Approved: February 7, 2005
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:33 P.M. on February 3, 2005 in Room 526-S of the Capitol.

Committee members absent:
Representative Brenda Landwehr- excused
Representative Patricia Kilpatrick- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:

Jim McLean, Vice President for Public Affairs, Kansas Health Institute
Jodi Mackey, Director, Child Nutrition and Wellness, Kansas State Board of Education
Representative Tom Sloan (written only, proponent)
Representative Annie Kuether (proponent)
Stephanie Weiter, Regional Vice President, American Cancer Society (proponent)
Ron Hein, Kansas Pharmacy Coalition (neutral)
L. J. Leatherman, representing the Kansas Trial Lawyers Association (opponent)

Others attending:
See attached list.

The Chair requested the committee sponsor a bill regarding a change of name requested by the Kansas Highway Patrol and the Capitol Area Security Patrol, changing the latter name to Capitol Police. A motion was made, seconded and passed to sponsor the bill.

Gary Robbins, Executive Director, Kansas Optometric Association, requested a bill to update the optometry licensure statutes. A motion was made, seconded and passed to accept the bill as a committee bill.

The Chair announced that testimony on the hearing for **HB 2137** would continue, and he welcomed Jim McLean, Vice President for Public Affairs, Kansas Health Institute, who spoke as a neutral party. (Attachment 1) Mr. McLean said if current trends continue, health care costs will continue to escalate, noting that the senate was considering a bill (**SB 154**) dealing with nutritional standards. He referred members to two recent studies on obesity published and placed on the institute's website, (www.khi.org) also noting that opponents to the bill spoke accurately in saying that the issue is a complex problem.

Jodi Mackey, Director, Child Nutrition and Wellness, Kansas State Board of Education, outlined neutral information, noting that she was responsible for administering the state's child nutrition programs for the U.S.

information, noting that she was responsible for administering the state's child nutrition programs for the U.S. Department of Agriculture as well as administering school health programs, informing the committee that the public school lunch program started in 1946 when the U.S. government discovered that those being drafted were malnourished. (Attachment 2) She said the nutritional environment needs a comprehensive approach and that working with schools on obesity and nutritional issues was not the complete solution, that parents, businesses, and other agencies needed to be involved as well.

Ms. Mackey also outlined the impact of the federal Child Nutrition Act of 2004, saying that by the summer of 2006 requirement standards must be established for all foods available in schools, standards which will affect not only school lunches, but also a la carte sales, vending machines, school stores, and vending company contracts. She said the State Board of Education will gather information and hold meetings with as wide a variety of interested parties as possible, collaboration which will enhance local control, promote local ownership, and establish good science. She called the present food choices for children a disaster, assuring the committee that the new guidelines will be flexible and provide more choices.

Conferees responded to questions as follows:

Cindy D'Ercole replied that 10-12 states are evaluating foods with low nutritional value. Jodi Mackey said that the Texas policy regarding nutrition takes a "thou shalt" approach issued from the state level.

Members expressed concern at the incursion of private companies into the school food business and commented that school boards have the authority to make changes.

Ms. Mackey replied that the food service problem is exacerbated by budget shortfalls and the fact that the school lunch program is supposed to be self-supportive. Often the food service director is forced to find independent sources of revenue; she cited one district that required its director to find $750,000 in additional funds. Ms. D'Ercole said schools use a variety of strategies to encourage healthy foods. Ms. Mackey said the State Board of Education has the authority to accomplish changes by fiat, but she wants to build a framework for local control, noting that the USDA guidelines are not overly specific and would allow carbonated beverages and pure-sugar confections as foods. She said the bill as written would only affect beverage machines, especially diet soft drinks. She urged members not to push forward with the bill, but to let the federal mandate through local site councils and other cooperative efforts create a more comprehensive approach.

Jim McLean said there were several studies regarding nutritional choices and differential pricing. He said he would provide these to the committee. (They were later posted on the committee website.)

Donna Whiteman explained that money drives most of the contract arrangements with beverage companies, who see exclusive contracts as a way to create brand loyalty that may last a lifetime.

The Chair closed the hearing on **HB 2137** and opened the hearing on **HB 2077**, which would establish a

cancer drug repository through the State Board of Pharmacy.

Representative Tom Sloan was unable to attend, but provided written testimony as a proponent. (Attachment 3)

Representative Annie Kuether, in support of the bill, told of her husband's death from cancer, stating that her loss was intensified by having to dispose of thousands of dollars worth of medications, noting that if the bill had been in statute, someone else could have benefitted from the drugs. Answering questions, she said that the bill would apply only to individually sealed blister-pack medications and that rules and regulations would be developed for handling the donated drugs. She replied that 18 other states have similar statutes and that the bill was narrowed to apply only to cancer patients so it would have a better chance of passing the legislature.

Ron Hein, representing the Kansas Pharmacy Coalition, spoke as a neutral party, stating that his clients are a coalition of local pharmacists and chain pharmacies. (Attachment 4) He acknowledged the good intent of the legislation, noting that the bill was an improvement from last year's bill, since it did not violate federal laws and addressed safety issues, allowing his clients to withdraw their objections.

Stephanie Weiter, Regional Vice President, American Cancer Society, commented that many dollars of medications are throw away at the same time that needy Kansans could be helped by these life-saving drugs. She said that cancer treatments are expensive and this bill is good for Kansans. (Attachment 5)

A member responded to another member's question that missionary organizations allow physicians to take medicines overseas that cannot be used in the United States. A member expressed concern that the bill allows a handling fee and a restocking fee, actions which raise the possibility of fraud.

L J Leatherman, a local attorney representing the Kansas Trial Lawyers Association, spoke as an opponent of the bill. (Attachment 6) He said in spite of the good intent of the bill, the danger to public health and safety outweigh its intent. He pointed out gaps in the secure handling of the donated drugs (*e.g.,* the person who picks up drugs from a hospital and brings them to the pharmacy), and he said if the safety of the drugs can be guaranteed, there is no need for the limitations on liability in section 3.

Responding to questions, Mr. Leatherman said even blister packs are not tamper-proof and that dating and tracking of the drugs will create opportunities for errors or worse. He recommended the Nebraska and Missouri statutes dealing with this issue, which he said were better crafted legislation.

Staff provided a briefing on the policy expressed in **HB 2204**, which grants a sales tax exemption for health and fitness organizations, including membership charges and initiation fees. Answering questions, Ms. Galligan said 501(c)(3) organizations are already tax-exempt; this bill would add for-profit organizations. She said only one other state (Tennessee) has such an exemption. A member noted that the bill seemed lop-sided to single out only one organization.

MINUTES OF THE House Health and Human Services Committee at 1:33 P.M. on February 3, 2005 in Room 526-S of the Capitol.

The Chair announced that a new policy regarding testimony in any House or Senate hearing: testimony must include the name of the conferee, state of residence, and whom the person represents..

The meeting was adjourned at 3:11 pm. The next meeting is scheduled for Monday, February 7, 2005.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: February 3 2005

NAME	REPRESENTING
Joe Smith	American Cancer Society
Ward Cook	American Cancer Society
Lynne Schlosser	American Cancer Society
Stephanie Weiter	American Cancer Society
M. Madlene Hall	ACS
Michelle Burhenn	KC Star
Rebecca Bailey	KMS
Mike Heim	Heim Law Firm
CINDI SHERWOOD	Kansas Dental Assn.
Kristina Hilbrant	Intern Rep. Watkins
Bill Hess	Sunflower Foundation
Cindy D'Ercole	KAC
a. Glenn Hegberger	Kansas Dental Assc.
KEVIN ROBERTSON	KANSAS DENTAL ASSN.
~~Kevin~~ Cassidy	Kansas Dental Assoc
[illegible]	KANSAS DENTAL ASSOC.
Jodi Mackey	Ks Dept of Education
Deb Billingsley	KS Bd of Pharmacy
DEBORAH STERN	KS HOSP. ASSN.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: Feb. 3 2005

NAME	REPRESENTING
[illegible]	KS Health Institute
Lucas Bell	Kearney and Associates
Zach Cobla	Intern Rep Shoewalter
Charles Mossman	KCA
Carolyn Ward	KS Action for Children
Teresa Schwab	Oral Health Kansas
Joe Baba	Kansas Dental Assn.
Dr. Mike Baba	
M. Barbara Hall	ACS
Michelle Peterson	KS. Governmental Consulting
[illegible]	KS Trial Lawyers Assn.
[illegible]	KS Trial Lawyers Assn.
[illegible]	KPTS
Callie Denton	KTLA

KANSAS HEALTH INSTITUTE

For additional information contact:

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House Health and Human Services Committee February 2, 2005
House Bill 2137
Jim McLean **Vice President for Public Affairs** **Kansas Health Institute**

Healthier Kansans Through Informed Decisions

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

Attachment 1
HHS 2-3-05

Testimony to the House Health and Human Services Committee
Wednesday, February 2, 2005
House Bill 2137

Chairman Morrison and members of the committee, I'm Jim McLean, vice president for public affairs, at the Kansas Health Institute.

KHI is an independent, nonprofit health policy and research organization. Our mission is to conduct research and policy analysis on issues that affect the health and well-being of Kansans and communicate that information to you and other policymakers so that you can make informed decisions.

While KHI is technically neutral on House Bill 2137, we can say without qualification that the problem this bill seeks to address is real and in need of urgent attention.

The rate of childhood obesity has doubled in the last 20 years. Type 2 diabetes, an obesity related disease once uncommon in children, is now seen in children as young as six, placing them at risk of renal failure, blindness, and even death by the time they become young adults.

Research indicates that 70 percent of overweight children 10 to 13 years of age will be overweight or obese as adults.

Already, obesity related medical expenditures in Kansas total $657 million a year. If current trends—including the climbing rate of childhood obesity—continue, one of every five dollars spent on health care in the year 2020 will be spent on obesity related treatments.

The causes of child and adolescent obesity mirror those in the adult population. They include lack of regular exercise, a more sedentary lifestyle, and over-consumption of high-calorie foods driven in part by advertising that promotes the consumption of such foods.

Research suggests that a broad range of actions are needed to combat the problem of childhood obesity. In addition to restricting children's access to unhealthy foods while at school, as House Bill 2137 would do, educating them about the benefits of eating healthy foods and exercising regularly have proven effective.

In closing, the Kansas Health Institute encourages the members of this committee to comprehensively address the growing problem of childhood obesity in Kansas.

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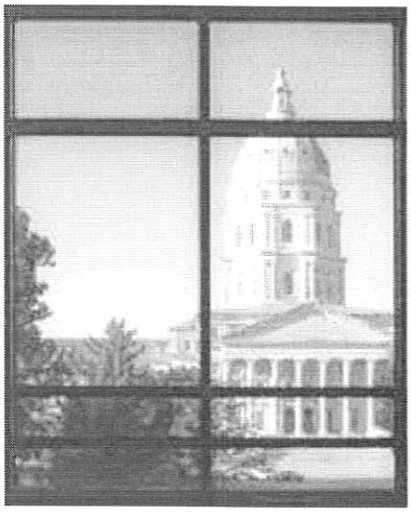


Issue Brief

KANSAS HEALTH INSTITUTE

Is Obesity a Public Policy Problem?

Anthony Wellever

Results in Brief

- In Kansas, the cost of obesity-attributable medical expenditures totals $657 million per year, at least $143 million of which is paid by the Medicaid program.
- Obesity is a public policy issue because its health costs are born by society at large and because weight bias affects the ability of obese people to participate equally in the political, social and economic life of their society.
- Between 1999 and 2003, thirty state legislatures adopted 79 separate policy initiatives that target obesity and physical inactivity.
- The greatest number of state bills had to do with improving school-based physical education. Sixteen bills instructed the state department of health or a newly created commission to study the topic of obesity and to make recommendations.

More information

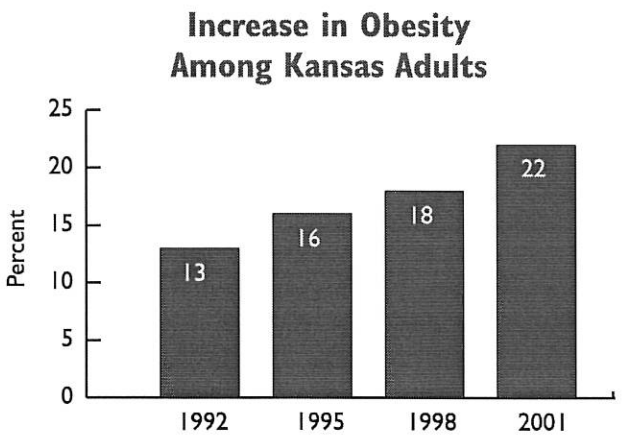
For more information on this topic, visit www.khi.org to read two reports on obesity and public policy. The first report is *Obesity and Public Policy: Legislation Passed by States, 1999 to 2003,* and the second report is *Obesity and Public Policy: A Framework for Intervention.*

Research for this project was funded by the Sunflower Foundation: Health Care for Kansans.

The Centers for Disease Control and Prevention (CDC) announced in February that obesity will overtake tobacco use as the leading cause of preventable death by 2005. Next year, obesity will be responsible for the deaths of an estimated 500,000 Americans. These deaths will come from a variety of diseases resulting from obesity, such as heart disease, diabetes and some forms of cancer.

The direct physiological causes of obesity are known and simple. People gain weight when they consume more calories in the form of food and drink than they expend in their physical activities. But an individual's weight also is determined by a combination of genetic, metabolic, behavioral, environmental, cultural and socioeconomic influences.

Obesity is certainly a public health problem, but is it also a public policy problem that demands attention? Some argue that public health problems, by definition, are public policy problems because they affect the welfare of the entire population. Others claim that the aggregate of individual behavior that does not affect the health of others is not sufficient



Source: Kansas Department of Health and Environment, 2003

to raise a public health problem to the level of a public policy problem.

On the other hand, certain health issues such as sexually transmitted diseases and diseases caused or exacerbated by secondhand smoke may become public policy issues if policymakers perceive that the prevalence of the behaviors is a danger to the public. Because obesity is not a communicable disease and its direct impact on the health of others is limited, many policymakers claim that the "obesity epidemic" requires no public policy intervention.

Personal behavior rises to the level of public policy, some claim, when it negatively affects a group or class of individuals. Such may be the case in regard to obesity. Consider the social consequences of obesity in the following circumstances:

Obesity-related social costs

On average, annual health care expenditures of non-elderly obese people are more than one-third greater than people of normal weight. In Kansas, the cost of obesity-attributable medical expenditures totals $657 million per year, at least $143 million of which is paid by the Medicaid program. If current trends continue, one dollar out of every five spent on health care in the year 2020 will be spent on obesity-related conditions.

While many economic and non-economic costs of obesity are born by overweight individuals, some of the economic costs of obesity related to health care are shifted to others. Just as healthier people subsidize the care of those who are less healthy and who consume more health care services, people who are not obese pay higher health insurance premiums to subsidize care provided to obese members in their health plan and those without health insurance. Medicaid expenditures, financed by tax revenues, are greater than they would be if the obesity rate of beneficiaries was lower. Obesity lowers profitability of businesses and may lower productivity, employee pay raises and benefit expansions.

Bias and discrimination

Clear evidence exists of pervasive bias against overweight people across key sectors including employment, education, health care and housing. The power of negative attitudes (bias), in some cases, may produce unreasonable actions (discrimination) against overweight people.

No federal laws exist currently to protect obese individuals from discrimination. Michigan is alone among states in prohibiting employment discrimination on the basis of weight. A handful of cities have adopted ordinances that include weight in their definitions of unlawful discrimination.

Overweight and obesity are associated with lower incomes and lower levels of educational attainment, but association is not the same as causation. How much of the association results from overweight people being unfairly denied opportunities at school, at work and in the medical system? To what extent is overweight a cause of lower income and lower education? Certainly, other explanations exist for the relationship between obesity and income

and education, but we may be mistaken to think that the explanations flow in one direction only.

Racial and ethnic disparities

African Americans and people of Hispanic origin living in the U.S. have a higher prevalence of overweight and obesity than White Americans. One possible explanation is that low-income minorities are subject to environments in which low-cost, energy-dense foods composed of refined grains, added sugars and certain fats are more readily available than more nutritious foods. Unequal access to health education and treatment services may exacerbate obesity and its accompanying health conditions in some minority groups.

Certainly, not all members of a particular minority group are overweight. Because obesity has a tendency to aggregate in families, however, there may be a genetic component to obesity susceptibility. Recent research concludes that genetics play a "large part" in susceptibility to obesity. This stream of research suggests that a number of genes, each with a small effect, contribute to an individual's susceptibility to obesity. Obesity, like many other health conditions, is caused by the interaction of genetics and environmental conditions.

Some argue that indigenous people in pre-modern societies developed a biological adaptation that allowed them to cope with alternating periods of feast and famine. The so-called "thrifty genome model" allowed them to store fat when food was plentiful as a hedge against starvation in times of famine. The genes, which were once important to survival, now no longer serve a function. In fact, they have become harmful, because fat, originally stored for famine situations, is not used up. Additionally, many have traded a more active lifestyle for one that is more sedentary.

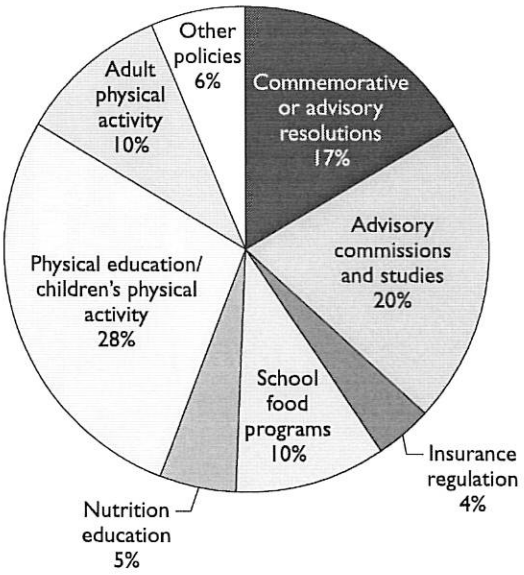
Ultimately body weight is determined by individual behavior, but the same behaviors can affect individuals differently. Many minorities may be disadvantaged by their genetic predisposition, poverty and the environments in which they live.

The role of public schools

One approach for reversing the epidemic of obesity is to concentrate on obesity prevention in children. Learning healthy behaviors at a young age will accrue benefits throughout the life-course of an individual.

As quasi-governmental organizations, public schools have a duty to protect the health and safety of the children in their charge. As learning institutions, schools should attempt to remove barriers to performance within their control that allow children to optimize their potential. Offering instruction in good health habits (bal-

Obesity-Related Bills Passed in State Legislatures, 1999–2003*



**79 bills were passed in 30 states during the period.*

1-5

On average, annual health care expenditures of non-elderly obese people are more than one-third greater than people of normal weight.

KANSAS HEALTH INSTITUTE

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NUMBER 17 • AUGUST 2004

anced nutrition and physical fitness) and reinforcing the lesson by providing an environment that supports healthy eating and physical activity fulfills both duties.

Legislative efforts

Because obesity is influenced by multiple factors, policy solutions to reduce its prevalence are not immediately evident. To find out what policymakers in other states are doing about obesity prevention and treatment, policies recently passed by state legislatures were examined.

Between 1999 and 2003, thirty state legislatures adopted policies that target obesity or attempt to increase physical activity. Seventy-nine separate policy initiatives passed by state legislatures were identified during the period. In 2001, Surgeon General David Satcher issued a report, *Call to Action to Prevent and Decrease Overweight and Obesity,* calling for increased recognition of obesity as a major public health problem. Since that time, the number of obesity-related laws has increased substantially. Sixty-three percent of the bills passed during the five-year period related to obesity were passed in 2002 and 2003.

The greatest proportion of bills (28 percent) had to do with improving school-based physical education. Approximately 20 percent instructed the state department of health or a newly created commission to study obesity and make recommendations to the legislature. The third most frequent state action (17 percent) was a resolution encouraging citizens to lose weight and become more active, urging state agencies to undertake obesity-related programming, or proclaiming an obesity prevention-related day, week or month. Fewer bills targeted general physical activity and school food programs. Insurance regulations, generally mandating that surgical procedures endorsed by the National Institutes of Medicine for the treatment of morbid obesity be offered, were passed in three states.

Obesity is a clear threat to the public's health. Some environments, such as schools, may unwittingly promote the consumption of empty calories by their competitive food policies. In inner cities and isolated rural areas, food stores that sell fresh fruits and vegetables may not be accessible. In suburbs and rural areas, there may be no sidewalks, walking trails or bike paths that encourage physical activity. The environment and some of the other factors that influence obesity may be altered positively by public policies that target the population as a whole rather than individuals. Legislatures in thirty states have recognized the importance of this issue and have begun to take action.

State legislation is not the only avenue of public policy open to those who want to reduce the prevalence of obesity in Kansas. State government administrators, communities, school boards and employers around the nation have also focused their attention on population-based initiatives to limit and control the obesity epidemic. The actions they have taken to date do not represent the full spectrum of possibilities. But they are a start.

Kansas state department of Education
leadership and support for student learning

Child Nutrition & Wellness
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785-296-0232 (fax)
120 SE 10th Avenue • Topeka, KS 66612-1182 • 785-296-6338 (TTY) • www.ksde.org

DATE: February 2, 2005

TO: House Committee on Health and Human Services

FROM: Jodi Mackey, Director, Child Nutrition & Wellness
Kansas State Department of Education

RE: **Update on New Federal Requirement for Local School Wellness Policies (House Bill No. 2137)**

Thank you for the opportunity to appear before you today. The Child Nutrition & Wellness section of KSDE administers the following federal Child Nutrition Programs:

- National School Lunch Program,
- School Breakfast Program,
- Special Milk Program,
- After School Snack Program,
- Child and Adult Care Food Program,
- Summer Food Service Program, and
- Team Nutrition, a nutrition education initiative.

We also administer the Coordinated School Health Program through a grant from the U.S. Centers for Disease Prevention and Control (CDC).

These programs are a partnership between the federal, state and local levels. At the state level, we have five major responsibilities: (1) program approval, (2) regulatory oversight, (3) technical assistance, (4) training and (5) payment of reimbursement and grant funds to local program sponsors.

Since HB 2137 deals with controlling foods sold in school vending machines, I think it is important for you to be aware of other initiatives that are underway to set guidelines for foods available in schools. My objectives for today's hearing are to:

1. Update you on recent changes in federal law requiring school districts to implement local wellness policies, and
2. Explain the steps that KSDE will take to assist school districts with meeting this new federal requirement.

Requirement for Local Wellness Policy

Public Law 108-265 reauthorized federal Child Nutrition Programs and was effective June 30, 2004. Section 204 of this law requires that not later than the beginning of the 2006-2007 school year, **local educational agencies participating in the school meal programs must establish a local "school wellness policy"** that, at a minimum:

1. Includes nutrition guidelines for all foods available on the school campus during the school day (e.g. school meals, a la carte, vending, school stores, fund-raisers etc.);

Attachment 2
HHS 2-3-05

2. Provides an assurance that guidelines for school meals are not less restrictive than those set by the U.S. Secretary of Agriculture;
3. Includes goals for nutrition education, physical activity and other school-based activities designed to promote student wellness in a manner that the local educational agency determines appropriate;
4. Establishes a plan for measuring implementation of the local wellness policy; and
5. Involves parents, students and representatives of the "school food authority" (i.e. school nutrition program), the school board, school administrator and the public in development of the local wellness policy.

KSDE's Plan for Facilitating Development of Local Wellness Policies
All Kansas public school districts participate in the federal school nutrition program, so all districts will be required to develop a local wellness policy. Rather than expecting each district to develop a wellness policy from scratch, KSDE will facilitate the process and assist districts with developing plans that:

- Follow established protocols for developing standards;
- Build upon the best wellness policies from across our state and the nation;
- Include input from national and Kansas experts in the fields of nutrition, nutrition education and physical education;
- Consider feedback from the various groups impacted by the wellness plan; and
- Provide for consensus, flexibility and local control.

A brief overview of the steps and tentative schedule for this process is as follows:

Jan-Feb, 2005..... KSDE selects and invites members to participate on three expert panels:
- Nutrition Standards
- Physical Activity
- Nutrition Education

KSDE reviews standards and policies from other states. Based on this review, KSDE develops a first draft prototype wellness policy. At this developmental stage, the initial prototype is expected to provide more restrictive standards for elementary students than for older ones. In addition, there will probably be three levels of achievement:
- Basic, would comply with all requirements of the federal law;
- Advanced, would implement standards that exceed federal law; and
- Exemplary, would implement standards representing the ideal.

Mar. 2005..... Expert panels meet to review/revise the first draft prototype policy resulting in draft two of the prototype policy.

Apr. 2005 ..... Expert panels present the draft two prototype policy to representatives of groups impacted by the wellness policy. Input from these stakeholders results in draft three of the prototype policy.

May 2005 ..... Draft three of the prototype policy is posted on KSDE's website for review and comment. Interested groups and organizations are invited to provide feedback. The prototype policy is also presented to the State Board of Education as an information item.

June 2005 ..... Public meetings are held at locations around the state to obtain further input resulting in draft four of the prototype policy.

July 2005..... Draft four of the prototype policy is presented to the State Board of Education for approval.

Aug 2005 –
June 2006 ..... KSDE and partners provide training and technical assistance to local school districts to enable them to adopt and/or adapt the prototype policy to meet local needs.

July 2006..... Local school districts will have a local wellness policy in place. This policy will be incorporated into each district's program renewal agreement with KSDE for the School Nutrition Program.

In summary, this approach to enacting local wellness policies will enable Kansas school districts to create a healthier environment for students in a manner which will provide local schools and communities with a quality prototype policy, flexibility and local control.

I welcome your questions and the opportunity to provide further information. Thank you.

Jodi Mackey
785-296-2276
jmackey@ksde.org

Rep. Tom Sloan

Testimony on HB 2077
Health and Human Services Committee
February 3, 2005

Mr. Chairman, Members of the Committee: You were briefed yesterday on the specifics of HB 2077, therefore I will focus on the bill's objective.

Every year, literally millions of dollars worth of medications are thrown away in this country because the patient's prescription has been changed or the patient is deceased. Aside from environmental consequences in landfills and waste water treatment plants, there is a human cost associated with lost opportunities.

HB 2077 will permit the donation of medications within a program that makes those products available and affordable to persons in need. For example, Health Care Access in Lawrence relies on donations of time and services by health care physicians, pharmaceutical product donations by manufacturers, and cash contributions by individuals. Individuals, however, do not currently have the legal authority to donate approved, unopened medications.

Last week the Lawrence Journal World ran a 2 inch notice of HB2077 being introduced. That night a woman from Baldwin City called and reported that her husband had died of cancer last October. The widow had thrown out all of his medications except for a one month's supply of Arissa. She could not bear to throw away $2,000 worth of medications.

I introduced a similar bill during the 2004 session, but pharmacy interests rightly raised questions about how the bill could be implemented. During hearings last year, no one opposed the bill's intent. With my encouragement, the Board of Pharmacy coordinated discussions and drafting of this bill. Again, to my knowledge no one opposes the bill's intent and I

Attachment 3
HHS 2-3-05

believe that through the efforts of Debora Billingsley at the Board of Pharmacy we have addressed and resolved all previously identified problems associated with the bill's implementation.

A drug repository program has been developed in states as diverse as Nebraska, Ohio, and Virginia. I ask for your support of HB 2077 and will respond to questions.

HEIN LAW FIRM, CHARTERED

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Fax: (785) 273-9243

Ronald R. Hein
Attorney-at-Law
Email: rhein@heinlaw.com

Testimony re: HB 2077
House Health and Human Services Committee
Presented by Ronald R. Hein
on behalf of
Kansas Pharmacy Coalition
February 3, 2005

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Pharmacy Coalition (KPC). The Kansas Pharmacy Coalition is an ad hoc coalition comprised of the Kansas Pharmacists Association and the Kansas Federation of Chain Pharmacies.

HB 2077 provides for a voluntary cancer drug repository operated pursuant to rules and regulations of the State Board of Pharmacy.

The KPC has opposed and expressed concerns about legislation which was introduced and heard before this committee last year. This year, the bill's sponsor, Rep. Sloan, has addressed our concerns. He has worked with our industry, the Board of Pharmacy, and others to craft a bill which is workable. As a result, we have withdrawn the objections that we expressed to last year's legislation.

We appreciate Rep. Sloan's efforts on this legislation to develop a system to bring unused cancer medications and people who need such cancer medications togther.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

Attachment 4
HHS 2-3-05

Gary Deeter

Health and Human Services Committee

February 3, 2005

House Bill 2077 - Cancer Drug Repository Program

Mr Chairman and members of the Committee, my name is ~~Lynne Schlosser~~ Stephanie Weiter and I am the Director of Government Relations for the American Cancer Society. I will be brief in my comments as I think the bill really says it all.

Each year, millions on dollars of usable medications are being thrown away in our Health Care Facilities and Nursing Homes while thousands of Kansans do not have access to needed medications. The Establishment of a Cancer Drug Repository Program can provide medications to Kansans that would not other wise have be able to attain live saving drugs.

The idea for this legislation first surfaced in Ohio. A volunteer of the American Cancer Society's wife had lost her fight with cancer and he had $10,000 worth of perceptions he had just refilled. He took the drugs to his local pharmacist in hopes that he could give them to someone else but instead, the pharmacist helped him to flush the medications down the toilet. He was devastated and decided he needed to find away to reuse individually bubble wrapped medications to benefit those in need, and the idea of a drug repository was born. I believe 18 other state have now followed suit with Ohio and passed simular legislation.

This bill is good politics, it is good for Kansas, and it will not only save the state dollars, but it will save lives.

Thank you.

Attachment 5

HHS 2-3-05

To: Chairman Morrison and Members of the House Committee on Health and Human Services

From: L J Leatherman on behalf of the Kansas Trial Lawyers Association

Date: February 3, 2005

Re: **HB 2077**

Chairman Morrison and members of the House Committee on Health and Human Services, I appear before you today on behalf of the Kansas Trial Lawyers Association. I am a Kansas attorney and member of KTLA. KTLA is a statewide, nonprofit organization of lawyers who represent consumers and advocate for the safety of families and the preservation of the civil justice system. We appreciate the opportunity to present written and oral testimony on HB 2077.

The Kansas Trial Lawyers Association supports the good intentions behind HB 2077 and is reluctant to bring to the committee's attention the public health and safety issues that we believe the bill presents.

State and federal laws assure the safety of medication from the time the medicine is produced until it reaches the consumer's hands. However, once a drug is dispensed, there are no protections guaranteeing the continuing integrity of the drug, that tampering has not occurred, and that it has been stored properly. Although the bill attempts to limit the dangers, we believe that the unprotected window when the medication is in the consumer's hands make the medication unusable for a second consumer who would have access to the drugs under the cancer drug repository program.

We also believe that if the integrity of the medications can be truly verified and guaranteed, there is no need for the limitations on liability found in section 3 (a) and (b). Further, if the medication's safety is assured, we believe that patients who receive prescriptions from the cancer drug repository program are entitled to the same protections against defective products, negligence, criminal acts and professional misconduct as patients who are the initial consumers of the drugs, and that the limitations on liability are therefore inappropriate.

Despite the laudable goals outlined in the bill, we believe that the health and safety risks to Kansas patients are too great. We respectfully request your opposition to the bill.

Attachment 6
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