		11,961,002	0	(11,961,002) **	0	0	0	0	0	0
TOTAL		62,529,094	8,037,312	111,230,972	20,541,082	18,262,322	8,486,759	476,077	(250,000)	229,313,617
Budgeted Expenditures		62,529,094	7,446,983	0	12,300,000	10,973,923	4,073,736	0	226,077	97,549,813
Balance Available for FY 2004		(0)	590,329	111,230,972	8,241,082	7,288,399	4,413,023	476,077	(476,077)	**Total 131,763,804**

* Requires language to divert $58,605,404 from SSTI
** Requires language to transfer $11,961,002

• KANSAS COUNCIL OF SILVERHAIRED LEGISLATORS *
• 503 Kansas Ave. * Topeka, KS 66603 * (785) 368-7236 *
• (Email) silverhaired@aging.state.ks.us

REMARKS OF
JIM SNYDER, PRESIDENT
SCR 1621
FEBRUARY 28, 2002

Mr. Chairman, members of the Senate Ways and Means Committee. My name is Jim Snyder. I am the President of the Kansas Council of Silver Haired Legislators which is the Legislative Corporation of the regular Kansas Silver Haired Legislators.

I am here in support of Senate Concurrent Resolution 1621 which provides for a request of the Congress of the United States to provide monies in the Medicare Portion of Social Security funds to help in the purchase of prescription drugs by senior citizens.

I am sure it isn't necessary to tell this Senate Panel of the rapid increase in costs of prescription drugs. In fact, it is much more than any cost of living increases, or other items which could alleviate concerns of Seniors who are on fixed incomes.

The Silver Haired Legislature passed this Resolution unanimously at our recent October Session and a copy of our Resolution 1817 is attached. We would appreciate your support by passing this Resolution through the Senate and encouraging House members to do the same. Thank you.

I shall answer any questions of which I can.

Senate Ways and Means
2-28-02
Attachment 19

SILVER HAIRED LEGISLATURE RESOLUTION NO. 1817

By PSA 3

A RESOLUTION urging the Congress of the United States to enact legislation providing prescription drug coverage under the federal Medicare programs.

WHEREAS, Most senior citizens are on fixed incomes; and

WHEREAS, The cost of prescription drugs are rising higher and higher; and

WHEREAS, Some senior citizens must choose between paying bills and paying for their prescriptions and are foregoing their needed medicines due to cost: Now, therefore,

Be it resolved by the Silver Haired Legislature of the State of Kansas: That the Congress of the United States is urged to enact legislation providing prescription drug coverage under the Federal Medicare programs.

AARP Kansas

555 S. Kansas Avenue
Suite 201
Topeka, KS 66603
(785) 232-4070
(785) 232-8259 Fax

February 27, 2002

Good morning Senator Morris and members of the Senate Ways and Means Committee. My name is Dr. Ernest Pogge and I am the coordinator of the AARP Kansas Legislative Task Force. AARP Kansas represents the views of our more than 350,000 members in the state of Kansas. AARP is the nation's leading organization for people age 50 and older. It serves their needs and interests through information and education, advocacy and community services provided by a network of local chapters and experienced volunteers throughout the state and country. Thank you for this opportunity to express our views in ***support*** of Senate Concurrent Resolution 1621.

Prescription drugs aren't a luxury but sometimes they cost as much.

Modern medicine increasingly relies on drug therapies. Yet the benefits of prescription drugs elude more beneficiaries every day. Drug costs continue to rise unabated. Employer-based retiree health coverage is eroding. There are fewer managed care plans in Medicare. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. The need for a Medicare drug benefit will only continue to grow.

We know that enactment of a Medicare prescription drug benefit will require a sizable commitment of federal dollars. We also recognize that budget constraints are greater than last year. But the situation facing millions of older and disabled persons who cannot afford the drugs they need, constitutes a health care and financial emergency that cannot continue to be ignored.

AARP is committed to creating an affordable prescription drug benefit in Medicare, that would be available to all beneficiaries, so that they may benefit from longer, healthier lives with reduced health care cost. Enacting a meaningful Medicare drug benefit this year is a top priority for AARP and our members. Therefore AARP ***supports*** Senate Concurrent Resolution 1621.

Thank you again for this opportunity to express our views. I stand ready to answer questions.

Senate Ways and Means
2-28-02
Attachment 20

Kansas Pharmacists Association
Kansas Society of Health-System Pharmacists
Kansas Employee Pharmacists Council
1020 SW Fairlawn Rd.
Topeka KS 66604
Phone 785-228-2327 ✦ Fax 785-228-9147 ✦ www.kansaspharmacy.org
Robert (Bob) R. Williams, MS, CAE, Executive Director

TESTIMONY

Senate Concurrent Resolution No. 1621
Senate Ways and Means Committee

February 28, 2002

I am Bob Williams, Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee regarding SCR 1621.

The Kansas Pharmacists Association supports SCR 1621. All of the national and state professional pharmacy organizations have been working with Congress regarding the addition of a comprehensive pharmacy benefit to Medicare.

We are happy to report that "The Medicare Drug and Service Coverage Act of 2002" (MEDS Act– H.R. 3626) has been introduced in Congress. The original co-sponsors are Representatives Jo Ann Emerson (R-MO) and Mike Ross (D-AR). KPhA has contacted our Representatives in Congress asking them to sign on as sponsors. We encourage the Kansas Legislature to do so as well. Thank you.

Senate Ways and Means
2-28-02
Attachment 21