Approved: February 24, 2005
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:30 P.M. on February 21, 2005, in Room 526-S of the Capitol.

Committee members absent:
Representative Brenda Landwehr- excused
Representative Judy Showalter- 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:
Representative Barbara Ballard
Representative Delia Garcia
Rod Bremby, Secretary, Kansas Department of Health and Environment
Kathy Damron, Girl Scouts of Kansas
Charles Mossman, Kansas Chiropractic Association
Chris Ward, representing PHRMA (Pharmaceutical Research and Manufacturing Association); former Government House Leader, Province of Ontario, Canada
Debra Billingsley, Executive Secretary, Kansas Board of Pharmacy
John Kiefhaber, Executive Director, Kansas Pharmacists Association
Karen Braman, Deputy Director, Governor's Office of Health Planning and Finance
Maren Turner, State Director, AARP Kansas

Others attending:
See attached list.

The minutes for the Health and Human Services meetings for February 16 and 17 were approved.

The Chair opened the hearing on **HB 2417.**

Representative Barbara Ballard spoke as a proponent. (Attachment 1) She noted that this bill joins other legislative initiatives on obesity, saying that the bill reflects the mission of the Kansas Council on Obesity Prevention and Management and, through the services of the Kansas Department of Health and Environment, will make Kansans more aware of obesity as a disease, will save lives, preserve human dignity, and decrease the cost of health care. Members complimented Representative Ballard on the focus of the bill and posed several questions. Representative Ballard said the Center for Disease Control had statistics showing the fiscal impact of obesity; she further noted that the cost of obesity included emotional factors that were more difficult to quantify. Observing that the bill was modeled after Louisiana legislation, she said she did not want to duplicate other efforts, but wanted the legislature to be included with other obesity initiatives.

Representative Delia Garcia presented personal information in support of the bill. (Attachment 2) She said the bill is comprehensive, diverse and collaborative. She presented her personal health statistics to show the value of reducing obesity.

Rod Bremby, Secretary, Kansas Department of Health and Environment, testified as a proponent. (Attachment 3) He reviewed statistics to illustrate the extent of obesity in children, youth, and adults, saying the prevalence of obesity can be considered an epidemic; he noted that, besides the significant direct costs, indirect costs include loss of productivity and absenteeism. He cited the Governor's *Healthy Kansas: Taking Steps Together* program and other groups aligned to increase awareness of the problem and decrease the incidence of obesity; he encouraged the committee to find mechanisms to integrate and coordinate the concepts of the bill with the *Healthy Kansas* initiative.

Kathy Damron, representing the Girl Scouts of Kansas, spoke in support of the bill. (Attachment 4) She said the incidence of obesity in children has doubled and in adolescents has tripled, noting that only 2% of children eat a healthy diet. She said the bill could bring together various groups to work together through the proposed Kansas Council on Obesity Prevention and Management.

Rebecca Rice, Kansas Chiropractic Association, speaking for Dr. Charles Mossman, suggested the bill be amended to include an appointee from the Kansas Chiropractic Association, since chiropractors have a long history of facilitating the outcomes that the bill envisions. (Attachment 5)

The Chair closed the hearing on **HB 2417** and opened the hearing on **HB 2337.**

The Chair welcomed Chris Ward, representing PHRMA (Pharmaceutical Research and Manufacturing Association) ; Mr. Ward has a consulting firm, Ward Health Strategies, and was formerly Government House Leader for the Province of Ontario, Canada. He spoke as a proponent for the bill. (Attachment 6 and Attachment 7) He listed issues that he said make importation of drugs from Canada inadvisable and dangerous to consumers. He noted that, given the monetary exchange rate between to two countries and the fact that Canadian employee compensation is half that of the United States, Canadian seniors find prescription drugs no more affordable than U.S. citizens do.

Commenting on the safety of imported drugs, Mr. Ward stated that although Canadian agencies regulate prescription drugs carefully, any drugs imported into Canada for the purpose of mailing them out of the country–or drugs ordered through the Internet–are not regulated; therefore, the safety of the products can be neither verified nor guaranteed, leaving consumers at significant risk. Further, he said that Canada does not have enough drugs to meet the needs of the American market, commenting that if all Canadian drugs were diverted to America, the U.S. would still have a $3.1 billion shortfall.

Making another point, Mr. Ward said that five years ago 60% of Canadian drugs originated in the U.S.; however, currently Canada has prescription drug partnerships in over 30 countries, alliances which often result in trans-shipment of drugs from other countries to Canada as a way station for shipment to the U.S.; he further

noted that 60% of drug imports to Canada now originate in one of 86 other countries, often making Canada a pharmaceutical portal, not a destination, a fact that has caused the Canadian government to begin developing a plan to prohibit such practices. He said such activity should also make U.S. citizens more wary of the efficacy of drugs they receive through Canada.

Debra Billingsley, Executive Secretary, Kansas Board of Pharmacy, spoke in favor of the bill. (Attachment 8) She said the Board's duty is to assure the safety of the drug delivery system and protect the health of Kansas citizens. She stated that the bill helps to give clarity to the law and gives the Board tools to help protect the public.

John Kiefhaber, Executive Director, Kansas Pharmacists Association, testified as a proponent. (Attachment 9) He observed that by importing prescription drugs from outside the U.S., consumers are losing a key to drug safety, since local and hospital pharmacists know proper drug dosage and side effects and can educate and protect citizens. He observed that importation of prescription drugs violates up to four provisions of the federal Food, Drug and Cosmetic Act.

Karen Braman, Deputy Director, Governor's Office of Health Planning and Finance and a licensed pharmacist, spoke in opposition to the bill. (Attachment 10) She said that although importation of drugs from outside the country is against the Food and Drug Administration (FDA) rules, the agency has to date taken no action to prevent importation of prescription drugs for personal use, noting that over two million Americans have imported pharmaceuticals from Canada and other countries because they are less expensive. She cited the Kaiser Family Foundation survey, which showed that many low-income individuals, especially seniors who have chronic health problems, have desperate health needs and few resources to provide for them. She stated that the Dorgan-Snowe bill currently in Congress contains important safety protections and offers the possibility of access to lower medications from other countries, and she noted that the Governor is working with Kansas pharmacists to establish a pooled buying program to reduce medication costs, saying that Kansas should provide a variety of options for its citizens. Ms. Braman advised the committee of an appendix to her testimony that cited various sources to support the Governor's program.

Maren Turner, State Director, AARP Kansas, testified as an opponent. (Attachment 11) She lamented the fact that individuals were forced to seek affordable drugs outside the U.S., but she said for many with low incomes, they are often forced to choose between drugs and utilities or between drugs and food. She commented that it was unwise to criminalize something as basic as prescription drugs.

Norman Marvin, a medical doctor from Overland Park, provided written testimony as an opponent. (Attachment 12)

The Chair invited members to ask questions, to which conferees responded thus:

Mr. Ward repeated his statement that although Canadian prescription drug regulatory oversight is equal to

the U.S., mail-order and internet sales lie outside the jurisdiction of regulatory agencies; therefore organizations supplying prescription drugs to the U.S. get their products from secondary wholesalers in one of 30 different countries and ship them to the U.S. with no inspection or oversight by Canadian regulatory agencies. He quoted from liability waivers that import companies require importers such as the I-Save-RX to sign. He noted that imported drugs can easily be counterfeited, and, even if they are genuine and safe, they have been diverted from the supply reservoir of other countries. He commented that the only requirement for a Canadian company to export drugs to the U.S. is an export certificate.

Mr. Kiefhaber said the Pharmacists Association was working with the Governor's office to develop systems to reach target populations with prescription drugs. He expressed optimism regarding the Medicare Drug Benefit program, which will go into effect January 2006.

Ms. Billingsley said that the Board is adamantly opposed to the Governor's import program because it is not possible to assure that the imported drugs are safe; she said it is difficult to oversee licensed individuals and nearly impossible to track unlicensed individuals.

Ms. Turner said the Governor's office is considering many tools to bring affordable prescription drugs to those who need them: importing drugs for senior, encouraging the passage of the Dorgan-Snowe bill, working with pharmaceutical companies to regulate prices, and educating seniors about Medicare Part D. She said her office tries to educate individuals regarding the risks of importation. She stated that the FDA has no laboratories in other countries.

Mr. Ward said that because Canada does not have a free market in health care, generic drugs are specifically tied to brand-name prices. He commented that prescription drugs imported into Canada for Canadian consumers have a mutual-equivalency requirement that assures quality. He agreed with a member that drug manufacturers provide oversight regarding equivalent drugs, but many importers have no arrangement with the manufacturer and import prescription drugs through the black market. He stated that the Canadian government is presently promulgating regulations to stop the drug-exporting business. He admitted that, because he represents drug manufacturers, his agenda is aimed at protecting his clients, adding that importing prescription drugs from Canada is a shortcut that is imprudent and ineffective.

Ms. Billingsley said she has no records to indicate any Kansans who import prescription drugs have been harmed, noting that the Board is often put in an awkward position in dealing with an increasingly popular practice of importation of drugs, further commenting that it is not the Board's duty to develop cost-saving programs, but to ensure that the drug distribution network is safe for the public.

The Chair closed the hearing on **HB 2337.**

The meeting was adjourned at 3:16 p.m. The next meeting is scheduled for Tuesday, February 22, 2005.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: FEBRUARY 21 2005

NAME	REPRESENTING
Jan Sides	AARP / SEAK
Bill Nolting	AARP
Jim Snyder	AARP / SHL / SCACA
Mary Obley	SRS
Ward Cook	American Cancer Society
Michelle Peterson	Ks. Governmental Consulting
Linda Lubensky	KS Home Care Assoc
Jim Schaller	AARP
Arlen Tappan	AARP
Charles Mossman	KCA
Rebecca Rice	Ks Chiropractic Assn.
Deb Williams	KDHE
Deborah Stern	KS. HOSP. ASSN.
Tom McMahon	AARP
Marty Kennedy	KDOA
Stephanie Wurtz	WIBW-TV
Thelma L. Bray	AARP
Burnadu F Sihemann	AARP

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HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: 2-21-05

NAME	REPRESENTING
DAVID Klepper	KC STAR
Eric Enns	Canada Drug

Testimony before the House Health and Human Services Committee on House Bill 2417

February 21, 2005

Dear Chairman Morrison and Members of the Committee:

Thank you for allowing me to speak in support of HB 2417, creating a Kansas Council on Obesity Prevention and Management. Specifically, duties of the Council shall include, but not be limited to the following:

> *The collection and analysis of data regarding the extent to which children and adults in Kansas suffer from obesity, and the programs and services currently available to meet the needs of overweight children and adults, and the funds dedicated by the state to maintain such programs and services.*
>
> *The collection and analysis of data to demonstrate the economic impact on the state of treating obesity-related diseases and the estimated cost savings of implementing a comprehensive statewide obesity prevention and management model. (Sec 2, part a-b)*

The function and additional duties of the Council, as well as the composition of the Council, are included in HB 2417.

In the report, *Healthy Kansans 2000*, Kansas Department of Health and Environment (KDHE) recognized obesity among the known risk factors contributing to serious health consequences. The KDHE would oversee the Council. The diverse make-up of the Council would be an added and significant contribution as KDHE continues to monitor and collect data regarding the obesity epidemic.

Treating obesity as a disease goes beyond just losing weight. As a state, it is important to look at the big picture. If we focus on the big picture, which is to review thoroughly the effect of obesity in children and adults, we can save lives, preserve human dignity, and decrease the cost of health care. The Council would make Kansans more aware of obesity as a disease. A disease which can be treated, prevented, and managed. In addition to any legislative appropriations, the Council may accept and expend grants and private donations from any source, including federal, state, public and private entities.

I come before you today to ask that you pass HB 2417. I will be happy to stand for questions.

Sincerely,

Barbara W. Ballard
Representative

Attachment 1
HHS 2-21-05

February 21, 2005

To: Dr. Jim Morrison, Chair and House Health and Human Services Committee Members

From: Rep Delia Garcia

Re: Proponent Testimony on HB 2417

Attachment 2
HHS 2-21-05

Purpose of HB 2417

This act recognizes that Obesity is a problem and should be addressed in a comprehensive manner in our great state of Kansas. This act is a result of five years of research and brainstorming of fellow legislators and experts in this area in Kansas and other states.

This act would create a Council that will be within the Department of Health and Environment.

The Council includes the goals of the other two related Obesity Prevention Bills presented to us that we in our committee were interested in; and is inclusive of the participation of the parties involved, with this 26 member Council.

The reason I fully support HB 2417:

As I mentioned on the first day our Committee met, I requested to be on this committee so I could be in a position to contribute to the creation/ improvement of quality health initiatives in Kansas, with Obesity Prevention being at the top of the list.

As I also mentioned on the first day we met, I lost 81 pounds from Oct 2003-June 2004. Though I have fluctuated these past six months, I have made a lifetime change of lifestyle in where I am consistently conscious of everything I consume and physical activity necessary to maintain and lose more weight.

Losing this weight was a challenge in addition to pursuing my masters degree simultaneously and beginning my campaign. I want to share with you my story so you see why I fully endorse HB 2417 that comprehensively addresses this serious issue.

My Story

I was 26 years old, 5 ft 2 in. I am one of five daughters (the middle one), and always the heaviest one since I was a child. I grew up in a family owned Mexican restaurant in Wichita, that obviously didn't help. I exercised little and ate unhealthily, and it showed.

Luckily, I was accepted to graduate school in San Antonio the Summer of 2003 as if it were a sign, even though I applied late. I moved in August 2003. I thought to myself that this was a good opportunity for me to attempt to lose weight again because I was going to be away from all major distractions for the time being. In August, I began dieting and exercising on my own. In September, I had my annual physical and realized that I better do something about this seriously. The clinic I went to had a nurse who made me feel so uncomfortable and told me in a harsh way that I needed to lose weight and that I was basically unhealthy all around. She ticked me off so bad in the way she said it without tact, but ticked me off so much to do something about it. I needed to get healthy. I was tired all the time and I started seeing many signs of my body's deterioration. I hated being 26, and feeling 76. I knew I'd have to really change my eating habits, and that it would be hard. I knew that diet alone wasn't going to do. I knew that I had to develop a solid exercise program that would work and that I'd stick with for the long haul, but I needed direction from professionals.

On October 3, 2003, my sister Sonia came to visit me from D.C. and she took me to the Whole Food Store and spent 3 hours explaining every product to me in every isle and where I could look up help. Ironically, I had received a flyer earlier in the mail that day from St. Mary's University Health Center about Flu Shots. On October 10, I got my flu shot and asked on my way out if I could weigh myself because I was dieting and wanted to see how much I had lost. Elisa Noriega kindly weighed me and then told me about Walk San Antonio and the weight loss programs available there through their office with outside partnerships. I was so excited! The staff was so nice! I came back the next week began the Walk San Antonio Program. I had to first get a doctor's note to get permission since I was so overweight. I began to meet with Dr. Vasquez every two weeks and took blood tests in October, as you see on this power point that show my results then in October 2003 and then five months later in March 2004! Everywhere I turned, I was reminded to eat and act healthy in my car on the radio who had a consistent "Health is Life" campaign on the popular radio station, on my university, on tv on frequent watched channels, at my apartment complex laundry room, select restaurants, and the list goes on. This was a result of a 'COMPREHENSIVE EFFORT' of different key partners who are experts in the area of health an also govern the area. http://www.healthcollaborative.net/aboutus/aboutusHome.html

I am the healthiest I have ever been in my entire life! I sweated and stumbled, but persevered and progressed. My metabolism is so high! I look forward to working out every day and discovering new ways of developing healthy eating and exercise habits. I now know that this is my weapon against health risks. My family is very proud to see me as a strong and healthy woman, and I work towards that goal everyday.

Walk San Antonio Program, uses a 'comprehensive effort plan' similar to HB 2417

http://www.healthcollaborative.net

Mission:

To improve the health status of the community through collaborative means.

Vision:

- Enhance positive community health outcomes by leveraging appropriate resources
- Play a leadership role in evaluating, developing, funding and implementing health initiatives
- Increase the number of partners in the collaborative
- Decrease duplication of health services in the community and promote coordinated efforts for the best possible community health outcomes
- Adopt appropriate community health improvement measurement system

Improvements from my weight loss

From Oct 2003 to March 2004, I had lost over 52 pounds in @ five months

My recent blood results from Oct 22, 2003 and March 1, 2004:

	OCTOBER	MARCH	HEALTHY RANGE
Cholesterol:	183	163	< 200
Triglycerides:	173	106	< 150
Calculated LDL:	109	106	< 130
Sodium:	139	133	133 - 146
SGOT (AST):	48	35	5 - 35
SGPT (ALT):	63	40	7 - 56

My Blood Pressure was about 109 over 62

I have lost inches in my waist, arms, thighs, and chest

I went down 4 dress sizes

August 2003 BMI: 49% March 2004 BMI: 39% Target BMI: 21-33%

Thank You

I will be glad to answer any questions you may have or respond to any comments or concerns you may have.

Delia Garcia Weight Loss Formula

- EAT EVERY 3-4 HOURS (5 times/day: 3 meals & 2 snacks)
- DRINK LOTS OF WATER (at least 1 gallon/day)
  [We need to drink at least ½ our body weight in ounces of water. Dehydration slows down the body's metabolism. It regulates the temperature of the human body, carries nutrients and oxygen to cells, cushions joints, protects organs and tissues, removes wastes, and can deter hunger pangs. It helps food digestion. The body is 80% water, 75% of the brain, 22% of bones, 75% of the muscles, and 92% of our blood.]
- EAT 1200 CALORIES DAILY (except Friday nights)
- EAT LOW FAT FOOD (20-40 g Daily)
- EAT LOW IN SODIUM (2400 mg Daily)
  [Avoid fast food and canned foods, and use spices and flavors instead of salt. High blood pressure, stroke, heart/ kidney disease & forms of cancer are linked to a high sodium diets.]
- EAT LOW IN CHOLESTEROL (300 mg Daily)
- TAKE A MULTI-VITAMIN MINERAL WITH HERBS (Daily)
- TAKE 2 CALCIUM TUMS EX (Daily)
- TAKE 1 TABLESPOON OF FLAX OIL (Daily)
  [Flax Oil lowers risks of breast and colon cancer, helps to restore proper metabolic function, enables the excretion of fat and toxins that are trapped within the tissues (flushes bad fat out), and prevents indigestible synthetic oils from showing up on the body as cellulite! Besides preventing @ 60 diseases, it shields your skin from wrinkling!]
- EAT HIGH IN FIBER FOOD (Daily)
  [High fiber is indigestible and has no calories; and food passes through our system so fast that the body doesn't have a chance to absorb all the calories eaten. So the more fiber you eat, the more calories will be excreted, and the greater the weight loss.]
- CONSUME SOY ISOFLAVONES (100-160 mg Daily)
  [Soy stimulates the metabolism, contains more protein than milk without the saturated fat or cholesterol. Soya beans are the only beans to be considered a complete protein because they contain all 8 essential amino acids, and has high fiber content. It helps maintain our alertness and mental energy. It regulates blood-sugar and insulin, which helps you feel more satisfied and less hungry. It prevents heart/bone/kidney diseases.]
- EXERCISE REGULARLY (at least 5 times/week for @ 1 hour)
- DOCUMENT ALL OF THIS IN MY HEALTH JOURNAL BINDER

Delia Garcia's Healthy Diet
Delicious Snack Options
Low in Calories and Fat

- Apple- 1 medium one is 81 calories and .4g fat
- Orange- 1 medium one is 60 calories and .5g Fat
- Strawberries- 6 (1 cup) is 45 calories and .6g Fat
- Fat Free Whipped Topping- 6 tbsp is 45 calories and NO FAT
- Fat Free Silhoette's Strwby Ice Cream Sandwich- 1 sandwich is 130 calories and 2g Fat
- Soy Lemon Ginger Cultured Ice Cream- ½ cup is 120calories and 3g Fat
- Fat Free Muffin Blueberry (medium)- 1 of a 2 package is 95 calories and 5g Fat
- Wal-Mart Fat Free Muffin (Choc,Blueberry)- ½ of big one is 130 calories and NO FAT
- Slim Fast Peanut Butter Crunch Bar (tastes like Butterfinger)- 1 is 130 calories and 4g Fat
- Slim Fast ChewyChoc Nougat Bar (tastes like Milky Way)- 1 is 120 calories and 3.5g Fat
- Slim Fast Peanut Butter Crisp Bar- 1 is 120 calories and 4g Fat
- Kellogg's Special K Berry Bar- 1 is 90 calories and 2g Fat
- Nutri-Grain Apple Cobbler Twist Bar- 1 is 140 calories and 3g Fat
- Nutri-Grain Stwby Chzck Twist Bar- 1 is 140 calories and 3g Fat
- Chewy Trail Mix Fruit & Nut Bar- 1 is 140 calories and 4g Fat
- Whole Grain Caramel Rice Cake- 1 is 80 calories and .5g Fat
- Fat Free Yogurt (all flavors)- 1 is 80 calories and NO FAT
- String Cheese- 1 stick is 60 calories and 2g Fat
- Kashi Go Lean Chocolate Caramel Karma Bar (high Fiber)- 1 is 140 calories and 3g Fat
- Kashi Go Lean Sublime Lemon Lime Bar (high in Fiber)- 1 is 160 calories and 3g Fat
- Holiday Fat Free Chewy Fruit Slices- 1 is 60 calories and NO FAT
- Fat Free Vanilla Pastel Meringue Cookies- 1 is 16 calories and NO FAT
- Spectation Wafer Bar- 1 is 50 calories and 3.2g Fat
- Teddy Graham Bites- 12 are 130 calories and 3g Fat
- Devil's Food Cookies- 1 is 50 calories and 1. 5g of Fat
- Shortbread Lavender Cookie- 1 is 89 calories and 5g Fat
- Fig Newton Bars- 1 is 45 calories and 1g Fat
- Snack Well's Sugar Free Lemon Crème Cookies- 3 are 130 calories and 6g Fat
- Low Fat Cinnamon Graham Crackers- 1 whole bar is 65 calories and 1.5g Fat
- Three Cheese Baked Crisp Crackers (tastes like Cheez-Its) 9 are 65 Calories and 2g Fat Sugar Free Jello Cup- 1 is 10 calories and NO FAT
- Crème Saver Swirl Chewy Candies- 1 is 24 calories and NO FAT
- Jolly Ranchers Assorted Flavors hard candy- 1 is 9 calories and NO FAT
- Sweet-n-Low Flavored hard candy- 1 is 10 calories and .5g Fat
- Extra (Berry/Wintergreen/Mint) Gum- 1 stick is 5 calories and NO FAT

K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony

HB 2417: Creating the council on obesity prevention and management
Presented to the
House Health and Human Services Committee
by
Roderick L. Bremby
Secretary
Kansas Department of Health and Environment

February 21, 2005

Good afternoon, Chairman Morrison and members of the Committee. My name is Roderick L. Bremby, Secretary of Kansas Department of Health and Environment (KDHE). I appreciate the opportunity to address you regarding House Bill 2417, which creates a council on obesity prevention and management.

The stated purpose of establishing this task force is to collect and analyze current data regarding the impact of obesity in Kansas and to develop recommendations to address obesity. The growing prevalence of obesity in the general population and its subsequent health and economic impact certainly warrants the attention of state and local policy makers.

Kansas has not escaped the obesity epidemic. Data from the 2003 Kansas Behavioral Risk Factor Surveillance System (BRFSS) indicate that 60.5% of adults ages 18 years and older in Kansas are overweight and obese. 60.5% of adults ages 18 years and older in Kansas translates to an estimated 1,184,000 individuals who are overweight or obese. 37.8% of adults ages 18 years and older (approximately 740,000 adults) were overweight and 22.7% of adults ages 18 years and older (approximately 444,000 adults) were obese. According to 1992-2003 Kansas BRFSS data, the prevalence of obesity among adults has increased by almost 70% since 1992.

Adults are not the only victims of this epidemic. According to the 2002-2003 Kansas Youth Tobacco Survey, 11% of adolescents in grades 6-12 are overweight (body mass index $\geq 95^{th}$ percentile for age and sex). 13.6% of adolescents in grades 6-12 were at risk of overweight (body mass index $\geq 85^{th}$ percentile but less than 95th percentile for age and sex).

DIVISION OF HEALTH
Office of Health Promotion
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 230, TOPEKA, KS 66612-1274
785-291-3742 Fax 785-296-8059 http://www.kdhe.state.ks.us/bhp

The estimated annual total direct medical cost attributed to obesity among adults in Kansas was $657 million. This accounts for 5.5% of all medical expenditures. The estimated annual Medicare expenditures (direct medical cost) attributed to obesity among adults in Kansas were $138 million. This accounts for 6.4% of all medical expenditures. The estimated annual Medicaid expenditures (direct medical cost) attributed to obesity among adults in Kansas were $143 million, which accounts for 10.2% of all medical expenditures. These estimates are limited to direct medical costs and do not include indirect costs such as absenteeism and decreased productivity attributed to obesity. All above-mentioned information was developed using data from primary data sets that include: 1998 Medical Expenditure Panel Survey (MEPS) data set, 1996 & 1997 National Health Interview Surveys (NHIS) data sets and 1998-2000 BRFSS data sets. (Source: Finkelstein E.A., Fiebelkorn I.C., Wang G. State-level estimates of annual medical expenditures attributable to obesity. *Obesity Research.* 2004; 12(1): 18-24).

Recognizing that obesity has reached epidemic proportions, KDHE, as part of the Governor's overarching Healthy KANSAS plan, has developed the **Healthy KANSAS: *Taking Steps Together*** initiative. This initiative is designed to target three different preventable behaviors-- physical inactivity, poor nutrition and tobacco use-- in three different populations-- children in schools, adults in the workplace and seniors. For children in schools, we are working with the Kansas State Department of Education to coordinate this effort through the Coordinated School Health Program, the focus of which is to promote tobacco use prevention, physical activity, nutrition and obesity prevention through a coordinated school health approach that engages the broader community in supporting the schools' initiatives to improve child health.

In addition, the Governor recently announced the establishment of a Child Health Advisory Committee as part of the KDHE initiative. The 15-member committee will identify state priorities for child health and promote policies to improve the health of Kansas children. The process of making appointments to the Committee will begin immediately, and an initial meeting of the members is scheduled to occur before the Legislature adjourns. KDHE is also currently working to reconvene the Governor's Council on Fitness and researching guidelines for presenting fitness awards and healthy community designations.

For adults in the workplace, we are working with other partners to design a model workplace wellness plan for state employees as well as private businesses. One goal is to provide a "tool kit" on the Healthy KANSAS website (www.healthykansas.org) that would address strategies for on-site weight management and nutrition classes, employee-sponsored physical activity programs and healthy food options. Finally, for Kansas seniors, KDHE will work with the Department on Aging to provide technical assistance for local wellness programs for seniors; expand the senior farmers' markets; and encourage community gardens.

House Bill 2417 proposes to collect and analyze data regarding the extent to which children and adults suffer from obesity, current services available, the economic impact of obesity, and estimated cost saving of implementing a comprehensive statewide obesity prevention and control model. We believe the components of the Healthy KANSAS: *Taking Steps Together* initiative will address the issue of obesity in a comprehensive manner and will achieve many of the same goals outlined in HB 2417. The agency applauds your recognition of the serious health impacts of obesity and welcomes your assistance in developing a response to this epidemic in our state.

To the extent possible, I request that the components of this bill that address the underlying causes of obesity be addressed through the Healthy KANSAS: *Taking Steps Together* initiative. Doing so would result in greater coordination and teamwork and would ultimately enable the state to achieve the level of success necessary to combat the obesity epidemic.

Thank you for your time and I will be happy to stand for any questions.

Testimony of Kathy Damron
On behalf of the Girl Scouts Councils serving Kansas Girls
Before the Kansas House Health and Human Services Committee

In Support of House Bill No. 2417
Tuesday, February 21, 2005

The Girl Scouts is an organization dedicated to young women and their future success. It is important to instill leadership, values, social conscience and confidence in each and every young child. The Girl Scout Councils of Kansas serve over 41,000 girls, ages 5-17, from across the state. Because of the large number of young women that we service in our state, we feel that it is important to help each girl reach their fundamental program goals, to provide for a successful future.

Our programs educate our children in leadership, arts and sciences, exploration, outdoor activities and health and fitness. With the increase in obesity and unhealthy habits, we feel that it is important that health and fitness become an ultimate goal within our organization and state. The Girl Scouts is dedicated to providing girls with unlimited opportunities in sports and fitness, and supporting them in eating well. However, we feel that it is important to address these issues among society as well.

The Girl Scout Research Institute recently completed a report on health and obesity. The report entitled, "Weighing In," showed that obesity rates have doubled in children and tripled in adolescents, such that obesity is now the most chronic health problem among American children.

The obesity epidemic has been influenced by the lifestyles, culture, and behavior of children. According to the center for Science in the Public Interest, only 2 percent of children eat a healthy diet, consistent with the standards set forth by the USDA food

Attachment 4
HHS 2-21-05

guide pyramid. If these diet and exercise issues are addressed at an early age, the obesity epidemic could be reversed.

Most people believe obesity is just being overweight. However, according to the National Institute of Diabetes & Digestive & Kidney Diseases, health professionals define overweight as an excess amount of body weight which includes muscle, bone, fat, and water, while obesity specifically refers to a long-term (chronic), complex disease in which having too much body fat increases your risk for developing other health problems. Most conditions and diseases resulting from obesity will leave lasting effects on the individual, so it is important to address obesity before other health problems occur.

In addition to the physical harm that results from being overweight, research suggests that related social and emotional issues also have an impact on the overall quality of life. Overweight individuals, namely young females, struggle with self-esteem issues early into adolescents. It is important to address these issues early to prevent the social and emotional issues that will continue to cause psychological problems.

To ensure the overall success of our young women and children, we must address the issues that our youth will continue to face. The Girl Scout Councils of Kansas will continue to educate on health and fitness and teach obesity prevention to the young women of our state. However, we feel that it is important to create a council on obesity prevention and management to reach our fellow Kansans.

According to the Centers for Disease Control and Prevention, obesity will overtake tobacco use as the leading cause of preventable death in 2005. It is estimated that obesity will be responsible for over 500,000 deaths next year. The obesity problem will only worsen without additional research and education on the issue. I urge the

committee to consider House Bill 2417, before the prevalence of the disease is too much to overcome.

I would be happy to address any questions that the committee may have.

Dr. Charles Mossman, Legislative Liaison, Kansas Chiropractice Association
February 21, 2005

Thank you Mr. Chairman and members of the Committee, for allowing me to speak to you today on behalf of the Kansas Chiropractic Association regarding HB 2417.

My name is Charles Mossman, and I have been a practicing chiropractor for 23 years. The chiropractic profession is well aware of the problem of obesity in today's population, and the impact it has on the health of the individual and the cost to society in terms of healthcare dollars.

Since its inception over one hundred years ago, the chiropractic profession has been well aware of the importance of diet, nutrition and lifestyle on health, and that importance is stressed to each and every chiropractic patient. The chiropractor's education and training in these areas is a part of the core curriculum of every chiropractic college, and that education is second to none. Indeed, as one of the licencees of the Healing Arts Act in Kansas, our practice act specifically charges us with the responsibility and privilege of addressing these areas with patients. As a result, the chiropractic profession has a wealth of knowledge and experience to share with the other proposed members of the council on obesity.

It is for this reason that I respectfully request that a representative of the Kansas Chiropractic Association be included as a member of the council on obesity. I believe that our inclusion would be very beneficial as part of the collective and collaborative effort to address the problem of obesity for the citizens of Kansas.

Thank you.

Charles E. Mossman, D.C.

Attachment 5
HHS 2-21-05

Importation & Issues in International Drug Pricing & Drug Spending
March 2005

Chris Ward

Ward Health
Strategies Inc

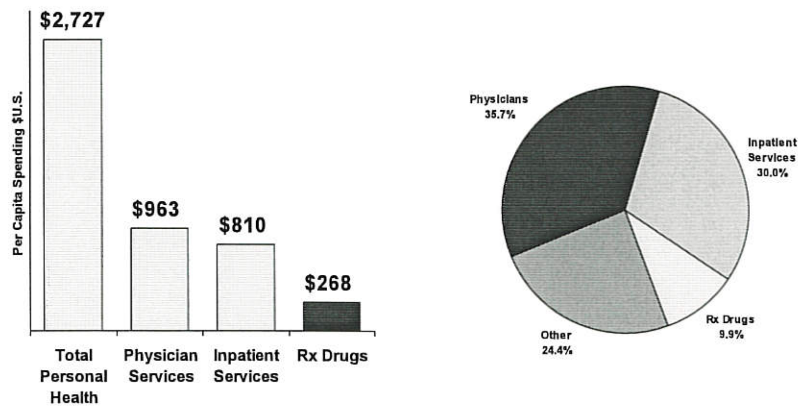
Importation

- Puts consumers at risk by evading supply chain safeguards
- Requires Americans to waive their rights to protection of U.S. law
- Violates international trade laws and NAFTA
- Provides no certainty of supply
- Avoids dealing with the fundamental issue of providing adequate benefits to seniors & other vulnerable populations
- Destroys the incentive to search for new medicines that save lives and reduce the financial burden of illness and disease

Ward Health
Strategies Inc

Attachment 6
HHS 2-21-05

Canada U.S. Health Spending Gap 2002



O.E.C.D. Health Data 2004

Ward Health Strategies Inc

Why Health Services & Supplies Cost More in the U.S. than in Canada

Macro Economic Differences

Differences in Liability Costs

Price Controls

Ward Health Strategies Inc

6-2

Why Health Services & Supplies Cost More in the U.S. than in Canada: Price Controls

Selling drugs at lower prices in Canada is not a matter of choice for manufacturers.

The government sets manufacturer's price for all patented drugs in Canada.

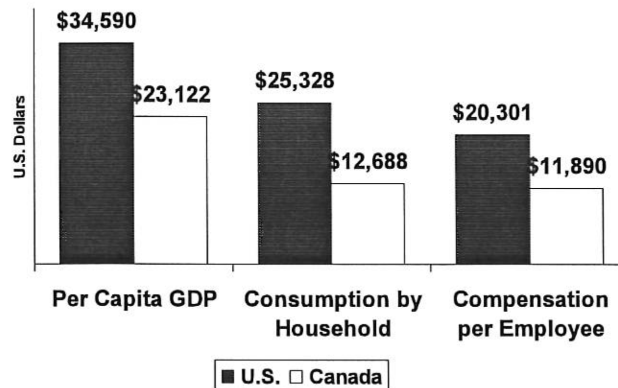
Canadian drug prices are not a matter of choice nor are they freely negotiated by pharmaceutical companies

A breakthrough drug in Canada can be sold for no more than existing drugs in the same therapeutic class or the median price of the same drug in 7 other countries (U.S., U.K., Switzerland, Sweden, France , Germany, and Italy).

If a company refuses to market a drug in Canada the patent can be taken away through a compulsory license.

Ward Health Strategies Inc

Economic Differences Canada U.S. 2000

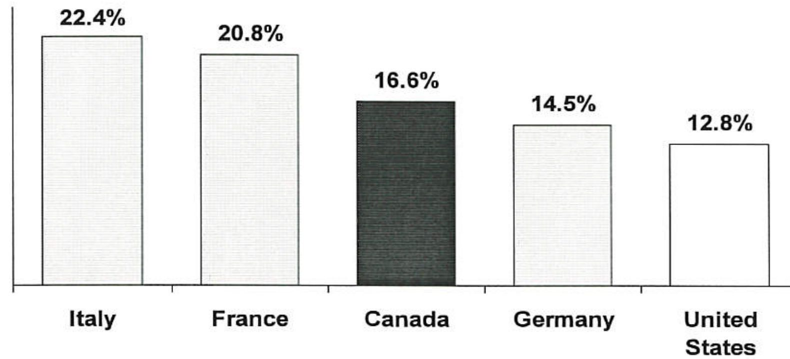


OECD Health Data 2004

Ward Health Strategies Inc

Comparing Drug Spending Among Developed Countries 2002

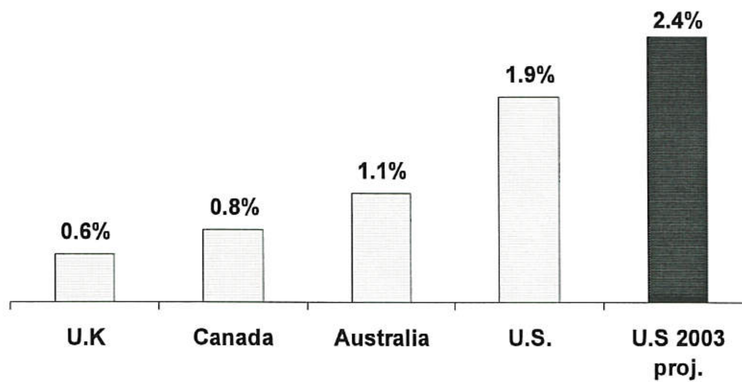
Drugs and other non-durables as a percent of total health spending



OECD Health Data, 2003

Ward Health Strategies Inc

Tort Costs as a percent of GDP Selected Countries 1998

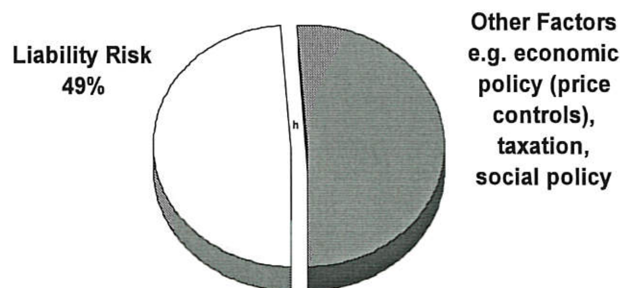


Tillinghast- Towers Perrin

Ward Health Strategies Inc

Liability Risk Accounts for Most of the Difference in U.S. Drug Prices

Drug Price Difference Between Canada and the U.S. Attributable to Liability Risk



R.L. Manning, Journal of Economics and Law

Ward Health Strategies Inc

Safeguards that Ensure the Safety & Efficacy of the Drug Supply Chain

- The submission review process for individual products
- Establishment licenses for legal importers
- Record retention and recall mechanisms
- Mutual recognition agreements for pharmaceutical GMP requirements
- Packaging and labeling requirements.

Ward Health Strategies Inc

Personally Imported Drugs are of Unknown Quality

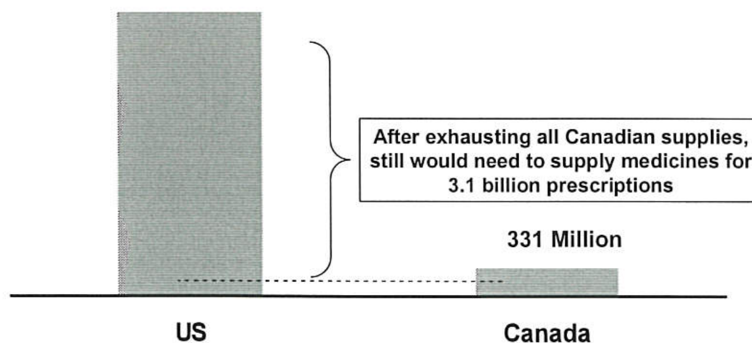
Importation of Human Use Drugs for Personal Use Enforcement Directive

The personal use exemption unfortunately provides an opportunity for these suppliers to conduct commercial activities, and to evade the submission review process for individual products, and/or the Establishment Licence requirements for importers, by supplying their drug products primarily through the mail to individual Canadians. These activities at times may include violative marketing and advertising activities by means such as the Internet. <u>This has ramifications related to safety because large quantities of products, which have not been reviewed for safety and/or efficacy, and which are of unknown quality, can enter the country and be distributed. The lack of an importer also means no person is responsible for meeting GMP requirements such as appropriate record retention or recall mechanisms.</u>

Ward Health Strategies Inc

Canadian Drug Supply Too Small to Have a Real Impact in the US

Total Prescriptions Filled in US vs Canada, in Millions - 2002



Source: IMS Health.

Ward Health Strategies Inc

The Trans - Shipment of Pharmaceutical Imports

Imports of Pharmaceuticals & Medicine from Selected Countries January to July 2004

COUNTRY	IMPORTS
China	**$44.7 million + 8%**
India	**$25.6 million +16%**
Mexico	**$24.6 million +13%**
Argentina	**$2.6 million +208%**
Indonesia	**$.37 million +1307%**
Thailand	**$1.6 million +55%**
Columbia	**$.48 million + 3036%**

Industry Canada, Trade Data Online, www.strategis.ic.gc.ca, accessed Oct 7, 2004

Ward Health Strategies Inc

Drugs Exported to U.S. May Not be Subject to Health Canada Oversight

37. (1) This Act does not apply to any packaged food, drug, cosmetic or device, not manufactured for consumption in Canada and not sold for consumption in Canada, if the package is marked in distinct overprinting with the word "Export" or "Exportation" and a certificate that the package and its contents do not contravene any known requirement of the law of the country to which it is or is about to be consigned has been issued in respect of the package and its contents in prescribed form and manner.

Canada's Food &Drug Act

"In documents filed in Federal Court late last month, CanadaRX Corp. has asked a judge to prevent Health Canada inspectors from visiting its facility, calling the proposed inspection "invalid and unlawful" and a violation of the company's charter rights."

Michelle MacAffee, Canadian Press, March 3, 2004

Ward Health Strategies Inc

Importation & Liability

Mail order importers require patients to waive their rights of protection under US law before filling a prescription.

Before a prescription can be filled in Canada it must be signed by a Canadian doctor. Canadian doctors have been told by the agency that insures them that they have no liability coverage for prescriptions they write for US patients receiving imported drugs.

Pharmaceutical companies have no way of tracking drugs illegally exported to the United States, therefore they have no means to issue warnings or recalls should post-marketing safety issues arise.

Ward Health Strategies Inc

Importation: Waiving Consumers' Rights of Protection Under U.S. Law

- "I hereby release and save GP and its employees and contractors… harmless from any and all acts, liabilities, damages (etc.) of any kind or nature… from any side effects… their manner of prescribing generic drugs and non-child-protective packaging."
- "This agreement along with any disputes that may arise…..will be governed and construed in accordance with the laws of Canada."
- "The State of Minnesota makes no warranty express or implied… and accepts no legal liability with respect to any product offered or pharmaceutical care provided ."

Seniorcarerx.net

Ward Health Strategies Inc

The Political Environment in Canada Protecting Canadian Consumers

January 31, 2005:

"I want to make sure that we protect ordinary Canadians, that we protect the supply, that we protect the pricing regime." Hon. U. Dosanjh, Minister of Health, Canada

- Prohibit Canadian doctors from co-signing prescriptions for U.S. patients they haven't seen.
- Prohibit prescriptions for foreigners who are not present in Canada.
- Create a list of widely used drugs that could not be exported from Canada

Ward Health Strategies Inc

Key Findings of HHS Study

- There are significant risks with the way people are currently importing drugs. "extraordinarily difficult and costly" for personal imp0rtation to be implemented in a way that ensures the safety and effectiveness of imported drugs
- Legalized importation will likely adversely affect the future development of new drugs for consumers.
- Legalized importation raises liability concerns for consumers, manufactures, distributors, pharmacies and other entities. Consumers harmed by imported drugs may not have legal recourse against foreign pharmacies, distributors or other suppliers.

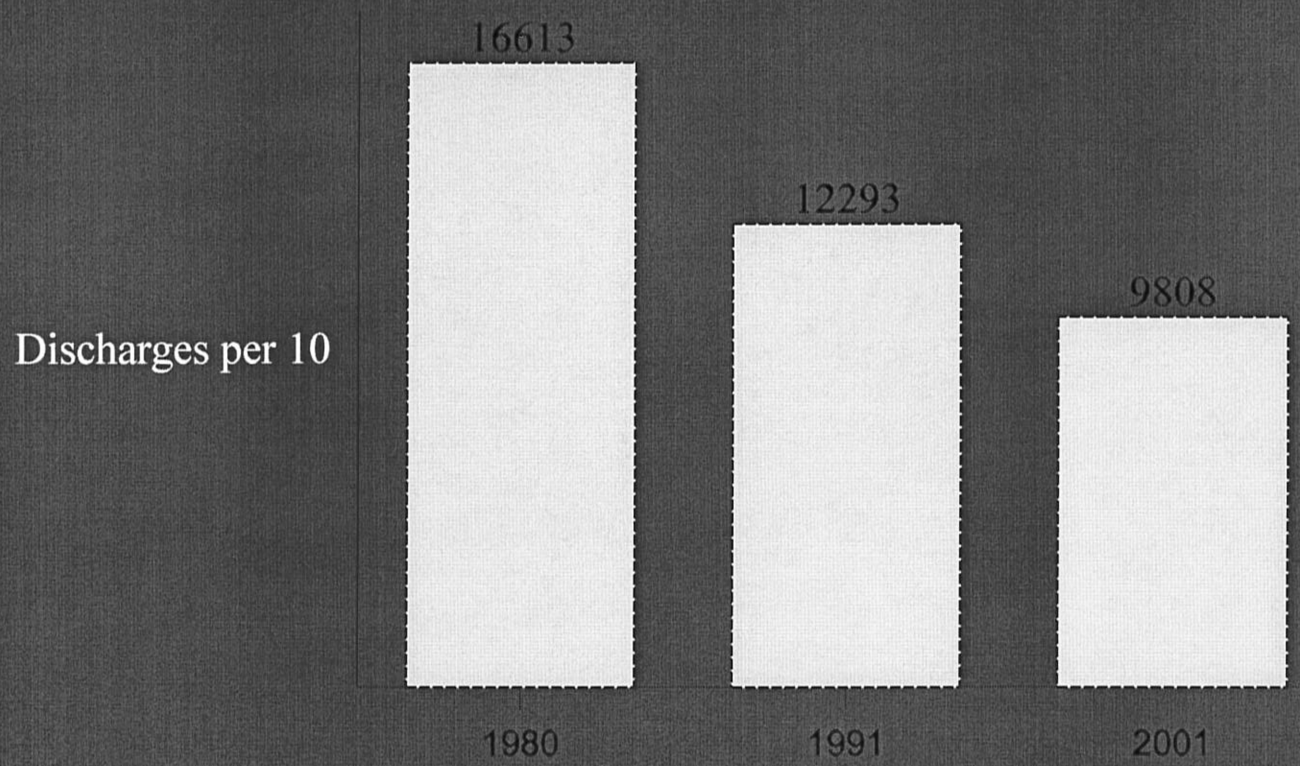
Ward Health Strategies Inc

Importation & Issues in International Drug Pricing & Drug Spending
March 2005

Chris Ward

Medical Innovation Contributes to Lowering Overall Healthcare Costs

Over the past two decades hospitalization rates in the US dropped more than 40%



Source: OECD, *Health Data*, 2003

Medical Innovation Saves Lives

Drop in death rates from selected causes (1991-2001)

Source: U.S. National Center for Health Statistics, *National Vital Statistics*.
From *Statistical Abstract of the United States: 2002*.

Importation

- Puts consumers at risk by evading supply chain safeguards
-
- Requires Americans to waive their rights to protection of U.S. law
-
- Violates international trade laws and NAFTA
-
- Provides no certainty of supply
-
- Avoids dealing with the fundamental issue of providing adequate benefits to seniors & other vulnerable populations
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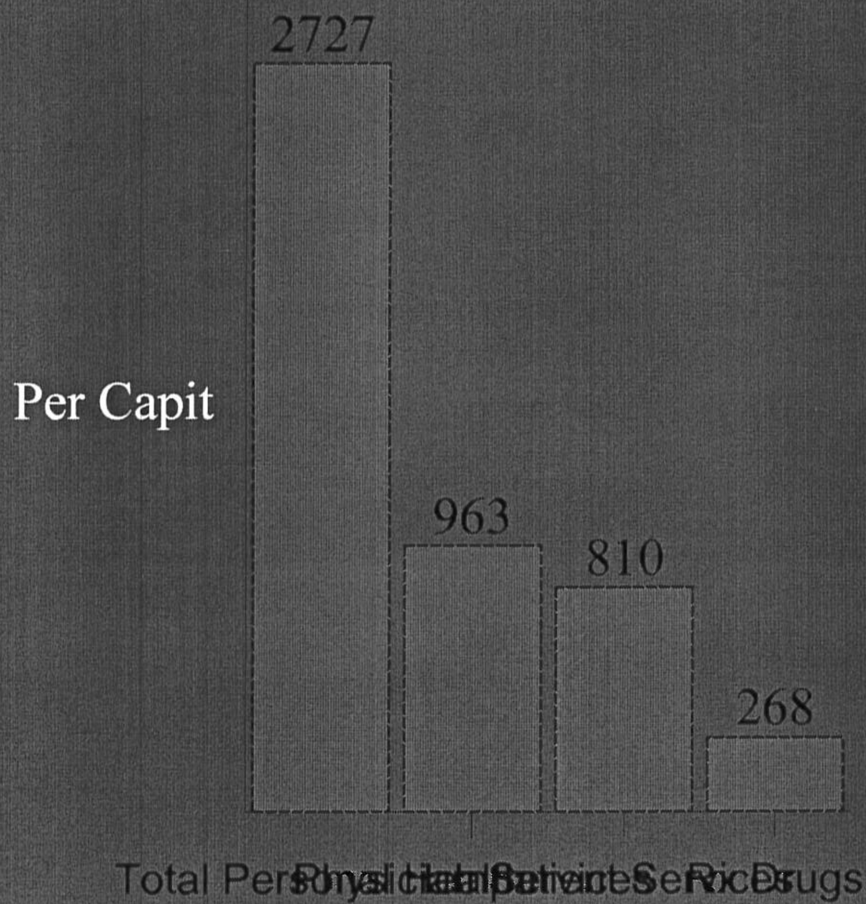
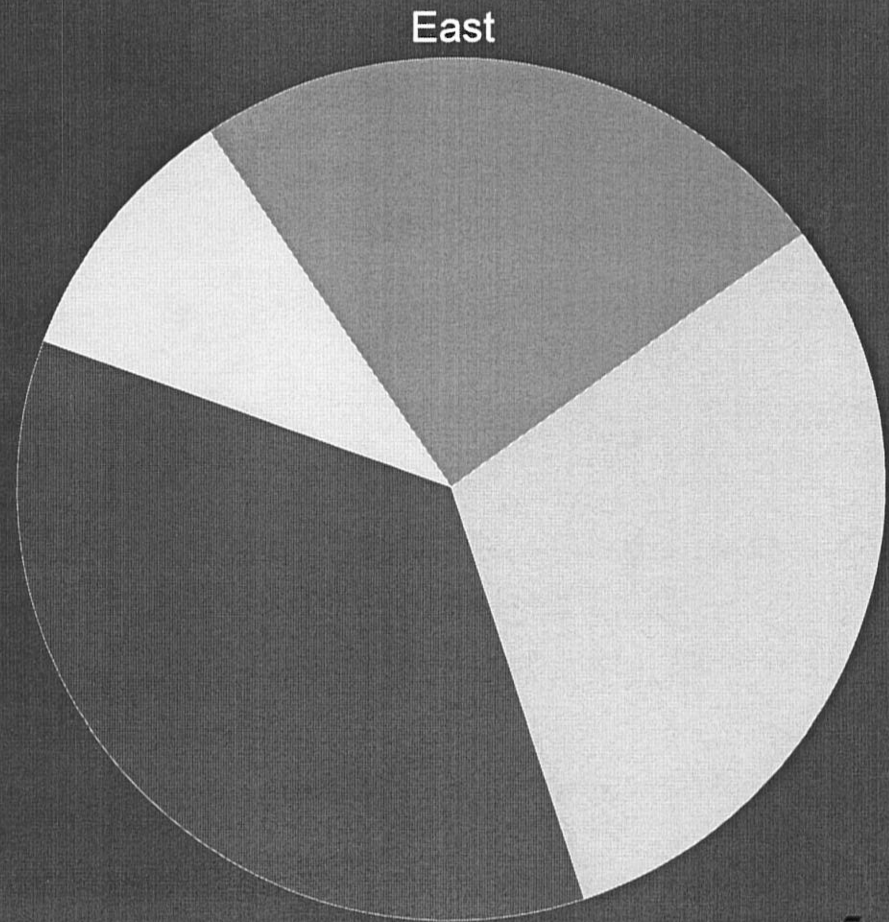
- Destroys the incentive to search for new medicines that save lives and reduce the financial burden of illness and disease

7-4

Canada U.S. Health Spending Gap 2002





O.E.C.D. Health Data 2004

Why Health Services & Supplies Cost More in the U.S. than in Canada

Macro Economic Differences

Differences in Liability Costs

Price Controls

KANSAS BOARD OF PHARMACY
DEBRA BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Testimony concerning HB 2337
House Health and Human Services Committee
Presented by Debra Billingsley
On behalf of
The Kansas State Board of Pharmacy
February 21, 2005

Mr. Chairman, Members of the Committee:

My name is Debra Billingsley and I am the Executive Secretary of the Kansas State Board of Pharmacy. Thank you for the opportunity to submit information for your consideration regarding drug importation. Our Board is created by statute and is comprised of six members, each of whom are appointed by the Governor. Of the six, five are licensed pharmacists and one is a member of the general public.

The purpose of the Kansas State Board of Pharmacy is to promote, preserve, and protect the public interest as it relates to the distribution of drugs into the public marketplace. The agency was put into place for the consumer's protection. The agency licenses and regulates all entities involved in the manufacturing and distribution of prescription and over the counter drugs into the state. The Board also licenses and regulates those entities and persons at the retail level who sell or dispense drugs to the public. The Kansas Pharmacy Act requires that only licensed entities may sell drugs or act as a pharmacy in Kansas. Given that medications are an integral part of disease management and medication therapy the delivery system of drugs is becoming more and more complex. Technological enhancements have improved the capabilities for legitimate patient monitoring. However, it has also enabled entities motivated by economic gain to erode the standards of care that have been in place for 65 years.

The importation or reimportation of prescription drugs from foreign countries violates one or more provisions of the Federal Food, Drug and Cosmetic Act (FFDCA). Under the FFDCA unapproved, misbranded, and adulterated drugs are prohibited from importation. Importation violates state law also. Each state put into place a licensing and regulatory agency to promote, preserve, and protect the public health, safety, and welfare by and through effective regulation of the many aspects of the drug delivery system. Our state requires that pharmacists attend an accredited professional degree program that has met established qualifications and standards. The applicant is required to have 1500 hours of supervised experience, pass a national pharmacy license exam (NAPLEX) and a multistate pharmacy jurisdiction exam (MPJE) prior to receiving a license. The applicant is backgrounded regarding his criminal record or whether the applicant has ever violated any federal or state law that would deem him to be unfit to practice pharmacy in Kansas.

Likewise, each pharmacy licensed with the Board is inspected prior to licensure. Each facility is inspected as to safety, cleanliness, ventilation, temperature, and security from unauthorized entry. Further, K.S.A. 65-1636 clearly states that the sale of drugs is limited to pharmacies operating under registrations required by the Kansas Pharmacy Act.

The Board currently licenses approximately 3, 778, pharmacists each of whom has met the standards and qualifications set out by the Board. The Board has issued 1,175 pharmacy licenses, 816 of which are located in Kansas. These individuals and entities are following all of the rules and regulations required by law in that they have received a license with the State Board. They are subject to consumer complaints regarding any aspect of their practice. They are following very rigorous federal and state standards regarding counseling of patients and they must ensure that patients are informed of recalls or harmful drug interactions. These are requirements that cost these individuals a lot of money. However, they follow these costly regulations so that patient safety is not compromised. They enter the field of pharmacy knowing it is a highly regulated profession based on the high risks related to the dispensing of medications. They enter this field because they are interested in providing patient care and education. They are interested in promoting excellence and integrity to their field. They are innovators guiding healthcare in a very competitive field. It is unfortunate and unjust that there are entities that do not comply with the laws that were placed to protect integrity that licensed pharmacists so highly regard. Facilitating the sale of foreign unapproved drugs outside of the regulatory scheme does not protect citizens, ensure that standards are met or that consumer complaints are properly handled.

The Board of Pharmacy believes that there are currently laws on the books that would prohibit storefronts that are not licensed from operating in Kansas. This bill would provide additional strength to the laws that are already present. The Board of Pharmacy believes that this bill clarifies the existing laws, notifies entities that they must be licensed, and provides a penalty to those who continue to erode the standards of care that were put in place to protect the public.

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

TESTIMONY

Before the House Committee on Health and Human Services

Concerning H. B. 2337

By John L. Kiefhaber, Executive Director

KANSAS PHARMACISTS ASSOCIATION

Chairman Morrison and members of the Committee:

The 1,300 professional pharmacists of the Kansas Pharmacists Association (KPhA) appreciate the opportunity to be heard by the Committee concerning **House Bill 2337: An Act … creating the crime of illegal importation of prescription drugs …"**

Probably better than an other health care professional, your pharmacist understands that prescription drug patients are desperate to find affordable prescription drugs. Over the years we have seen a steady increase in the number of drugs that are available to treat our illnesses, and a steady increase in prices for many of the most important of those drugs. We are not facing a new problem with drug prices, but we are facing a critical problem of fair and reasonable access to affordable prescription drugs in this country.

The professional pharmacist remains the key to effective drug therapy and counseling for patients concerning possible drug interactions, dosing adjustments and side effects. Without proper drug therapy management provided by the community pharmacists and the hospital pharmacists throughout the State patients could not achieve the full beneficial results promised by modern-day prescription drugs. Without proper drug therapy management the prescription drug consumer, and the Kansas Medicaid program, would not see substantial savings now afforded by pharmacist intervention with generic drug substitutions.

In reviewing H. B. 2337, KPhA pharmacists stand with the State Board of Pharmacy in opposing the illegal importation and reimportation of unapproved prescription drugs to Kansas consumers and in supporting this bill. Right now in the United States the importation or reimportation of prescription drugs from foreign countries generally violates one or more provisions of the federal Food, Drug and Cosmetic Act. This includes 21 USC 355 prohibiting introduction of non-FDA approved medications into interstate commerce, 21 USC 353 (b) (2) prohibiting dispensing a drug without proper labeling, 21 USC 331 (a) (d) (i) prohibiting marketing misbranded, adulterated or counterfeit drugs, and 21 USC 381 (d) (1) prohibiting reimporting drugs from foreign markets except for the drug manufacturer. In addition, 21 USC 1331 specifically prohibits the causing of any

Attachment 9
HHS 2-21-05

violations of the aforementioned statute. It appears to KPhA that some unlicensed operations in Kansas may be engaging in, promoting and encouraging the illegal importation of prescription drugs into this state.

But this bill isn't just about stopping illegal operations. One of the primary concerns here is that improperly distributed drugs are bypassing the traditional pharmacist in his or her role as counselor and educator of the patient. The pharmacist cannot use his or her history records for the patient's medications, which are critical for identifying the potential for adverse effects of a new or continuing prescription medication, if safe and legal distribution system has been bypassed. KPhA believes that the issues here are of paramount concern to Kansas consumers. The cost of medications is what is fuelling the crisis we are facing – but protecting the health and safety of Kansas citizens cannot be bypassed in a misguided attempt to reduce that cost. Instead, members of the Kansas Pharmacists Association have been working for months with the Governor's office and legislative leaders to find legal and safe ways to assist the uninsured and working poor in our state to get and keep access to the prescription medications they need. We are not there yet, but hope to find better ways to open access to all Kansans in the future.

We request that the Committee report H. B. 2337 out favorably so that we will have a state-level protection against the illegal importation of prescription drugs into Kansas.

2-21-05

GOVERNOR'S OFFICE OF HEALTH PLANNING AND FINANCE

ROBERT M. DAY, DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Testimony on House Bill 2337 to the House Health and Human Services Committee

by Karen Braman
Deputy Director
Governor's Office of Health Planning and Finance

February 21, 2005
1:30PM

For additional information contact:
Governor's Office of Health Planning and Finance
Karen Braman, Deputy Director

Landon State Office Building
900 SW Jackson Street, Suite 252
Topeka, KS 66612
Phone: 785-296-3512
Fax: 785-296-3468
www.ksgovernor.org/healthPlanning/workgroups_hpf.shtml

Attachment 10
HHS 2-21-05

Governor's Office of Health Planning and Finance
Karen Braman, Deputy Director

House Health and Human Services Committee
February 21, 2005

House Bill 2337

Good afternoon Mr. Chairman and members of the Committee. I am Karen Braman, Deputy Director of the Governor's Office of Health Planning and Finance. I appreciate the opportunity to talk with you this afternoon about HB 2337.

HB 2337 would make the importation of prescription drugs illegal, a practice that the United States Food and Drug Administration (FDA) currently maintains is in violation of the United States Food, Drug and Cosmetic Act. While the FDA maintains that importation is illegal, it has allowed consumers to purchase prescription drugs through Canada for personal use, and has even established a "personal use" policy that explicitly allows this practice.

Over two million Americans, including Kansas citizens, have purchased pharmaceuticals from Canada and other countries because they are less expensive. The FDA has chosen not to prevent these purchases and to date has taken no enforcement action against individual citizens or the many importation programs in operation in cities and states across the country.

Citizens have turned to importation over the years because there is a great need. According to a recent Kaiser Family Foundation survey, 37 percent of seniors age 65 and

over have incomes at or below 150 percent of the federal poverty level—roughly $14,000 per year. Seventy-one percent of seniors age 65 and over have two or more chronic conditions. Sixty-eight percent of Medicare enrollees have no drug coverage at all. As you can see, chronic disease coupled with poverty or near poverty means that many seniors who need life-saving medication are forced to make choices like splitting their medication, skipping doses or days of medication or not taking their medication altogether because they clearly cannot afford it.

If you were uninsured and with a limited income that was just high enough that you didn't qualify for assistance, yet needed your medication for high cholesterol, high blood pressure, diabetes, heart disease, or a host of other chronic diseases, wouldn't you want to have safe alternatives to obtain your medication at a lower cost? If you could obtain a three-month supply of Lipitor 80mg tablets that would cost you $314.03 in the U.S. for $215.61 from England, wouldn't you want that option? Or a 3-month supply of Nexium 20mg that would cost you $393.97 in the U.S. for $168.90 from Australia? Or a 3-month supply of Flonase that would cost you $252 in the U.S.for $89.90 from the U.K?

Opponents of prescription drug importation often refer to safety as their primary reason for opposition, but we know that there are mechanisms to ensure patient safety by regulating and monitoring pharmacies in Canada and other countries that import medications to the United States, and by tracking the medication using their unique identification numbers—similar to the National Drug Code (NDC) in our country. It is important to know that Canada and other countries approve medications for use in their countries and track

individual drugs just like the FDA does in the United States. As a matter of fact, Canada's chain of custody of pharmaceuticals is more tightly controlled than in the United States. In Canada, prescription drugs can flow only from the pharmaceutical manufacturer directly to the pharmacy or a wholesaler. In the United States, the chain of custody also includes repackagers, which introduces infinite opportunities for counterfeit medications to enter the system. The counterfeit Lipitor scare from a few years ago involved a repackager in Lexington, Nebraska and a Kansas City-based drug distributor.

Many Americans, including many Kansans support importation. An August 2004 survey conducted by the Kaiser Family Foundation found that 79 percent of Medicare enrollees favored importation of prescription drugs from Canada. The American Association of Retired Persons (AARP) supports Senate Bill 2328, the bipartisan bill sponsored by Senators Byron Dorgan (D-ND) and Olympia Snowe (R-ME) and 22 cosponsors, that would legalize the safe importation of prescription drugs from other countries.

And lack of access to prescription drugs is not just a problem for seniors. We know from the 2001 study of uninsured Kansans commissioned by the Kansas Insurance Department that over 240,000 Kansans are uninsured and the number is growing. The majority of uninsured Kansans are between the ages of 19 to 64 and make less than 200 percent of the FPL. Without insurance coverage, these hardworking individuals are struggling to pay for prescription medication.

In recent years, cities and states throughout the country have responded to the needs of their uninsured and those struggling to pay for medication by providing citizens access to programs that allow them to safely purchase prescription medication from Canada and other countries. These programs partner with pharmacies in other countries that have been inspected, approved, and found to meet pharmacy practice standards equivalent to those in the United States. City employees of Springfield, Massachusetts have been purchasing their prescription drugs from Canada for almost two years. Expedite Rx, a company based in Temple, Texas, has allowed individuals to safely import over 60,000 prescriptions from inspected, accredited pharmacies in other countries with no reported adverse events to date.

As a matter of fact, during the flu vaccine shortage this past flu season, the United States government imported tens of thousands of additional flu vaccine from Germany and France for use by American citizens.

When the Governor's Office of Health Planning and Finance began exploring prescription drug importation, the effort was supported by Senator Barnett. A November 15, 2003 Associated Press article, which I've attached to this testimony, describes Senator Barnett as a doctor who advises patients who cannot afford prescriptions at American prices to seek them at lower prices from Canada. Barnett said he does not want to hurt Kansas pharmacists but worries patients otherwise might go without medication. Senator Barnett was quoted as saying "I think anything pushing Congress to do more on the huge problem of prescription drug costs is a worthwhile effort", and "I think the pharmaceutical industry has Washington and Congress under its thumb."

While there are millions of individuals safely importing their prescription medications from other companies, we also recognize that there are unscrupulous storefronts or businesses that operate without oversight or inspection by regulating agencies or private companies to ensure patient safety. We support any measure to keep such operations out of business and that will make importation of prescription drugs safe for Kansas citizens, but believe outlawing importation altogether is not the way to go.

The Dorgan-Snowe bill currently in Congress contains several important safety protections for consumers; such as requiring wholesalers and pharmacies to register with the FDA and preventing pharmaceutical companies from shutting of supply to those who engage in importation. We support efforts such as this that emphasize patient safety while still providing individuals access to lower cost medications, including those from other countries.

We agree that importation is not the long-term solution to escalating prescription drug prices, however, we do believe that it offers many individual citizens access to prescription drugs they would otherwise not have. Many Kansans are without prescription drug coverage and have incomes that are too high to qualify for assistance from pharmaceutical manufacturers or other safety net programs. Under the Governor's health care reform program, we are also working with Kansas pharmacists to establish a pooled buying program that would enable uninsured low-income Kansans to purchase generic medications at a much lower cost than they can now. But that won't help everyone, and we believe it is important to offer individuals a variety of options to lower their medications costs that we know are safe.

For these reasons, the Governor's office opposes HB 2337 and instead encourages the consideration and evaluation of all options to assist Kansans in obtaining lower cost medications, while emphasizing important safety precautions.

Posted on Sat, Nov. 15, 2003

Sebelius seeks study of drugs from Canada

Associated Press

TOPEKA - Gov. Kathleen Sebelius has ordered a top health care policy adviser to study how much money the state could save by purchasing prescription drugs from Canada for its employees and needy Kansas residents.

Sebelius hopes the study will pressure the federal government to address rising prescription costs, her spokeswoman, Nicole Corcoran, said Friday. Several other governors and some members of Congress want to lift the federal ban on importing drugs from Canada.

"She's hoping this will help urge the federal government to take action," Corcoran said. "It isn't, obviously, something that can be fixed at the state level at this time."

As for actually purchasing drugs from Canada, Corcoran noted the federal ban and said, "It's definitely not something we're pursuing."

Sebelius said she had assigned the study to Bob Day, director of her office of health planning and finance.

Supporting her action was state Sen. Jim Barnett, a doctor who advises patients who cannot afford prescriptions at American prices to seek them at lower prices from Canada. Barnett said he does not want to hurt Kansas pharmacists but worries patients otherwise might go without medication.

"I think anything pushing Congress to do more on the huge problem of prescription drug costs is a worthwhile effort," said Barnett, R-Emporia. "I think the pharmaceutical industry has Washington and Congress under its thumb."

But Kansas House Appropriations Committee Chairman Melvin Neufeld, R-Ingalls, said Sebelius -- and her fellow Democratic governors and members of Congress -- are raising Canadian drugs as an issue to embarrass President Bush, a Republican.

"It's more political rhetoric than reality," Neufeld said.

A majority of U.S. House members favored lifting the ban on importing Canadian drugs, but many of the lawmakers writing the final version of a prescription drug bill in Congress opposed the idea, as does Bush and the Food and Drug Administration.

Critics argue Canadian drugs may not be as safe as their American counterparts, while pharmaceutical companies contend that they will lose revenue that supports research.

FOR IMMEDIATE RELEASE:
February 16, 2005

Contact: Brian McClung
(651) 296-0001

GOVERNOR PAWLENTY'S TESTIMONY BEFORE THE U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Washington, D.C. – Governor Tim Pawlenty testified this morning before the U.S. Senate Committee on Health, Education, Labor and Pensions regarding Minnesota's MinnesotaRxConnect.com website. The first in the nation website facilitates the purchase of prescription medicines from four Canadian pharmacies.

Following is the text of the Governor's submitted written testimony:

GOVERNOR PAWLENTY'S TESTIMONY TO THE SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

*(*Written testimony as submitted to the committee)*

Chairman Enzi, Senator Kennedy, and members of the Senate Committee on Health, Education, Labor, and Pensions, it is an honor to be with you today.

As I entered this building this morning, I saw the tribute to Senator Everett Dirksen carved in the marble downstairs. It strikes a fitting tone for his hearing.

It honored Senator Dirksen for "his unerring sense of the possible that enabled him to know when to compromise; by such men are our freedoms retained."

In an increasingly polarized environment, we need to know when to compromise and practice the art of the possible.

If ever there was an issue that we can come together on this is it. The rising cost of prescription drugs has sparked a prairie fire that is spreading across our nation. Today we have an opportunity to make bold steps toward progress.

We've all heard the arguments about why Americans pay more for prescription drugs than other countries. But the bottom line is that Americans pay more than the rest of the world and the price differential puts prescription medicines out of reach for too many Americans. The current situation is unfair and untenable.

That's why in Minnesota we've decided to take action. We're taking a method, trying it and finding strong success.

Minnesota's Plan

The Minnesota Plan for Prescription Drugs has a very simple goal – to get a better deal for Minnesotans. We have established a program to facilitate the purchase of prescription drugs from Canada by individuals.

We have established two websites – MinnesotaRxConnect.com for all Minnesota citizens and Advantage-Meds.com for state employees, retirees and their dependents.

Through MinnesotaRxConnect, Minnesotans are able to determine if their prescription medications are available at a lower cost from a Canadian pharmacy, and if so, how to order them. The site focuses on maintenance drugs that can be shipped safely from Canada. Only reputable Canadian pharmacies licensed by a Canadian province, willing to have their facilities and safety protocols reviewed by the Minnesota Department of Human Services are used. The four pharmacies affiliated with MinnesotaRxConnect have each been visited by pharmacists employed by the state of

Minnesota, including Minnesota Board of Pharmacy inspectors. The site also lets consumers know if there is a lower cost generic alternative about which they should see their doctor.

In addition, MinnesotaRxConnect is about more than just Canadian importation. It provides tips about how to become an informed consumer of prescription medicines including links to other programs that might assist consumers in purchasing their medications, such as state and pharmaceutical manufacturer programs.

Those individuals wishing to take advantage of the program need to obtain a prescription from their own physician and send a copy of the prescription, an order form and a medical history questionnaire to the Canadian pharmacy. To comply with Canadian law, the prescription is reviewed and countersigned by a Canadian physician. Assuming that all is in order, the pharmacy ships the medication to the patient by mail in the manufacturer's original, sealed container whenever possible.

Since the launch of MinnesotaRxConnect a little over one year ago, the Canadian pharmacies have filled more than 9,000 prescriptions for people ordering through the site. We have received only a couple of complaints about the pharmacies regarding billing issues. Those complaints were quickly resolved by the pharmacies when the state contacted them. We have received no complaints about the quality, effectiveness or safety of the drugs.

Let me repeat – we have not received a single complaint, out of more than 9,000 prescriptions filled – regarding the quality, effectiveness or safety of the drugs that were purchased utilizing our prescription drug website.

The top complaint we have received is not regarding Canadian pharmacies or drugs, but about enforcement actions taken by the U.S. government. A number of packages shipped by the pharmacies affiliated with our websites have been seized by the FDA, Customs or the Postal Service. When notified, the pharmacies promptly ship another supply at no cost to the customer.

Consumers who use MinnesotaRxConnect must first visit with their personal physician and get a prescription from them. The prescription is reviewed by Canadian pharmacists who contact the U.S. physician to clear up any potential problems. The prescription and the patient's medical history are then sent to the Canadian physician for yet another review. A Canadian physician then countersigns the prescription.

Recently, the Canadian government has raised concerns about the practice of countersigning. Canada's Minister of Health has said he considers physician countersigning to be unethical. We disagree. We see the countersigning process as an additional safety check, one more opportunity for a medical professional to review the prescription for potential problems.

If the Canadian physician was the only doctor involved, it would be unethical for them to issue a prescription to someone they had never seen or examined. But in this process, the Canadian physician is only double-checking a process that first included the patient being examined by their doctor and that doctor issuing a prescription.

Unfortunately, there are some unethical web-based operations that will have a physician write prescriptions based only on an online questionnaire that the patient fills out. In such cases, no physician sees the patient. Our system ensures that this does not happen by requiring that that the patient meet with and receive a prescription from their physician.

Through a second website, Advantage-Meds.com, state employees, retirees and their dependents can purchase certain prescription medicines at no cost through one of the Canadian mail order pharmacies affiliated with MinnesotaRxConnect.

During 2004 (May 13 - Dec 31):
1. 1,861 members enrolled

- Eligible members include 48,000 employees and 72,000 dependents
- A member can enroll but not order a drug
- A member can order more than one drug

2. 3,166 drugs were ordered
   - An order is one three-month supply of one drug
   - Represents about 1% of the drugs purchased by members
3. 27,526 persons made 42,232 visits to the website
4. $577,479 was spent by program
   - Average of $76,992 per month (7.5 months)
   - Average cost of $184 per drug (three month order)
5. Approximately $300,000 was saved by program and members
   - $98 per drug
     – $53 to program in reduced costs
     – $45 to members in waived co-payments
   - Results meet initial expectations

We recognize that these measures are not the long-term solution. They are, however, designed to provide short-term relief and to build pressure for long-term reform.

Ensuring Safety
Those who oppose reimportation often talk of great problems with safety. On this point, it is important to be clear about what we have done.

We reference services available from established, reputable, credible, accredited Canadian pharmacies. There is no evidence to suggest such pharmacies are unsafe. To the contrary, Minnesota Board of Pharmacy surveyors have visited the pharmacies and found no significant problems. Canadians are not dying or at risk because of their system. Assertions that a program like Minnesota's is unsafe suggests either the pharmacies we have chosen are unsafe or they are too inept to properly mail or deliver medicines safely. Neither is true. Moreover many reputable, established pharmacies in the U.S. already use a mail order, Internet or phone order system. The FDA apparently thinks it works well for them. For example, the Veterans Hospital in Minneapolis mails out a large number of prescriptions to patients each week.

Our program should not be confused with the questionable Internet pharmacy or "storefront" marketing entities that offer or have offered their services to U.S. citizens with little or no oversight. We agree that such operations present an unreasonable safety risk to consumers.

Our Department of Human Services conducted a review of Canadian practices, similar but independent of that done by the State of Illinois. We came to the same conclusion that they did: the Canadian system is comparable to ours in safety standards.

There is a misperception that reimportation from Canada is some risky endeavor in which we give up safety to use a Third World apothecary just to save a dime. Canada's pharmaceutical regulatory system is strong and effective. At the state level, we continue to monitor and ensure that those pharmacies serving our citizens are held to the highest standards of safety.

Let me briefly explain to you some of the safety and security protocols we are using as part of our reimportation program:

1. The pharmacies associated with our website are licensed by the Canadian province in which they are located;
2. The pharmacies have agreed to allow unannounced inspections of their facilities, and the Minnesota Department of Human Services Pharmacy Program Manager, who is a pharmacist, has conducted unannounced follow-up visits to all four pharmacies;
3. Medications are dispensed in the manufacturer's unopened, safety-sealed containers in appropriate amounts whenever possible;

4. Medications shipped are approved for use in Canada by the Therapeutic Products Directorate of Health Canada, which uses standards similar to those of the FDA when approving drugs;

The Industry's Actions
Pharmaceutical manufacturers such as Merck, Pfizer, Eli Lilly and others have withheld supplies of prescription drugs from Canadian pharmacies that serve Americans.

Their actions are unfortunate. I urge this committee to review the comments and actions of the companies involved.

Minnesota is Ready to Lead the Way
The states are often called the "laboratories of democracy." The State of Minnesota is proving that again by moving ahead in implementing this prescription medicine plan.

Let us be the experiment. Let us try it. Let us continue to put the arguments to the test. If it doesn't work, we'll admit it. The current system is not "safe" because too many people can't afford their medicine.

Thank you very much.

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February 18, 2005
Representative Morrison, Chair
Health and Human Services Committee
In opposition to HB 2337

Good afternoon Chairman Morrison and Members of the House Health and Human Services Committee. My name is Maren Turner and I am the State Director of AARP Kansas. Thank you for this opportunity to express our comments and opposition to HB 2337.

AARP Kansas, representing more than 350,000 Kansans over the age of 50, greatly appreciates the opportunity to share with you the Association's views on prescription drug importation, and to express our strong opposition to House Bill No. 2337. We believe this legislation is an inappropriate and overly drastic response to a complex problem facing all Americans. Kansans who are purchasing their prescription drugs from abroad are doing so because they cannot afford to pay escalating drug prices. Denying them access to the medications they need at a cost they can afford is simply wrong. We urge you to reject this bill and we pledge to you our willingness to work with you to find more effective ways to improve Kansans' access to safe and affordable prescription drugs.

The Medicare prescription drug benefit was an important first step in helping those over 65.. But now more needs to be done to control the rising costs of prescription drugs so that Americans of all ages can afford needed medications. Modern medicine increasingly relies on prescription drug therapies; yet the benefit of these therapies still eludes those Americans who cannot afford to pay escalating drug prices. Between 1998 and 2003, prescription drug prices rose at nearly twice the annual rate of inflation for that same period.

CMS estimates that, in 2003, per capita spending on prescription drugs rose approximately 12 percent, with a similar rate of growth expected for this year. Much of the increase in drug spending is due to higher utilization and the shift from older, lower cost drugs to newer, higher cost drugs. However, rapidly increasing drug prices are a critical component.

High drug prices, combined with the surging older population, are also taking a toll on state budgets and private sector health insurance costs. Medicaid spending on prescription drugs increased at an average annual rate of nearly 20 percent between 1998 and 2001. Until lower priced drugs are available, pressures will continue to squeeze public programs at both the state and federal level. Pressure will continue on the private sector as well, possibly leading to elimination of, or reductions in, employer-provided drug benefits. Further, over 43 million Americans currently have no health insurance coverage. Without access to negotiated prices, these Americans pay among the highest prices for prescription drugs in the world or, worse yet, don't fill prescriptions because

they cannot afford to pay for them.

AARP surveys demonstrate that our members consider drug prices exorbitant and the single most significant barrier to obtaining needed medications. Responses to an AARP Bulletin questionnaire last fall showed that our members split pills, skipped doses, asked doctors for free samples, and sold possessions because the costs of needed medications were too expensive. One woman poignantly noted that she begged for the unfinished prescriptions of friends who had died, hoping their left-over drugs would meet her needs.

Americans of all ages need affordable prescription drugs now. Safe importation of prescription drugs from Canada is one way to begin to secure lower priced drugs. Our members question why prices in Canada can be lower, sometimes far lower, than prices in the U.S. It is a national embarrassment that people from all over the world come to the United States to access our advanced medical systems while many of our own citizens need to look outside our borders in order to afford their prescription drugs. But with the same drugs selling, in some cases, at 30 percent and even 50 percent less in Canada and overseas, it is hardly surprising that so many make that choice.

It is no longer a question of whether we should or should not allow the importation of drugs from abroad. The simple fact is that importation is already happening. Many Americans travel to Canada for less costly prescription drugs, or purchase their drugs through the Internet without any systematic U.S. oversight process in place to assure safety. Importation of drugs is likely to continue whether or not Congress acts. The trend is growing, and we have a responsibility to ensure that Americans can access lower cost drugs without putting their health at risk. AARP therefore supports legalizing importation through a system that ensures safety and lowers drug costs.

That is why we support the Dorgan-Snowe prescription drug importation bill (S. 334), and its House companion, the Emerson-Brown bill (H.R. 700) which would legalize personal and wholesale importation of prescription drugs, starting with Canada. There are three key reasons why AARP supports S. 334 and H.R. 700:

1 It includes strong safety protections;
2 It attempts to prevent the drug industry from limiting supplies of drugs that would prevent importation; and
3 The Dorgan-Snowe and Emerson-Brown bills have bipartisan support.

While we believe that importation is largely a federal issue, we also support the efforts of state officials across the country to facilitate citizens' access to more affordable drugs. That is why we have filed an amicus brief in support of the State of Vermont urging the Secretary of Health and Human Services to grant that state a waiver to allow importation on behalf of its state employees, and that is why we have stood with state officials and legislators throughout the country to highlight the need for Americans to be able to obtain affordable prescription drugs from abroad.

We know that importation is not a panacea for the problem of soaring drugs. Nor is it the only answer to lowering drug prices. That's why AARP has launched a national

prescription drug affordability campaign that includes importation as one of several measures to contain prices. As part of this campaign we are advocating lower state prescription drug spending, using litigation to ensure that lower cost drugs get to the market, and shining a spotlight on drug prices.

In conclusion, AARP wishes to express its opposition to House Bill No. 2337, and urges you to reject this measure. It is a fundamental mission of AARP Kansas to improve access to safe and affordable prescription drugs. This bill is contrary to that mission.

Maren Turner
AARP Kansas

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February 8, 2005

Mr. Doug Mays
Speaker of the House
House of Representatives
Topeka, KS 66612-1804

Dear Speaker Mays,

I am writing in regards to the letter that you just mailed to the Citizens of Kansas. First let me assure you that I am not a democrat but I am very thankful to Governor Sebelius regarding her campaign to import drugs from Canada.

I am both a physician and pharmacist and there is **NO RISK** to Kansans or any US citizen using drugs from Canada. They buy their drugs mostly from the United States and the drugs are not even repackaged before they use them. As to safety, an example would be Lipitor made by Parke-Davis, sold to Canada who in turn sells them to US Citizens for 50-60% less than the prices paid in the U.S. These are the same drugs, made by Parke-Davis, but much cheaper than those sole in the United State under the same label. Your statement regarding the savings of 1% is totally false. This was erroneous information given to you. But you are responsible for making the accusation. As to exporting prescription dollars, our pharmaceutical companies are pricing their products way above what is necessary for anything other than the **BOTTOM LINE**.

It is very disconcerting to me that the White House has sold the United States Citizens a pack of untruths. President Bush (who I voted for) has proposed Medicare changes, such as a prescription plan that will not help. The Medicare prescription plan will be a failure just as his Prescription Card program was a failure nationally. President Bush likes to talk about being a compassionate conservative. Is the action regarding getting drugs from Canada the mark of a compassionate conservative? I don't think so.

You mentioned legal ramifications that Gov. Sebelius' plan would cause. The only ramifications are the result of US Congress passing laws that are note in the best interest of all US Citizens.

The Department of Health and Human Services are doing what they have been instructed to do. If the truth be known, I do not think any of them really believe that the drugs imported from Canada are unsafe. If they really believe this, why are they **buying and using** Flu caccine made in Canada and Great Britain? I suggest you get your drug information from a source other than our pharmaceutical companies, Health & Human Services and the members of the RNC.

As a senior citizen and a concerned citizen, I believe that if Kansas does not stand behind Governor Sebelius on this issue, we are going to cause Senior Citizens to have to make a choice – to eat **OR** to take their medicines.

I will do everything in my power to defeat any congressional member of Kansas who votes to

Attachment 12
HHS 2-21-05

follow the path you have laid out.

Sincerely,

Norman G. Marvin, M.D.
and Senior Citizen
CC: Gov. Sebelius, Rep. Patricia Kilpatrick