2009 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1440

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **HB 1440**

House ~~Finance and Taxation Committee~~ Industry, Business & Labor

☐ Check here for Conference Committee

Hearing Date: **February 3, 2009**

Recorder Job Number: 8477

Committee Clerk Signature Jan Prindle

Minutes:

Chairman Keiser called the joint hearing by House Human Services Committee and House Industry and Labor Committee to order to hear HB 1440. He explained the format of the hearing.

Representative Jon Nelson, District 7, introduced the bill. This bill repeals the 51% ownership law for pharmacies. The reason I got interested in this bill is in my private life I serve on hospital board in Rugby. We are in a situation in hospital based pharmacies where low volume hospitals have been at a disadvantage for a number of years—since the law was first passed. We cover call on weekends and after hours but we don't have volume to attract and retain pharmacists and build a pharmacy. I've gone through the times when citizens of ND have loaded up in buses and gone to Canada to purchase their prescription drugs. That wasn't right. Today we have a chance to fix that and allow people to buy from their local pharmacies in a competitive nature. We have instances where people are insulated from this—people who have insurance. The people that really need this bill are the people who are uninsured or underinsured who have health problems. With the increasing role that prescription drugs play in medical procedures, it's important that they have affordable access to these drugs. This bill is ultimately good for the citizens of North Dakota to give them more

access. Rural access is not issue. I'm a strong believer that the passage of this bill will increase rural access. It's time to change. It's time for this bill to pass and allow the free market to work in pharmacy as it has in so many other industries in our state.

Representative Jasper Schneider, District 21, spoke in favor of HB 1440. I want to thank the members of the audience. This is a testament of the open process we have. One of the Committees' tasks is to sort through the emotion involved with this bill. We are going to hear very compelling arguments on both sides. There will be a lot of emotion involved. We also need to keep in mind that there is also going to be a lot of financial motivations. It will be our task to cut through that. The reason I signed on to this bill is that I am looking out for the financial motivation of the citizens of North Dakota. The cost of prescription drugs is going up. It's very expensive; especially if you are underinsured or have no insurance at all. We are going to hear different arguments as to where North Dakota stands in relation to costs. One thing we know that is not in dispute are the groups that have come out and said they were going to save money if this bill is passed—most notably Blue Cross/Blue Shield, PERS, and the state through the Medicaid system.

Tammy Ibach, coalition manager for North Dakotans for Affordable Healthcare, testified in favor of the bill. **(Attachment 2) Note: there is no Attachment 1.**

Jacob Olson, son of Tammy Ibach, testified in favor the bill. **(Attachment 3)**

Roger Nitschke, from Ashley, testified in favor of the bill **(Attachment 4)**

Darwin Reinhardt, from Beulah, testified in favor of the bill. **(Attachment 5)**

Kim Christiansen, pharmacist, testified in favor of the bill. **(Attachment 5a)**

Dr. Eric Thompson, family practitioner, testified in favor of the bill, **(Attachment 6)**

Eric Christenson, director of Pharmacy, Heart of America Medical Center, Rugby, testified in favor of the bill. **(Attachment 7)**

Dr. David T. Flynn, Ph.D, director of the Bureau of Business and Economic Research at the UND, presented a study in support of HB 1440. **(Attachment 8, two items)**

David Hedahl, representing the North Dakota Chamber of Commerce, presented the organization's support of the bill. **(Attachment 9)**

Joel Gilbertson, appearing on behalf of Walgreens, introduced

Hal Rosenbluth, senior vice present, Walgreen Company, presented testimony in favor of the bill. (**Attachments 10 and 11)**

Representative Conrad: I have a question for the pharmacist from Rugby. You talked about the quality of service and one of the things I'm concerned about is the telepharmacy program. That is one thing we have been able to have in ND that has allowed for smaller communities to have a technician and the pharmacist may be someplace else but the pharmacist owns that so therefore they have an investment in it. Will this be hurt in any way by opening this up?

Erik Christenson: I don't see why that program would be harmed in any way. The places that have this program do not have the volume to support the salary of a full-time pharmacist. Most of the institutions that I am aware of in the retail sector do not have the volume to have pharmacist on staff. From the hospital perspective, we use telepharmacy in Rugby. I cover Harvey and Cando. By repealing the ownership law, I don't see how they would ever be affected.

Representative Amerman: My question is for Dr. Flynn. In your testimony you had a report that was confirmed by PERS, Blue Cross, and Blue Shield. Then you rejected the new rules project. Was that rejected by Blue Cross, Blue Shield, PERS and Human Service?

Dr. Flynn: I have no information on that at this time.

Representative Kasper: Again for Dr. Flynn. Last fall you had testimony before our interim committee and you presented some data—a complete report on your findings. During your

question period there and some of the rebuttal during that committee hearing, it was brought out that the numbers you used to come up with your conclusions were erroneous and that you used numbers that did not match with the actual numbers in North Dakota. What would be the impact of your study if you used the correct numbers? At that time you said if those correct, it would probably be very little impact. My question is: Have you updated your study to reflect the actual charges in ND compared to the study that you last fall.

Dr. Flynn: I do not believe my numbers before were erroneous. I've used the numbers provided by Blue Cross/Blue Shield of ND as far as the prescriptions filled in ND as far as the cost of prescriptions filled in ND and the cost of prescriptions filled outside of ND. If there is an error with the number they provided, that is their issue. I have updated the numbers to take in to account the fact that there are people who work in ND communities such as Fargo who live in MN. Those individuals would be highly unlikely to put in a "fill" in a ND pharmacy. We have assumed 20% of the out of state fills will not be coming in to ND whereas before we had assumed all those would return to ND.

Representative Boe: I don't know who wants to answer this question, but so far all we have heard about the testimony is about access and money. I understand it; the origination of this law in the '60s was eliminating doctors owning pharmacies. I'd like to draw that in to the debate and see how we were going to keep that from ever happening.

Dr. Eric Thompson: As a doctor, I know about this a little bit. It is a good idea to try to limit doctors from having that business as it a conflict of interest. There are federal laws in place nationwide to prevent that. We can't make any money off of ordering an x-ray, blood test, and we shouldn't be able to have a pharmacy we own to make more money. It is a conflict of interest and it's not in the best interest of the patient. There are other laws in place that will try

to keep that from happening so we don't have an abuse of greed which we can all be a victim to if we allow it.

Chairman Keiser: Are you certain if this were to pass, that the federal laws would absolutely eliminate doctors from owning pharmacies in the state of North Dakota.

Dr. Eric Thompson: I cannot state that for absolute certainty. I know it was the case in other states I practiced. I assumed it was federal, but I would have to look that up.

Representative Vigesaa: This question is for a representative from the big chain stores.

(Ryan Horne, representing Wal-Mart Stores

and Ron Weinert, pharmacist and director of government relations for Walgreens

stepped forward)

Representative Vigesaa: We have heard a lot about the $4 prescription through this entire debate. Would either of you be able to provide the average prescription price that is dispensed out of your pharmacies?

Weinert: I don't think I can do that. There is such a variance in costs per prescription. For example, my son has a growth problem and he's on growth hormone and the cash price for that drug is about $1200 per month. About 60 of the most commonly prescribed generic drugs are $4. There is such a variation it almost calls in to question how much information you are really getting from the number of what the average cash price overall would be. That's what calls in to question a lot of these economic and price analysis on both sides. Wide variations in price are very significant. What is really issue here from the perception of a very large company like Wal-Mart, Wal-Mart got very large by serving not very powerful people. The folks that don't have insurance are not going to be buying $1200 growth hormone. It's not going to be possible for them. What is really at issue here is a lot of the same people that we have made our business listening to--and that is quiet voices of not very powerful people.

That's why I think the discount drug issue is really what is at the essence of this at the end of day, not the overall average cash price. The average price is going up a little bit in ND and going down a little bit in the rest of the US. It's attributable to a lot of factors in the generic market in particular. What is really at issue here is that so far this debate has been dominated by loud voices: members of your local chamber, members of your local rotary, local business owners. I'm not a North Dakotan, I'm a Nebraskan. I look at the faces of the quiet voices that came here today—people who have never been to the capitol. Those people are not here because they need $1200 growth hormone, those people are here because they are living paycheck to paycheck or they don't have a job at all and are working to stay healthy. A $4 drug could make their lives better.

Ryan Horne: I would just add to what he said. The real concern here is the uninsured or the underinsured. It's not for someone who has an acute illness and has to take a prescription for one week that may be more costly. The issue is for patients that have chronic diseases and are on maintenance medications and take those for the rest of their lives—cardiovascular disease and diabetes which is affect about 13% of the population today. Generics cover those disease states very well. Walgreens, Wal-Mart—we have the discount programs. We have about 400 generic drugs that the consumer paid less than $1 per week for. We have another 5000 drugs that are on a discount program. I agree that the average price of a prescription drug is relatively immaterial. Specialty drugs that are over $1500 are the fastest growing sector of pharmacy. But, what we are concerned about are chronic diseases on maintenance medications. That's where these discounted generics really play the most.

Representative Vigesaa: Gentlemen, I'm surprised that neither one of you know the average price of a script out of your store. There has been a lot of discussion about the $4 issue and

we realize that not all drugs cost $4. That's why the question of what is the average cost of a drug prescribed out of your store.

Ron Weinert: The industry average is $60-$70 per prescription. That does get swayed by the about 20% of the prescriptions dispensed today that are at a very high cost.

Ryan Horne: The last CVS study showed that the average price in ND was about $65. That was up a couple of dollars from the previous year. That's 2007 data which is the first year in which discount generics were available in the other 49 states. The average price nationwide was $69 but has decreased by a couple of dollars in that same period.

Representative Nottestad: Much has been said throughout the debate pertaining to the $4 prescription. North Dakota is a very rural state. Many of our people will not be able to travel to the bigger cities. Will these $4 and discounted prescriptions be available via mail orders?

Ryan Horne: If you fill your prescription at our pharmacy and if you call in to refill it, we will mail it to you.

Ron Weinert: Walgreens does have two mail order facilities. One is in Tempe AZ and one in Orlando FL. Probably 99% of the prescriptions filled in those facilities are based on contracts with payers with employer groups or health plans for 90 day supplies where the customer is paying co-pay. Both do ship directly to consumers. There is access through the telephone and the internet. We will ship out prescription on our saving program.

Representative Nottestad: Wal-Mart will ship out from their stores in ND. Does yours?

Ron Weinert: We do mail from our stores if the patient request or requires it. But we will mail from our mail services facilities as well.

Representative Kilichowski: A couple of years ago Wal-Mart and the city of Grafton were in negations on Wal-Mart coming in. Would the repeal of this law be the trigger point about if a super Wal-Mart might come in to some of these smaller communities?

Ryan Horne: Not likely if you look at the health of the retail market and what's going on economically. ND fares much better than the rest of the country but I think the trends are going in the same direction. We've had a period of very fast growth in ND. We saw that in Bismarck where someone in the home office thought it would be good to open two stores and a Sam's club in one week. We got that done. Pharmacy is a very small part of our business overall. It's separately operated. The pharmacists don't report to the store manager and not part of the financial targets for the rest of the store. It's not a consideration in overall growth strategies.

Representative Weisz: You mention diabetes being an important part of some of the medications you sell. Some states offer, as does ND, a diabetes management program. Do your stores participate in those programs?

Ron Weinert: About two years ago, Walgreens formed a relationship with the Joslin Diabetes Center, a 110 year old in Boston affiliated with the Harvard Medical School, and every one of our 22,000 pharmacists across the country have access to all the Joslin diabetes information. They do continuing education, they are trained to educated and counsel and we are very active in the field of diabetes.

Representative Weisz: I am a pre diabetic. My friends in Linton don't always have that access to care, or are stubborn or whatever the heck it is, and go from the ranch to having some type of amputation or organ problem.

Ron Weinert: What Walgreens is doing is putting in technology to free up the pharmacist so they can provide diabetics with counseling and coaching along with other aspects of the entire health and wellness program to bring together nurse practitioners, pharmacists, health coaches, technology, etc. It's not exclusionary and includes all providers of all types employed or not employed by Walgreens. The key is for people to recognize whether or not they have

diabetes. This is about chronic care. The most important thing is for people to be diagnosed and then get on the proper medications and behavior changes to get rid of this insidious disease.

Opposition to HB 1440:

Howard C. Anderson, executive director of the ND State Board of Pharmacy, provided testimony in opposition. **(Attachment 12)**

Mike Schwab, executive vice president of the ND Pharmacists Association, spoke in opposition to the bill. **(Attachment 13)**

Representative Arlo Schmidt, District 7, provided testimony in opposition to HB 1440. **(Attachment 14)**

John Olson, appearing on behalf of the Pharmacy Services Corporation. Those of you that are old enough remember that I fought along with some of you against the blue laws in ND years ago. That was a free market issue. We ultimately have open retail establishments on Sunday. We still have the blue laws in the morning. No one is complaining about that. Archaic perhaps, but that addresses our quality of life in ND. This is what North Dakotans want. It amazes me that someone comes from out of state we are archaic in this area or that area. Are we doing so badly in this state that we have to take a look at our systems that are working? This pharmacy system is working and doing that in the interests of our patients and the consumers in ND. Then we have our flea market friends telling us this is all about free enterprise. We are not selling grain commodities or gas here. We are selling health care to people. We have systems in place designed to protect people. That's why only doctors can own clinics. That's why only dentists can own their dental practices. The big box stores cannot have physicians or dentists employed in their stores. Pharmacists are just as important. I caution you in doing something to our system that is going to cause risk and

danger to our state and our citizens. Sure, we are one of 50 states that have this ownership law, but it has served us well.

David Olig, pharmacist from Fargo, provided testimony in opposition to the bill. **(Attachment 15)**

Shane Wendel, pharmacist from New Rockford and Carrington, spoke in opposition to the bill. **(Attachment 16)** His testimony included support letters from **4th Corporation, Lutheran Home of the Good Shepherd, Golden Acres Manor**

Steve Baining, (sp ?) owner of Linson Pharmacy in Fargo, testified in opposition. I'm here to talk about price. He provided a list of price comparison. **(Attachment 17)**

Tony Welder, pharmacy owner, testified in opposition of HB 1440. **(Attachment 18)**

Representative Nathe: For Mike Schwab please. Will this measure change any service that is being performed right now?

Mike Schwab: In the short term I would not anticipate anything. It would be hard to put together the long term effects of the law. You can look at national trends but you would just be speculating on what would happen here.

Representative Nathe: What I don't understand is if the pharmacists are giving such great service, why are you so apt to think the minute Wal-Mart or Walgreens opens that their customer base is going to immediately leave them?

Mike Schwab: There would be a concern based on national trends based on vertical integration in the pharmacy market, what economists are saying, and sometimes how aggressive they are to get those customers.

Representative Ruby: In proponents and opponents there has been reference to a new rules project, could someone tell me what that is.

Justin Dulheimer, co author of the report: We are an organization that advocates for community centered economic develop. You guys have a very valuable law in this state and the benefits of having business owned communities in the state are obvious and can be quantified. Numerous studies have shown that locally owned businesses spend more in the communities in which they operate. Because of this law, there are more of those locally owned pharmacies in your state. What we did is replicate studies done previously and showed if the market share shifts to accommodate chains and mass merchandisers, which will happen a lot quicker than people think because these mass merchandisers have buildings up in ND that will accommodate pharmacies and they will go in there. When the market share shifts you will see a loss because of the multiplier effect. In pharmacies that multiplier is 17% that stays in the local economy. In chain retailer drug stores that number is only $9.20. When you take that in to account it equates to that $23 million loss in economic benefits. In our report we pose two scenarios. The one is 45% of market share and the other is if it migrates to the national levels. I would like to point out in the report where it talks about rural access. It shows across the board there is more access in populated areas of ND than in SD. That is magnified in rural areas where a lower populated area is twice as likely to be served by a pharmacy as a similar census track in SD.

Representative Ruby: That didn't answer my question at all. Who is involved with the new rules project? What is the purpose? Why do you study these things?

Justin Dulheimer: We are a national nonprofit organization and we focus on community based economic development and a lot of that has to do with retention of local wealth and resources. That is why we are focused on this law. This is a law that promotes that and keeps the economic benefits of the local pharmacy in the economy. We are funded 50%

grants and 50% private donations and the materials we produce. We are a 501.3c organization.

Representative Kasper: This question is for a pharmacist. A lot of you know that we currently allow Wal-Mart and the other chain stores to have pharmacy locations in their stores if they would only own up to 49%. Is there anyone in the room who has negotiated with them to put your drug store in their location? If so, what kind of negotiations occurred and were you successful or unsuccessful. If so, why or why not?

Tony Welder: I occupy lease space in the Wal-Mart in Fargo. Negotiations were slow starting, but they don't' have anything to say about our operation and we don't have anything to say about them. We don't buy product through them. We simply operate a pharmacy in that lease space. So the chains have options to have pharmacies in their locations. It's either like we have or they can own 49% of that pharmacy.

Representative Johnson: A question for a rural pharmacist. Representative Nathe kind of raised the question about why do you feel you will lose business in your community?

Unidentified Speaker: They take less reimbursement and then we do too. It becomes a question of "do I want to stay in this game anymore. It won't be quick—it could be ten years down the road. I think the perception is from the millions of dollars spent on advertising is that the chain drug stores are cheaper and of a better value. They have unlimited buying power and commercials to convince all consumers in rural area that it is better to get in your car and drive to a centralized larger community to get better value. I don't have the money to compete with that. The only thing I have is the relationship I have in providing that service.

Representative Potter: We have all sorts of good information about the pricing of drugs in ND and that we do have really good pricing. I appreciate this information. We have also heard that Blue Cross/Blue Shield thinks the consumer will save money. So I have that we

ARE going to save money and the consumer and we're NOT going to save money. We have a conflict here and I would like somebody to help me with this.

Steve Baining: I put that worksheet together and there is some assumption on the generic pricing that Blue Cross is stating that they are going to get the $4 price. If you look at the first page, the Walgreen column that is the price being billed to insurance. I take some issue with the $4/$10 generic programs; Wal-Mart states the price may be higher if billed to insurance. How can the price be higher if the cost of the drug is $10? The other thing that comes in to play when we look at brand name drugs, the insurance company sets the price on almost all the brand name drugs—it's a contractual agreement. One of the things that I fear as an independent owner is that I'm going to get a new contract offer significantly lower.

Representative Frantsvog: A question for any pharmacist—As you can probably appreciate we were bombarded with both and pro and con information on this issue. One of the comments made to me by a pharmacist discussed difference grades of generics. Could one of you explain different grades and does it affect the therapeutic value of generics?

Unknown Pharmacist: No, the FDA sets the standards and there should be no difference. I also sit on the advisory board of Blue Cross/Blue Shield. ND, based on a Human study in 2007, was number 2 in the nation for the generic substitution rate in the country. We were 14% lower than the national average. I can guarantee you, without asking Blue Cross, they would not substitute a generic substitution rate that the pharmacists had delivered to them for the $4 prescription plan because they spread between branded and generic prescriptions happens to be over $70 per prescription on average. ND's high generic dispensing rate saves a fortune and that is one of the reasons that rates are among the lowest in the nation.

Representative Ruby: We've heard information about this law being recognized across the country as a big plus. Is anyone aware of any efforts to apply our law to other states?

Howard Anderson: Part of the history is that ND passed the law at the end of other states trying to pass similar laws. When those laws were overturned by the US Supreme Court, in 1974 the Court was convinced to overturn that opinion. It was at the end of the period when it was politically possible to pass those laws in other states. We have lots of overtures from other states. Politically now in those states where 80% of pharmacies are already changed, they will never get that back. If we let it slip away here, we'll never get it back.

Representative Schneider: One of my concerns is the consumer does not have a voice here today. We have heard from both sides the financial motivations. I want someone to address the issues of the consumer. I think they are being underestimated in this process. I think if consumers want to go to a particular store because their drug is cheaper there, they should have that choice. Likewise, if the service is better at another store, they are going to go there. I sense some paranoia that we are underestimating consumers in this process.

Dave Olig: The voice of the consumer gets heard on a regular basis—they choose to go where they want to go. Shopping for prescription medications is not a good idea because it is important for them to have a continuity of care. We do monitor adverse reaction and that winds up in our systems. That is a big issue. 94% of prescriptions in my pharmacy are co pays so they pay fixed costs. You can shop for gas prices and you can shop for bacon, but shopping for health care is not recommended.

Rebuttal:

Tammy Ibach: With me today I have people. For many people it's about saving money. Norm, if you are up there, I'm telling your story. He's from Minot and a veteran. All veteran's get an $8 prescription drug plan. He still gets his prescriptions filled at Wal-Mart because the extra $4 that the government can save can take care of other veterans who need some benefits.

Maria Vasquez, type II Diabetic, insulin deficient and insulin dependent: I'm on pills and insulin. During the opposition, one of the pharmacies said $52 is the cheapest. $52 is not cheap for me. I get emotional about this because I have friends that are blind and have health problems. We are on SSDI. When my SSDI, goes up, my food stamps go down, my house goes up, electric goes up, heating goes up. I would like to see all the pharmacies here and the last person that talked—I want to ask you to live my life for two months trying to decipher what I have to cut out in order to afford my medication. I also own my own house and it's only $260 per month, but I have to cut things out. That's what nobody here understands that those of us on limited incomes who have not worked for over 30 years—what I have to take away from myself to give something to my grandkids. It's got to stop at some point. You have got to help us. We vote. We want you guys to do your best and I'm here to tell you on behalf of the people with disabilities in ND, we cannot afford even $52. To them it's low. Put yourself in my shoes because I have to budget my food, I have to estimate, I have to cut things out. We don't have the kind of money that the pharmacy has. That's a point they are missing from the consumer's point. I have friends who are cutting out their medication. One of my friends whose husband works doesn't qualify for anything. She was paying $400 for Blue Cross/Blue Shield and she cut it off because they couldn't afford it any more. She goes without some of her medication. She's got heart problems and four different eye sight things that there is nothing you can do for those. I was supposed to have a bone density test done. It's $800. I don't do it because I don't have it in my budget. I'm supposed have a mammogram every year. I don't do it because I can't afford it—it's not in my budget. I apologize for crying but this is a serious problem that pharmacies don't understand. I go to the family health care center and even though they give me a lower cost, there are other places that don't do that for other people. Even with them cutting their cost, I cannot afford it.

Beverly Adams, executive administrator of the Health Policy Consortium, provided rebuttal. **(Attachment 19)**

Ron Weinert, Walgreens: Walgreens is a 108-year-old company completely focused on pharmacy. 67% of the sales generated by our company are prescription drugs. The population is aging. The needs of the consumer are changing and getting extremely complex. We have addressed that by providing not just retail prescription services for all oral medication, but we have built infusion business, home care business, specialty pharmacy business. That is the fastest growing sector of pharmacy. We provide in depth clinical services surrounding that. We have documented cost saving. Of our 22,000 pharmacists that we employ, almost 10,000 of those pharmacists are trained, certified immunizers. This year we are going to provide 2 million immunizations to the public. Medication management: we train and work with managed care payers and provide their programs as well. We believe in service, we train our pharmacists and provide them the best tools and support systems in the world to provide that service.

Ryan Horne: I sent an email and now can tell you that nationally the average prescription price at a Wal-Mart store is $40.66. What's wrong with Wal-Mart owning 49%? Then we can't price.

Wendy Harmsen, Wal-Mart pharmacy manager, Dilworth MN provided testimony. **(Attachment 20 and 21)**

Representative Kasper: You indicated that pharmacists coming to ND would have to work for $15 per hour less. What is the average starting salary in Dilworth?

Harmsen: $55 per hour starting wage.

Representative Conrad: Representative Schmidt listed his wife's medications. I went through the list provided by Linsons Drugs in Fargo. Of the several drugs Marion is taking,

three are on this list. For those 3 if she were to buy them from Linsons would be 46.87, if she would buy it at Wal-Mart it would be $81.62. If she were to buy the 17.81 from Linsons and then go over and buy the two $10 prescriptions at Wal-Mart she would end up with $37.80 so she would save $9. Is that the kind of care and services we want to have in ND where people have to shop to find the price. Would you consider that appropriate? How are we going to handle that?

Harmsen: I don't think that's appropriate at all. I think people should support one pharmacy. Most pharmacies will match prices. We match any price in our pharmacy. I believe if you are in a pharmacy and you are established with a good pharmacist, you are going to stay there. You are not going to leave to save a couple of extra dollars. If you are going to leave the pharmacist will most like match the other pharmacy's price. One thing I would like to clarify is that every prescription that is paid by insurance is the same as the cash price.

Representative Boe: I presume the $4 dollar prescriptions we hear about are generics. Once they make the generic status, are there companies that abandon the generics and go after the next best thing.

Harmsen: Not that I am aware of.

Representative Porter: What are your hours of operation of your pharmacy in your Dilworth store?

Harmsen: Monday through Friday 9 a.m to 9 p.m. Saturdays 9 a.m. to 7 p.m. Sundays 10 a.m. to 6 p.m.

Joe Field, representing North Dakotans for Prescription Facts. I would like to respond to Representative Schnieider's question about consumers. I broke three copy machines last week copying 16,000 petitions that we took four weeks to get. There's your voice of the consumers right there. 16,000 in just 4 weeks.

Dr. Steve Schondeimeyer, professor of pharmaceutical economics at the University of Minnesota, provided information to the Committee **(Attachment 22)** Prescription drugs are a market very different than any other. ND has a population of about 638,000 and in 2007 they spent $564 million on prescription drugs at an average price of about $65.28. Each ND on average consumed 13.6 prescriptions last year. Nationally per person it was 11.4 prescriptions consumed at an average cost of $69.90. I have studied the pharmaceutical market at all levels for 30 years. The alleged impact in cost savings in the report that has been circulated to you (the Flynn report) really is not consistent with economic complexities in the US pharmaceutical market and does not compare with the experience we see in data in other countries similar to what you are contemplating. A basic assumption says the average savings North Dakotans would receive from a Wal-Mart pharmacy would be significant, averaging $16.90 per fill. That is not going to happen. That data was drawn from 17 hand-picked prescriptions. It's not a representative sample and you cannot draw conclusions from that set of 17 prescriptions per when there are 30 to 60,000 that could have been examined. As far as I can tell the comparisons were made to 1 pharmacy in ND and 1 in MN. That one pharmacy is hardly representative of the whole 148 in your state. The math in the Flynn report just does not add up. The numbers do not add up. Most of Europe has ownership laws similar to what you have in ND. A couple of countries have deregulated within the last decade and expected the same kinds of things I'm hearing here. What happened when they deregulated in Norway and Iceland they experienced rapid horizontal integration. Pharmacies banded together or chains coming into their market and building up. By 2004 they have extreme concentration of power in the marketplace. Two or three companies dominated the market and you no longer have competition or a free market. If you do make this change, know that it is irreversible.

Harvey Hanel, pharmacy director for Workforce Safety and Insurance, testified neutral on the bill. **(Attachment 23)**

Representative Kasper: It appears that under the Wal-Mart $4 generic plan you paid additional.

Hanel: We get paid on the usual and customary of that particular pharmacy. We adjudicate that based on our fee schedule which goes before public hearing. What we pay would be lesser of the fee schedule or the usual and customary. In the vast majority of cases, that usual and customary is above the fee schedule so we adjudicate it down to what our fee schedule price is. There is no billing either to the employer or the injured worker for that difference in price.

Representative Kasper: Could you add up for the Committee the totals of each column in each chart. It would be interesting to see that.

Hanel: I can do that and provide it to you.

Wal-Mart Representative: We currently have no pharmacies in ND and do not have an agreement with WSI right now. Overall the $4 generics are about 40% of all the scripts that we fill. The few instances are those that get scripts in ND and filling them in MN. I would also point out that it doesn't sound like prices were checked on CVS, Shopco, and Pemida, Walgreens or any of the other industry leaders that are offering these programs.

Student of Pharmacy (no name given). Am I supposed to expect that these corporate entities' main concern is patience access and patient care? I understand that everyone has to make money in business. These corporations do not swear the same oath pharmacists swear: to protect the health and the safety and the welfare, including economic welfare of our patients. My concern is that if we open the floodgate, that's going to impact our patients.

Fred Stoskopf: ND is unique; we have some things that are unique: Bank of ND, State Mill and Elevator. Obviously the 51% pharmacy law is the only one in the nation. We also have farming that must be family. For about 5 years my wife was on the Lipitor medication. Every 100 days she got a bottle of 100 days of 10 milligrams. After a while I went on the same drug. I shopped around and settled on an independent pharmacy. In a few min he came back with 50 pills, 20 milligrams. He broke the pill in half and told me it was much cheaper. The amounts involved for my wife and me for a year and in 2007 we saved $136.51. The independent pharmacist did something for us to save us money. The others were happy filling the script as the written. They enjoyed the $136.51 a year—we didn't. There is so much hype about the 4$ drug. I checked out one that I take. The last time I got it, I paid $8 and at Wal-Mart it would have been more. Some years ago, Wal-Mart wanted to start banking. They got their bank—it's in Mexico. They only pay 1% interest; most Mexican banks pay 2%. Wal-Mart's annual rate for consumer loans is 75%. This is not what we want in ND. If they drive out other pharmacists, we will be at their mercy so they can make the money.

Larry Gauper: I have no vested financial interest in this except as a consumer. Everyone one of the pharmacists that are opposed to the repeal do have a vested financial interest in this. I would like you to remember this when you consider the bill. There is no mandate in 1440 that says you have to leave your present drug store. What is important to me, living in an urban area, is attracting business from around the country like Microsoft and have choices available as in forty-nine other states. My doctor not my pharmacist manages my care. If I take my script to MN, I will pay $4 for that script because my co pay is $20. They will not balance bill Blue Cross/Blue Shield for $20. I save myself $16 and I save Blue Cross/Blue Shield $20. I don't see price fixing coming. Let's not do this. If I were a carpenter and this

law was in effect, Menards wouldn't be here, Lowes wouldn't be here. It's time this Legislature started acting like the free enterprise people I know you are.

Maari Larsen Loy, pharmacy student at NDSU, testified in favor of HB 1440. (Attachment 24)

Becky, Wal-Mart worker from Grand Forks: I answer the telephone at Wal-Mart and when they ask for the pharmacy and I tell them we have none, they tell me we have just lost their business.

Joe Schneider, from Dickenson, provided testimony to the Committee. **(Attachment 25)**

Chairman Keiser closed the hearing of HB 1440.

Not speaking but providing testimony to the Committee:

Name	Attachment
Erika Kallenbach, pharmacy student	26
Bob Treitline, Dickenson ND	27
Katy Boyer, Fargo ND	28
Crystal Toman, registered pharmacist	29
Ross Ebel	30
Ramona Danks	31
North Dakota Farmers Union	32
Tom Woodmansee, ND Grocers Association	33
June Enget, Powers Lake ND	34
Mike Rud, president of ND Retail Association	35
Terri Torgerson, Max ND	36
Brandie Hagert, 3rd year pharmacy student	37

Name	Attachment
Clarence & Debbie Olson, Fargo ND	38
Arnold Thomas, president of ND Health Care Association	39
Lisa Beine, administrator, Napoleon Care Center	40

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **HB 1440**

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: **February 9, 2009**

Recorder Job Number: 9000

Committee Clerk Signature

Minutes:

Chairman Kaiser opened the hearing of HB 1440. I have invited people here to respond to statements made in the media or in testimony that I want to clarify. We will start with WSI.

Marsha Buchwitz, WSI, appeared to provide information to the Committee. WSI has not taken a position on the bill. She distributed a list showing the price they paid for Wal-Mart's advertised $4 generic drugs and what were paid for them at comparable ND pharmacies.

Chairman Kaiser: This is not a true comparison as the days supplied varies.

Buchwitz: When we did the actual dollars (at the bottom of the column) we compared those that had like quantities. The only ones reflected in the total are exact matches.

Representative Kasper: Is there laws that say if Wal-Mart says these are $4 generics are they supposed to be billing WSI $4.

Buchwitz: That would be a legal question and I'm not sure I can answer that. The Wal-Marts that we have receipts from in this time frame represent about 9 different states.

Sparb Collins, PERS: Like WSI, PERS is neutral on this. However during the last couple of years we have been aware of this issue and did request some information from our carrier Blue Cross/Blue Shield for our education. He discussed a Board Memo **(Attachment 2)** that showed a possible savings and a very low actuarial savings.

Representative Kasper: Who is the PBM for the ND PERS fund? PBMs set the price on what they will reimburse for prescription drugs and what they require as co-pay.

Collins: We are under a fully insured contract with Blue Cross/Blue Shield so they contract with the PBM and that is Prime Therapeutics. The co-pays are set by the plan. It is my understanding that they have set rates with the pharmacies.

Representative Kasper: I would assume that if Wal-Mart were selling drugs in ND I would assume the PBM would negotiate a reimbursement schedule with them as they do with anybody else.

Collins: I'm not sure. We assume so.

Chairman Kaiser: Did you look at this chart from WSI and look at charge rates that aren't on the $4 list and determine if there were savings to be found there?

Collins: I can't answer that. We just asked the question "what would be the potential?" This is the answer we got back. We didn't explore it further.

Representative Kasper: What we have learned is the $4 generic fill with Wal-Mart has a limited number of drugs on that menu. From some of the emails I've been getting a lot of those are older, not very expensive drugs not even used a lot? Does this memo assume that all of them are on that $4 generic?

Collins: Keep in mind this memo is dated November 2007. I assume he used the list available at that time.

Chairman Kaiser: I'm curious that PERS would take a neutral position on something that there data says would save them money.

Collins: There's a whole series of opinions on this. The board ultimately decided that you are taking a look at this and the employers pay the majority of the premiums and this would be the

appropriate forum for it to be discussed. The board also heard from the Pharmacy Association and they pointed out a lot of issues.

Representative Kasper: I recall that there was an announcement that in the PERS plan about $1million would be saved. Did that come from your office?

Collins: That's this information. If you took the amount per quarter times four you would get that figure. What we were doing was sharing the information we had.

Rod St. Aubyn, representing Blue Cross Blue Shield of ND: At your request I garnered some information for you. **(Attachment 3)**

Representative Kasper: Do you know the percentage of generics used in your plan.

St. Aubyn: If there is a generic version of a drug, we have a very high percentage of use of that. Doctors and pharmacists are really good about steering people toward them. I would guess 60%. I have some exact figures I could furnish.

Representative Kasper: If this law would pass and Wal-Mart opened their drug stores, what would be the process that the PERS PBM would go through to negotiate the reimbursement schedule with Wal-Mart.

St. Aubyn: Wal-Mart is already a participating provider. We do not have individual rates for each pharmacy. We have a fee schedule and they accept that or elect not to. We do offer a fee schedule that is a little higher for the rural pharmacies. There is also a deeper discount for Prime National. Pharmacists may be signing more than one contract through Prime.

Chairman Kasper: If Wal-Mart opens a bunch of stores and Prime already has a contract with them for 10% off the basic price and your PBM negotiated rate with privately owned pharmacist is 15% off, would it not be incumbent upon Prime to negotiate with the local pharmacist to lower their rates.

St. Aubyn: I'm not sure I understand that question. It's a what if situation that doesn't exist. We do have a deeper discount from most of the other states they offer a Prime National contract that the ND pharmacists generally would not accept.

Chairman Keiser: The assumption is being made is that if the $4 generic program were available in the state, the 15% of the market that currently uses generics would take it and that would generate a $1.3 million savings. Is that correct?

St. Aubyn: That is correct. You have to understand those savings is split between what the plan actually saves and the member saves. Based on the experience we have seen so far, the split is about 50/50.

Chairman Keiser: I had asked someone from the hospitals to be here. I wanted them to tell me how they would deal with taxes, overhead, etc. That's a real concern I have about this legislation. It makes them eligible for an additional subsidy from the state of ND. I would like someone to explain the $4 prescription plan—how does it work?

Ryan Horn, Wal-Mart: It's for a 30 day supply and its $10 for a 90 day supply. It's a cash price. There's no reimbursement required. Whether or not your insurance company covers any of that cost is dependent upon the specific plan. In most cases it will not because in most cases the cash price is simply cheaper than the co-pay in most circumstances. Only if your co-pay is a percentage of the cost will your insurance pay any of it. So your out of pocket will be less than $4. If the cash price is less than the co-pay, the insurance company does not get billed and you simply pay $4. For the uninsured this is simply the cash price. Some pharmacy plans the co pay is a percentage. If your co-pay is 25% and you get a $4 drug, you pay $3 and your insurance pays $1. The pharmacist handles the paperwork.

Representative Kasper: You saw the WSI handout. You said on the $4 there is no billing to the insurance company. This data shows different.

Horn: We have been taking a look at this. In short, there is just not enough information for us to respond. All we have on that data is the drugs and the days. We don't know what state they were billed in. There is simply not enough information.

Chairman Keiser: With HEPA we cannot give you very much. The real question is that if this such a standard policy, why does it happen? The data from WSI says the $4 drug didn't happen.

Horn: We need to find those transactions. This is something we take very, very seriously. We don't know which of those drugs are in which states.

Chairman Keiser: We have been talking about average prescription prices. Do you have the average prices for Montana, South Dakota and Minnesota?

Horn: I don't have it for those states. Our average pharmaceutical price nationwide is $40.66.

Rod St. Aubyn: We will pay at the lesser price. If their bill charge is actually less than the fee schedule or the fee schedule whichever is less.

Representative Kasper: Do you know the price that Prime Therapeutics charges the PERS plan when people go to mail order compared to the price you would pay the local pharmacist for the identical drugs? Are the Prime prices lower than the local pharmacist? Is that why you drive them to the 90 day mail order?

St. Aubyn: We don't drive them to the mail order. You can get the same option at the local pharmacies. I will find out if they are less?

Chairman Keiser: Given that we are going to save $6 million, what's going to happen to premiums?

St. Aubyn: It is just applied to the overall cost factor. We spend $25 million a week on claims. It is relatively small overall.

Mike Schwab, executive vice president of the ND Pharmacists Association, provided additional comments. **(Attachment 4)**

Chairman Keiser: The cost that Blue Cross Blue Shield shows is not in terms of the cost of the drug itself, but the difference is primarily the reimbursement rate which providers are willing to sign a contract for. Is that true?

Schwab: Yes. Maybe some of the pharmacists could answer the question with regards to the direct contracting methods used and if those are actually negotiable.

Chairman Keiser: Chip (Thomas), the hospitals that currently have commercial pharmacies in them, are they paying property taxes, insurance premiums and are the administrative costs included in the hospital's administrative cost or they segregating 100% of the operations of the business and making it taxable in every way possible?

Arnold Thomas: That question was asked during the interim and I had legal counsel respond. I would be happy to make that available to the Committee.

John ___?__, legal counsel: I don't know but I can assume most hospitals and there are 6 that are grandfathered in this situation so I will only talk about six. All, I believe, are associated one way for another with for profit ventures so they treat the pharmacy revenue in a manner consistent with the way they treat their other for profit entities. I have no personal experience with that so I cannot attest to that. That is my assumption.

Gary Boehler, Thrifty White Drug: After hearing the testimony from earlier this morning, I have a couple of comments. The first has to do with contracting with the PBMs. Standard, boiler-plate language when you talk about the rates of reimbursement is that we must submit usual and customary price and that's how that pricing coming back to the pharmacy will be provided. It's usual and customary or the contracted rate whichever is less. The second is the comment that Spark Collins had—assuming that there was a 100% fill rate of the $4

generics with Wal-Mart that's where that $240,000 savings would come in. When you look at SD Medicaid, Wal-Mart has about a 10% market share. In ND when Human Services attached a fiscal note, the assumption was made that the market share would be about 15% for all the big chains coming in and since CVS and Walgreens have their own club program, those numbers would not apply because they wouldn't be a participating factor. That 15% would probably be reduced by at least half if not more. I would question if that fiscal note would be that high.

Chairman Keiser: There is a national contract rate that can be signed. ND providers have in many cases chosen not to sign the national but a different rate. Is that accounting for the difference in the BCBS chart?

Boehler: I think that the comparison is being made against the reimbursement rates that are available today in the state versus what Prime Therapeutics' national contract rate is. I can also speak to the 90 day contracts. They are so predatory that you can't make money on them. They all whip rates below what we are able to purchase the drugs for. Hence, the reason a lot of this is being pushed to their mail order facilities. A local independent today simply cannot afford those rates—you fill below your cost.

Representative Kasper: When you negotiate with Prime Therapeutics for contracts in ND is there any negotiation or how does that process work? Do you have any room or is it a take it or leave it offer.

Boehler: Generally it's a take it or leave it. Rural pharmacies may get better rates. We have 7 rural locations and I don't get any better pricing in any of those rural locations.

John (legal counsel): I may have misspoken before. All of those 6 pharmacies should be done as for profit. It is my belief they all segregate that for tax purposes.

Representative Nottestad: What about clinics? For example, Altru in Grand Forks where the doctors own the pharmacy. Is that taxable?

John: That pharmacy is a strange abrogation. It is owned by physicians who are not operating not-for-profit fashion. They have to be running that pharmacy as a for-profit entity.

Ryan Horn, Wal-Mart: I would like to comment about selling drugs below cost. That's a serious charge and is against the law in virtually every state. We do not sell these drugs below cost. We sell these drugs above cost and take a small margin. It has become an industry standard by other chains in all states.

Representative Kasper: Does Wal-Mart own their own PBM?

Greg McGinnis, director of public affairs, Wal-Mart: In the state of ND, Wal-Mart contracts with an independent third party called Third Party Solutions. They provide our billing to WSI. As far as nationally, I don't have that information with me.

Representative Kasper: Does Wal-Mart receive rebates on drugs sold either in ND or nationally and if you do, what are you doing with those rebates as far as crediting back to the plan or the consumer.

McGinnis: We do run pharmacies in ND and nationwide we do not receive rebates for our generic brands. We do not work with PBMs nationwide and do not receive rebates for $4 generic drugs. We do receive rebates on our brand name drugs.

Representative Vigesaa: For Ryan—back on this WSI pricing. The $4 program is that nationwide or do you decide state by state which drugs are $4.

Horn: We rolled it out state by state. It is now in 49 states.

Brandon Joyce, pharmacy administrator for ND Medicaid, testified neutral. **(Attachment 5)** When we developed the fiscal impact for David Flynn, we compared the best information we had at the time. We presumed there would be about a 15% market share and evaluated

based on most recent pricing of generic drugs we could find at that time. I believe it was about October when we ran the analysis. We have since found that Wal-Mart has 8.5% of Montana's Medicaid. In SD they get 2%. We base our 5% between those two.

Representative Boe: Where did you come up with the 15%?

Joyce: We talked to other states. We just looked at it as chains in general.

Chairman Keiser: Would you explain the general/federal.

Joyce: The total is what goes out the door. The general is the state Medicaid, the federal is the federal matching funds.

Tony Weilder, Bismarck Pharmacist: I couldn't let that predatory pricing thing go the way it was. If you take a product off the shelf—if someone comes in to my pharmacy and buys a bag of cough drops that's the net price that I can make a profit on. A prescription is totally different. When you get that prescription you have to process it in to something the patient can use. That takes counting, running it through a computer, doing some billing, or sometimes you dispense partial bottles. The national average of the cost of dispensing a prescription is anywhere between $9 and $10.50. So if someone says they are dispensing a prescription at $4 and making money on it, I question that.

Hearing closed.

Not attending, but providing written testimony in opposition to HB 1440:

Cari Wiest, pharmacist in Wishek and Napoleon ND. (Attachment 7)

Later on that same day, Chairman Keiser opened discussion of HB 1440.

Representative Schneider: I passed around an amendment. What my amendment does is creates a rural pharmacy grant program to help encourage pharmacists and municipalities to open pharmacies in rural North Dakota. The grant program provides up to $50,000 per

applicant not to exceed five applications annually. This was drafted similarly to what we already do for dentists. I think everybody's concern is for rural pharmacies in ND. There are arguments made that 1440 helps or hinders that issue. This grant program most certainly does. The funds would come out of the community health trust fund. It would be $500,000 biennial appropriation. The grant does hold that the community must provide at least 50% match for the grant and the state health council would outline the provisions and qualifications for who could receive the grant money.

Representative Kasper: How does this coincide with the bill before us? Many people think the bill before us as you heard testimony will impact negatively rural pharmacies. We have a problem in rural ND admitting what the opponents of the bill are saying and now we put on a bill to help access to rural pharmacies which the opponents say we are going to lose rural pharmacies. To me this is not germane to the bill at all or the question on the bill.

Representative Schneider: It is absolutely germane. Reasonable arguments could be made on both sides whether 1440 helps or hurts the rural pharmacies. Personally, I think it helps. It buys more flexibility for communities, for nursing homes, for hospitals, and for clinics to open up pharmacies in rural ND. This amendment was drafted as a result of hearing all the testimony and concerns of the opposition to help incentive rural pharmacies to open up. If you are a pharmacist or a small community and lost your local pharmacist to retirement, the cost of establishing a new business is extremely expensive. We dealt with this issue for the dental profession in ND. This grant program will go a long way to address rural pharmacy access issues.

Representative Boe: How many dollars are in this fund from which we are going to be taking this $500,000 out of?

Representative Schneider: I don't know the answer to that. Jennifer Clarke from LC is the one who drafted this amendment and perhaps can answer that.

Representative Amerman: Under number 4 requirement, the 5 mile territorial boundary is that the city limits or is that 4 miles those larger cities have as far as their control?

Representative Schneider: I believe it would apply to the area that they have control over.

Chairman Keiser: This can be used for buildings, equipment or operating costs. Would there be anything it wouldn't cover? So this designed to be very broad in its application.

Representative Schneider: The goal is to encourage people to establish pharmacies in rural ND. With or without the passage of 1440, it's an issue that we are experiencing.

Representative Ruby: Even with the existing law, pharmacies in rural areas struggle. They have issues where they look for buyers and there is no one to buy it. I think he is definitely on to something.

Chairman Keiser: On subsection 2, page 1, I would like you to consider a number 5 "which may not compete with an existing pharmacy." I think it would be an unfair situation if there were a pharmacy in say Lincoln and then someone gets a grant to establish another pharmacy in that community. I think that would be not proper.

Representative Schneider: I would agree. That plays right in to that.

Representative Nottestad: Here it speaks about a pharmacist must be on duty. Does this mean in a community where they have already set up a telepharmacy?

Representative Schneider: I suppose that would be left to the determination of the state health council. The factors listed here must be included. Certainly the health council could look at more.

Representative Boe: On the recommendation of the competition clause, how do we define whether or not they are truly competing?

Representative Schneider: I suppose that would be up to the state health council to determine that.

Representative Johnson: This is an interesting grant program. I wish it would have been a standalone bill so we could have debated it and had the council come in and find out the needs.

Representative Schneider: A member of the pharmacy profession would please comment when they have a chance to look at it.

John Olson, representing the Independent Pharmacists: If you put this into this bill right now to try to "buy off" what the intent in. Opposition to pharmacists is not where we are at in principal. Where we are at in principal is the fact we don't want to compromise the pharmacy profession in ND. We don't want to compromise the arguments that we made on what kind of big box problems are going to come into the state. That issue is not addressed in this amendment. Our position is we are opposed to the bill and this is not going to improve it. I think it is undermining the process that we have had as we have gone forward on both sides. I don't think we should be changing the base here. I agree with Representative Johnson, kill the bill, hog house it and put this amendment on.

Representative Ruby: John, are there any ways the pharmacists or especially the corporations that currently have the carve outs the existing law, are there any programs they have to assist communities with pharmacies.

Olson: You would be better off asking that of the pharmacists that are in the field. I think we presented testimony that there are a lot of things being done in pharmacy in ND right now—rural and urban by our pharmacists.

Howard Anderson: We have some loan repayment programs administered through the health council. We have them for nurse practitioners, for physicians, for veterinarians, and for

dentists. Those are loan repayment programs for professionals going to our rural communities. This is a departure from that. Here you are talking about a business. I would say if a pharmacist is willing to go to a rural community we would give that professional some loan repayment program. We did have a bill like that a couple of years ago. I don't know that we have to depart from what we are doing now and say we are now going to give businesses money. We work hard now when a pharmacist wants to retire and wants to sell his business in contacting other pharmacists. I also talk to people who are interested in telepharmacy. We work very hard at this in an unofficial manner.

Representative Schneider: If this bill were to pass, would you prefer that the amendment be on there or not?

Olson: The Board of Pharmacy is not in favor of the bill and to put something on that you like on a bill that you don't like is not a good legislative strategy.

Representative Ruby: One of the things we heard a lot last week was that the reason to keep the law the way it is that one-to-one relationship with the pharmacist who has the care not just for the bottom line but for the customer. In a situation like the Garrison pharmacy hiring someone to run the operation in Kenmare, how is that different than another company hiring a pharmacist?

Olson: It makes all the difference in the world because as you know with a corporation the guy who controls the purse strings controls the policy. If you have the 51% control then you make the decisions for that other pharmacy that you own.

Representative Thorpe: I would **move the amendment (28291.0101) adding a non compete to subsection 2.**

Representative Schneider: Second

Representative Kasper: I served on the interim IBL Committee. We heard since September or August the battle of the pharmacy ownership and other things having to do with pharmacies. We had at least a month of open debate throughout the state where millions of dollars have been spent on one side compared to hundreds of thousands on the other side to try to pass 1440. The proponents have realized the bill is going to go down in flames. Now to come in at the eleventh hour and propose an amendment that is not germane to the bill and has no business in the bill to try to save the bill. There is a saying that we had during the presidential campaign: "you put lipstick on a pig, you still have a pig." I hope you resist this amendment. The dialog and the debate has been nothing about this. To come in with this at this time to try to save the bill is wrong and I hope you vote this amendment down.

Representative Schneider: This amendment is timely. There is a concern we all share about rural access to pharmaceuticals and this amendment makes the bill better. It will provide incentives to open up pharmacies in rural ND. In my mind that's a good thing. I'm certainly not going to discourage it.

Representative Amerman: My thoughts are that this is a good idea and as a standalone bill would have more merit to me. If this law passes and the pharmacists that are out there, and I won't say for sure, over time might disappear. If I were a pharmacist looking to set up a business, I certainly don't think I would go to the small districts of ND because I don't think this will be enough incentive.

Representative Boe: I agree. This should be standalone. There is a vehicle to bring this forward in the future and I hope that everybody that supports it now will support it in the future. I am going to resist putting this on this particular bill.

Chairman Keiser: I don't want this to affect your decision; I just want to review the process. Adoption of this amendment does require it to go to appropriations. One never knows what

appropriations will do with the bill. They are not likely to support this, but they might. It does delay consideration for all parties involved. Appropriations might hold this bill for quite a while just because they have so many bills in front of them and it's coming in late. It's a great concept. We don't know what the impact on the community health fund would be and whether the dollars there or what the dynamics are. It's over the limit and appropriations would have to take a look at it and see if it's practical, possible and desirable.

A roll call vote was taken on the adoption of the amendment: No: 9, Yes: 4, Absent 0.

The amendment fails.

Chairman Keiser: We have the HB 1440 before us. What are the Committee's wishes?

Representative Kasper: I move **Do Not Pass.**

Representative Nottestad: Second

Chairman Keiser: The time is here Committee members. We can't delay it any longer. I do want this opportunity to thank all the people in this room that have participated to make it as information as possible. It is a difficult decision for every member on this committee. If we could back two months and ask the Committee do you want this in this Committee or another Committee—that vote would be unanimous and I know what it would be! This is a very, very difficult vote but I have full confidence that everyone will vote their true conscience and feelings on this bill and that following the vote there is no personalization. Everyone has an absolute right to their position on this legislation.

A roll call vote was taken: Yes: 8, No: 5, Absent: 0

HB 1440 Did Not Pass. Representative Johnson will carry the bill.

98291.0101
Title.

Prepared by the Legislative Council staff

February 9, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1440

Page 1, line 1, after "to" insert "create and enact a new section to chapter 43-15 of the North Dakota Century Code, relating to a rural pharmacy grant program;"

Page 1, line 2, after "pharmacies" insert "; and to provide an appropriation"

Page 2, after line 28, insert:

"**SECTION 2.** A new section to chapter 43-15 of the North Dakota Century Code is created and enacted as follows:

Rural pharmacy grant program.

1. The state health council shall establish and administer a rural pharmacy grant program that provides grants to qualified pharmacists and to qualified cities and organizations.

   a. A pharmacist who met the educational requirements of section 43-15-15 within the previous five years may submit an application to the state health council for a grant for the purpose of establishing or purchasing a pharmacy in a community that meets the requirements of this section.

   b. A city or organization may submit an application to the state health council for a grant under this section for the purpose of establishing or purchasing a pharmacy in a community in the state which meets the requirements of this section.

2. The state health council may award a maximum of five grants per year and shall establish the criteria for the grant program under this section which must include:

   a. A maximum grant award of fifty thousand dollars per applicant;

   b. A requirement that the community in which the pharmacy will be established or purchased:

      (1) Shall provide a fifty percent match for a grant;

      (2) Must have a defined need for the services of a pharmacy;

      (3) Must have a population that does not exceed seven thousand five hundred; and

      (4) Must be at least five miles [8.05 kilometers] from the territorial boundaries of a city with a population that exceeds seven thousand five hundred;

   c. A requirement that a recipient of a grant under this section shall use the funds for buildings, equipment, or operating expenses or for any combination of these purposes;

d. A requirement that a city or organization that receives a grant under this section shall employ a pharmacist;

e. A requirement that a pharmacist selected for a grant under this section shall commit to practice in the community for a minimum of five years; and

f. A provision that the grant must be distributed in equal amounts over a five-year period.

3. The state health council shall apply the following selection criteria in determining whether to award a grant to an applicant in a community:

a. The size of the community, with rural communities with a population that does not exceed two thousand five hundred given the highest priority;

b. The number of pharmacies in the community and surrounding area;

c. The access by community residents to pharmacies in the community and the surrounding area; and

d. The degree to which the community residents support the addition or the retention of a pharmacy within the community.

4. In evaluating a community under subsection 3 for participation in this program, the state health council may consult with public and private entities and may visit the community.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the community health trust fund in the state treasury, not otherwise appropriated, the sum of $500,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the rural pharmacy grant program as provided under section 2 of this Act, for the biennium beginning July 1, 2009, and ending June 30, 2011. Section 54-44.1-11 does not apply to the appropriation provided by this section."

Renumber accordingly

Date: Feb 9 - 2009
Roll Call Vote # 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1440

House House, Business & Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98291.0101

Action Taken ☐ Do Pass ☐ Do Not Pass ☒ As Amended

Motion Made By Thorpe Seconded By Schneider

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		✓	Representative Amerman		✓
Vice Chairman Kasper		✓	Representative Boe		✓
Representative Clark		✓	Representative Gruchalla	✓	
Representative N Johnson		✓	Representative Schneider	✓	
Representative Nottestad		✓	Representative Thorpe	✓	
Representative Ruby	✓				
Representative Sukut		✓			
Representative Vigesaa		✓			

Total (Yes) 3 No 10

Absent 0

Floor Assignment [redacted]

If the vote is on an amendment, briefly indicate intent:

Date: Feb 9 - 2009
Roll Call Vote # 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1440

House House, Business & Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☒ Do Not Pass ☐ As Amended

Motion Made By Kasper Seconded By Nottestad

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe	✓	
Representative Clark		✓	Representative Gruchalla		✓
Representative N Johnson	✓		Representative Schneider		✓
Representative Nottestad	✓		Representative Thorpe		✓
Representative Ruby		✓			
Representative Sukut	✓				
Representative Vigesaa	✓				

Total (Yes) 8 No 5

Absent 0

Floor Assignment N Johnson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1440: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO NOT PASS** (8 YEAS, 5 NAYS, 0 ABSENT AND NOT VOTING). HB 1440 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

HB 1440

HB 1440
Testimony of Tammy Ibach
February 3, 2009

Chairman Kaiser, Chairman Wiesz and members of the IBL and Human Services Committee

My name is Tammy Ibach.
I am the coalition manager for North Dakotans for Affordable Healthcare.
We are a collective voice of consumers from all legislative districts throughout the state speaking out in favor of HB 1440.
There are many members of our coalition here today and you will hear some of their stories – the stories that motivated them to take action and be heard.
The stories we have heard at North Dakotans for Affordable Healthcare are compelling and real – stories about your neighbors who drive miles to save money.
Stories from medical professionals who understand patients quality of life can be better - if they take their medicines because they CAN afford them.
You will hear from a city council member from Beulah who believes free enterprise is good for competition.
The people here today are citizens taking part in a legislative process – they are customers of Thrifty White Drug and other local pharmacies – they are people who just want a fair price.
The Fargo Forum newspaper wrote on Sunday "The claim 70 independent drug stores would close is baseless." And today you will hear that ordinary North Dakotans are saving real money shopping outside the state of North Dakota.
The passion of this coalition started with the passion inside of me. I work on projects that I believe in and have experience in. The medical issues and prescription drug hassles that I have experienced in the last three years has been an eye opener. As many of you know, moms and women in general are the healthcare conduit in all families and when family members fall ill, the care is generally placed in the hands of women.

Please vote yes on HB1440 to help the **600,000** residents of North Dakota have a better quality of life, save money and live healthier lives.
You will now hear testimony from my son Jakob – and his personal story on why he wants HB 1440 to pass. Jakes story is about drug access and convenience in a hospital setting and saving money on his routine medicines.

Testimony from Jakob Olson

Chairman Kaiser and Chairman Weisz and members of the committee:
I am Jakob Olson. I am nine years old and have had 7 surgeries. I also have asthma and allergies. Just a few months ago, I was taking a lot of medicine.

My mom talks about this project so much at home that my dad started to call it the Jakob Bill. I don't really know what that means, but my mom told me she wants this law changed and it's because of me and other moms who are busy taking care of their kids.

You see, three of my seven surgeries have been at Children's Hospital, in Minneapolis and when I am there, my doctor, Dr. Nissan, has all of the pain medicine and my other pills ready for me in a bag when I leave the hospital. Then my mom can just get me back to the hotel. She doesn't always know her way around!

After surgery I can't walk, so my mom is really busy taking care of me and she wouldn't have time to get to the drug store to get medicine in Minneapolis. That's what we really like about being in Minneapolis- the doctor just gives my mom the medicine I need.

My mom is busy taking care of me and she has to take care of my dad too because he has bad hips and has had lots of surgeries too. When he has surgery in Bismarck, my mom has gotten really smart, she asks the doctor for the drugs so she can pick them up before she gets dad – because he can't walk after surgery either!

I guess this law prevents hospitals from giving moms the medicine they need to take care of boys and dads too!

I think if you change this law, it would make it easy for kids and moms in the hospital just like in Minneapolis and I know one of my medicines is already less expensive at Walmart. It's only $9.00 for my inhaler at Walmart compared to $18.00.

Thank you.

Testimony of Roger Nitschke, Ashley

Chairman Kaiser and Chairman Wiesz and members of the Industry Business and Labor and Human Services committee, I am Roger Nitcke from Ashley.

A few years ago I sold my family farm and in 2007 my wife and I we went to Virginia to take care of our grand child while our daughter was sent to the Persian Gulf – she is career Navy. During our stay there, I decided to find a job which wasn't easy for a guy like me who's only job was farming.

But after a few tries I landed a good job at Home Depot –a job I really liked because it had health insurance and prescription drug coverage. Good for me I thought.

While in Virginia I learned many other "box stores" offered lower prescription drug prices and I said to my wife, North Dakota must have that by now!

When my daughter returned from the Persian Gulf we knew it was time to get back to Ashley and our home. I was looking forward to coming back and knew I could transfer my job to Home Depot in Bismarck. That a lasted a short time.

Now here I am 61 years old and getting my own health insurance again. Now that I am self insured again, I am paying very close attention to all my medical expenses. I have been taking a drug called Gabapentin – this is for my nerve condition.

I was paying $107 dollars to have my prescription filled at the north Dan's location while working in Bismarck and knew it was outrageous. I was talking to my brother about how expensive this medicine has gotten for me and he told me he gets all his medicines filled at ShopKo in Aberdeen South Dakota.

So I took my brothers advice and drove the 72 miles one way and discovered the same drug, same prescription will only cost me $36.00. **Now you tell me, how can the same drug cost $70 less 72 miles down the road?**

One time the nurse in Ashley even called the KMART in Aberdeen to see what the price was for my medicine. How nice is that? ShopKo still had the best price.

For a man without a job, that's $840 a year I get to keep– and I don't even have to drive, I just call the 800 number and they send it to me POSTAGE PAID. How nice is that?

This law must be keeping drug prices higher in North Dakota. I tell everyone about the savings I get from ShopKo in South Dakota, a "big box" store and I wonder how many others there are that driving to save money!

I think my story is becoming more and more common. There are people like me living in every town like Ashley. Please, help us help ourselves.

Testimony on behalf of HB 1440
Darwin Reinhardt

I am Darwin Reinhardt from Beulah. I am here in support of House Bill 1440 and the repeal of the pharmacy ownership law.

I have lived in Beulah all of my life and I firmly believe small town pharmacies will not close if you change this law. I have not seen or found any evidence that proves this arguement. One would have to assume all of us small town folks would drive 60 plus miles for our medications. This simply will not happen. There are those who have already found ways to find cheaper prescription drug prices and they currently do not support their local pharmacist because of that reason. I for one am not willing to drive – but I would welcome the opportunity of mail order or internet pharmacy sales.

The town where I live may even gain a pharmacy – now that would be considered economic development by many of us. It has been long enough where independent pharmacists have profited as a protected group – 46 years to be exact.

Contrary to what I have been seeing in the TV ads, local pharmacists don't dispense medications. Where I live, the tech does that. The independent pharmacists are busy managing their business. These TV ads also tell us that patient prescription oversight would be compromised by a big box pharmacy. What a bogus argument. All pharmacists abide by a code of ethics as set forth by the board of pharmacy. Why would anyone believe that a pharmacist employed by Walgreens is any less professional than a pharmacist employed by Thrifty White Drug.

I am proud to have joined North Dakotans for Affordable Healthcare and will work with them until this law is repealed. I am asking you to vote yes in support of HB 1440. Thank you.

5A

Kim Christiansen, R.Ph.
Bismarck, ND
Testimony in favor of HB 1440

Chairmen Keiser and Weisz and members of the committees, I am a pharmacist and a consumer who is supporting the repeal of the pharmacy ownership law. I am frustrated with the stranglehold the Board of Pharmacy and leadership of the ND Pharmacist Association have had on the consumers and pharmacists of our state for 45 years. They have successfully limited every one in the state from choosing any new corporate owned pharmacy services provider.

I am especially concerned about the claims opponents of this bill are making about the effect this change will have on rural pharmacy services.

While I appreciate the challenges of rural pharmacies, it is unlikely rural pharmacies will close as a result of the loss of business to corporate owned pharmacies. If you were to ask most rural pharmacy owners to list the biggest threats to their existence, they would name three things:

1. Loss of population.
2. Inadequate levels of reimbursement from third party payers, like Medicaid.
3. And the lack of young pharmacists willing to practice and purchase pharmacies in rural areas.

Rather than asking the legislature to protect them from competition, I believe the independent rural pharmacists would be better served seeking solutions to the real threats to their existence. I would support them asking legislators for assistance in assuring adequate Medicaid reimbursement and developing a young pharmacist program to help young pharmacists locate in rural communities.

Most of all, I am concerned that urban independent pharmacists are using the rural access issue to deflect the real and most troubling issues of the current law: protectionism.

If the urban independents are truly concerned about the amount of business potentially siphoned from rural pharmacies by these new urban competitors, I have one question for them. Do they turn away customers who present them a prescription to be filled with a Hankinson, Grafton, Mott or Crosby address? Do they suggest the customer return to their rural pharmacy to have it filled?

For the current players to trumpet the evils of this business practice, and not include themselves as co-conspirators, is hypocritical.

I urge you to repeal the ownership law, put an end to this hypocrisy and protectionism, and provide consumers and pharmacy employees the freedoms of choice and opportunities they deserve.

Testimony of Dr. Eric Thompson
Supporting HB 1440

Chairman Weisz and Chairman Kaiser and members of the IBL and Human Services Committee, I am Dr. Eric Thompson a family practice doctor here in Bismarck. Originally I am from Wyndmere, ND, same town as Representative Dotsinrod. Some of you might know him.

I attended medical school at UND and have spent my career as a medical professional in Utah and California.

Here I am, back in my home state now doing what I truly love - seeing patients. But having practiced in Utah for four years, I had grown accustomed to the $4.00 prescription drug plans offered by all the major retailers – so accustomed in fact, that I would discuss the prescription options with my patients since I had the list nearly memorized and if I knew one of the generics would benefit this patient both in treatment and in the pocket book, I would recommend it.

My first few days seeing patients here at home was a real eye-opener – the biggest surprise was finding out that the $4.00 prescription drug plans aren't available here in North Dakota. I knew I had been out of the state a long time, but I didn't think that it had been THAT LONG. Imagine my shock to learn that North Dakota is the only state in the country not offering discounted prescription drug plans. As you know, the pharmacy ownership statue in our state prohibits those types of retailers from operating here. This statue, while probably relevant 45 years ago, is clearly outdated and in serious need of revision. In fact the statue reminds me of the old Sunday BLUE LAW that was eventually repealed. Yes, even doctors work on Sundays -- we work in various "walk-in" clinics or are on call 24/7.

Then along came North Dakotans for Affordable Healthcare with their message and desire to get this archaic law changed. I'm now passionately involved because I know how important it is for my patients to save money on healthcare, specifically on their prescriptions. It's so important in fact that I have suggested to several of my patients, that if they're going to be in the Fargo Moorhead area, you can get this prescription filled in Moorhead for $4.00. I wish I had a picture to show the surprise on their faces.

As a dedicated medical professional I know there isn't a $4.00 script to fit the needs of all my patients, however, over the years, I have found many of the top prescription drugs to be on the list. And over the years, I have had patients who have stopped taking their medicine or cut them in half because they can't afford it.

Let me clear, I respect the pharmacy profession and the extraordinary service they provide on a daily basis. However, as a medical doctor, my first priority is the well being of the patient. And repeal of this old law will help many, many people.

This bill before you today is clearly not about pharmacists or doctors, it's about people, it's about your fellow North Dakotans and their access to affordable healthcare, more importantly, and it's about **access to affordable prescription drugs.** Keeping this law would benefit 158 pharmacists. Repealing this law would benefit 600,000 North Dakotans.

Testimony of Dr. Eric Thompson

Chairman Weisz and Chairman Kaiser and members of the IBL and Human Services Committee.

I am Dr. Eric Thompson a family practice physician here in Bismarck. Originally I am from Wyndmere ND, the same town as Senator Jim Dotzenrod, whom you may know.

I attended medical school at UND, did my residency in California, and have spent my career as a medical professional in Utah, and now in North Dakota

I moved back to North Dakota in 2007 to raise my family and be closer to my own family. After practicing in Utah for four years, I had grown accustomed to the $4.00 prescription drug plans offered by all the major retailers. In fact, I was the medical director of a busy Urgent Care Center and had the list posted for the 10 providers that worked under me. I would often discuss the prescription options with my patients and had the list nearly memorized. If I knew of a generic medication that would benefit my patient both in treatment and in the pocket book, I would recommend it.

My first few days seeing patients here at home was a real eye-opener. I was appalled to discover that the $4.00 prescription drug plans aren't available here in North Dakota. I knew I had been out of the state a long time, but I didn't think that it had been THAT LONG. I was shocked to learn that North Dakota is the only state in the country not offering discounted prescription drug plans. My colleagues in other states could not understand it as well.

As you know, the pharmacy ownership statue in our state prohibits those types of retailers from operating here. This statue, while probably relevant 45 years ago, is clearly outdated and in serious need of revision. In fact the statue reminds me of the old Sunday BLUE LAW that was eventually repealed. Yes, even doctors work on Sundays = we work in various "walk-in" clinics or are on call 24/7.

I was so frustrated that I wrote a letter to the editor in the Bismarck Tribune trying to get North Dakotans to take action. Then along came North Dakotans for Affordable Healthcare with their message and desire to get this archaic law changed. I'm now passionately involved because I know how important it is for my patients to save money on healthcare, specifically on their prescriptions. It's so important that I have suggested to several of my patients, that if they're going to be in the Fargo Moorhead area, they can get this prescription filled in Moorhead for $4.00. I wish I had a picture to show the surprise on their faces. Other patients have learned of this restriction and asked for extended prescriptions to fill out of state.

As a dedicated medical professional I know there isn't a $4.00 script to fit the needs of all my patients, however, over the years, I have found many of the top prescription drugs

to be on the list. And over the years, I have had patients who have stopped taking their medicine or cut them in half because they can't afford it, which compromises their health.

Let me be clear, I respect the pharmacy profession and the extraordinary service they provide on a daily basis. However, as a medical doctor, my first priority is the well being of the patient. Repealing this old law will help many, many people.

This bill before you today is clearly not about pharmacists or doctors, it's about people, it's about your fellow North Dakotans and their access to affordable healthcare, more importantly, and it's about **access to affordable prescription drugs.**

Keeping this law would benefit 158 pharmacists. Repealing this law would benefit 600,000 North Dakotans.

Nov 12, 2007 - 04:04:36 CST

By ERIC THOMPSON
Bismarck

As a physician, I am trained to try to provide the best possible care for my patients.

One of the common dilemmas I face is the cost of medical care.

I have practiced medicine in California, Utah and now North Dakota, and one of the most surprising differences in my ability to care for my patients is the cost of medication.

It seems North Dakota has a semblance of a monopoly on pharmaceutical products. In other states, a patient can save quite a lot of money by getting generic medications at Wal-Mart pharmacies for $4.

However, in North Dakota, there is a law that states pharmacies must be at least 51 percent locally owned.

I understand the intent of the law to limit big corporations moving in, but now that stores like Wal-Mart and Target are already here, why limit them further and force the public to pay more for their prescriptions.

Many blood pressure medications, antibiotics, anti-depressants, among numerous other medications, could be available to patients at $4 for a month's supply. Hearing the struggles with medication costs from my patients, I implore all who read this column to attempt to speak for change in North Dakota law so we can end this medication monopoly and make health care more affordable.

HEART OF AMERICA MEDICAL CENTER
(701) 776-5261 Fax: (701) 776-5448 TDD: (701) 776-5043
800 South Main Avenue Rugby, ND 58368

Testimony on House Bill 1440

A BILL for an Act to amend and reenact section 43-15-35 of the North Dakota Century Code

Erik Christenson, Pharm.D.
Director of Pharmacy
Heart of America Medical Center
Rugby, ND 58368

I wish to share with the representatives of the State of North Dakota my experiences as a pharmacist and how those experiences relate to the pharmacy ownership law as it now reads. I am a graduate of NDSU and I completed a pharmacy practice residency in North Dakota. I have worked as a hospital pharmacist for the last 9 years working at both Heart of America Medical Center and Trinity Medical Center. I have also been a fill in pharmacist for Osco Drug (currently CVS pharmacy), White Drug, and a couple of privately owned pharmacies. My experiences have greatly influenced my opinion of the ownership law.

My primary point of this testimony to highlight the fact that ownership by an individual or company other than a pharmacist in no way affects the quality of care given to a patient.

First of all from a retail perspective, large chain pharmacies normally have more stringent regulations of the need for patient education and communication, compared to the privately owned pharmacies. While I worked for Osco Drug they spend far more time on patient consultation and patient phone contacts than any of the other retail pharmacies I have worked for. We would spend large chunks of each day calling patients to ensure compliance. Osco Drug was also able and willing to hire the staff required for appropriate patient education.

From a hospital perspective there is no doubt that the pharmacists that work for these hospitals and the organizations themselves can provide the patient care required for ambulatory patients. Hospital pharmacists work with every type of patient from the new born neonates in the hospital neonatal intensive care units (ICUs) to the elderly in our swing bed transitional care units. Many hospital pharmacists are trained over and beyond the standard education for a pharmacist, with many completing 1 to 2 years of postgraduate residency training. These very same residency programs, which are mandatory for some hospital positions, are opposed by some retail organizations due to the financial concerns. This extra training better equips these pharmacists for knowledgeable communication with both the physicians and patients and better solidifies the pharmacist's knowledge of drug therapy.

My experience at Trinity and Heart of America hospitals has shown me that hospital pharmacists already perform many of the tasks required for a retail position. While working for Trinity Hospital, pharmacists had to fill all emergency room (ER) prescriptions after the retail stores closed, which was around 9PM, and on many of the holidays. We as hospital pharmacists had to juggle both the critical care issues of the hospital such as the neonatal ICU and the adult ICU and the outpatient prescriptions through the ER. We also had to answer questions regarding medication issues for many outpatients while their pharmacies were closed. I have the same situation in Rugby at the Heart of America Medical Center, where because of the ownership law, our small community owned hospital can not provide outpatient prescriptions for our own patients. This is not because we don't have the expertise to provide the medications, but because we are not owned by a pharmacist. I am conveniently available as the hospital pharmacist over the weekends and holidays, as the hospital never closes. This lends itself to me being the on call pharmacist for the community. Over the past two weeks I have provided medications for three nursing home patients that were not my own because the retail pharmacist was not readily available. I do not mean to degrade the work that retail pharmacists do, but in our situation the hospital pharmacist is suited very well to provide outpatient prescriptions. It should also be noted that if the retail store's emergency stock ever runs out, which it does from time to time, the long term care nurse will pull medication from my hospital stock. Again the hospital pharmacy seems to be the fall back for all mediation needs.

Another side light in this issue is the repackaging of medications for nursing home patients that are not hospital patients. This involves repackaging the patient's home medications into a standard medication dispensing container for the nursing home. Retail pharmacies refuse to repackage any medications that were not filled by their facility. Therefore, they expect the hospital pharmacy to repackage all of these medications whether or not the hospital filled these medications. This can be tricky, as the medication quality and accuracy has to be assured, which can be difficult to do if the medication was removed from its original container. Again if quality is the issue, why can the hospital pharmacies repack medications, but not be allowed to fill for these patients? I know if no satisfactory answer.

It is only fair to allow hospitals, especially those that are community owned, to operate their own retail pharmacies. There is no doubt in my mind what so ever that they can provide the exact same patient care as any other retail pharmacy or organization. Allowing hospitals to open pharmacies on their own campuses would only better the health care services for the communities they serve.

There are many other issues revolving around this law, but I feel that patient care is the primary issue when it comes to health care and in my opinion this law does nothing to enhance patient care. In Rugby, North Dakota there is definitely no benefit from this law.

My recommendation to this congress is to pass this piece of legislation repealing the ownership law.

INDUSTRY, BUSINESS AND LABOR COMMITTEE
HUMAN SERVICES COMMITTEE
Tuesday, February 3, 2009
Auditorium, North Dakota Heritage Center
Bismarck, North Dakota

TESTIMONY OF DR. DAVID T. FLYNN, Ph.D.

Re: HB 1440, Removal of Pharmacy Ownership Restrictions

Chairman Keiser, Chairman Weisz, Members of the Committees:

At the request of North Dakotans for Affordable Healthcare, I undertook an economic analysis of likely changes to North Dakota's economy with the passage of House Bill 1440 which removes the ownership restrictions on the operation of pharmacies.

My key findings are:

1. Prices on prescription drugs in North Dakota will decrease;
2. Salaries for pharmacists in North Dakota will increase to match regional trends;
3. The resulting decrease in prescription prices will increase output in the state and create more jobs, including in pharmacies, with savings to the consumer and higher tax revenue for the state.

The estimated savings for consumers is confirmed by a pricing survey of regional chain Thrifty White Drug Stores which has 28 locations in North Dakota. The survey of commonly prescribed generic and brand name drugs indicates that, on average, North Dakotans pay $7.88 more to fill a prescription here than what the chain charges in Minnesota. The White Drug North Dakota prices are $16.92 higher than Wal-Mart's cash price.

Pharmacists are paid less in North Dakota, as compared with regional trends. With greater competition for jobs in the pharmacy sector, it is expected that salaries of pharmacists will increase to conform to regional salary trends.

Finally, the economic impact analysis indicates a significant economic benefit to the state. My report includes two scenarios to indicate a conservative impact and maximum possible impact on the economy. Scenario 1 assumes that the lower prescription prices will be matched throughout the market. The maximum consumer benefit generates $46.4 million in additional output through consumer spending and other factors. With the output increase there are also more than 300 jobs created and just under $1.5 million in additional tax revenue. Scenario 2 assumes a more conservative, and perhaps realistic, set of assumptions. This more conservative estimate shows increased output of over $8 million, a tax collection increase of nearly $350,000 and over 60 new jobs created in North Dakota's economy.

The findings discussed in my report have been confirmed by other organizations, including Blue Cross/Blue Shield of North Dakota, the North Dakota Public Employees Retirement System and the North Dakota Department of Human Services, Medical Services.

One point is very clear. A removal of the pharmacy ownership restriction will create competition which will benefit consumers and North Dakota's overall economy.

I have reviewed a report from the New Rules Project, based in Minnesota that estimates dire consequences to pharmacy access in rural areas with added competition from chain or "big box" retailers. While I agree that competition will increase, there are simply too many variables to consider and too many changes possible to say with any degree of certainty how competition will impact pharmacies in rural areas.

The New Rules Project report is largely based on weakly-supported assumptions and ignores several key factors existing in North Dakota's current market. As an economist, I have several concerns with the New Rules Project report. First, I question the validity of numerical estimates from studies examining data from neighborhoods in Chicago or a coastal region of Maine, where discount retailers and local retailers already compete. The report simply ignores the economic

impact of savings to consumers and the beneficial impact of additional retailers. These savings are not trivial and should not be ignored. Second, the New Rules report fails to recognize that Thrifty White Drug Stores is a chain already existing in North Dakota. The study wrongly identifies these White Drug locations as independent pharmacies. Third, factors such as travel costs are not considered in consumer decision-making. The report merely assumes that consumers will travel or will have to travel to purchase their medications. This assumption is unsupported and inconsistent with consumer behavior. Fourth, the report bases its conclusions on an immediate market share of 45% to chains, "big box" retail pharmacies and supermarkets. The assumption of an immediate market share is unrealistic and fails to recognize that the White Drug chain and pharmacies in supermarkets already exist. Finally, the report mentions the superior service provided by independent pharmacies, but fails to recognize that service will likely be one of the key factors in determining where a consumer may purchase medications. The report merely assumes that service will be lost without considering its impact on consumer behavior.

It is likely that pharmacies located in highly populated areas of North Dakota will face competitive pressure on pricing. It is less likely that this same measure of competitive pressures will affect pharmacies located in rural areas. Rural pharmacies have a competitive advantage of location, convenience and service that cannot be ignored.

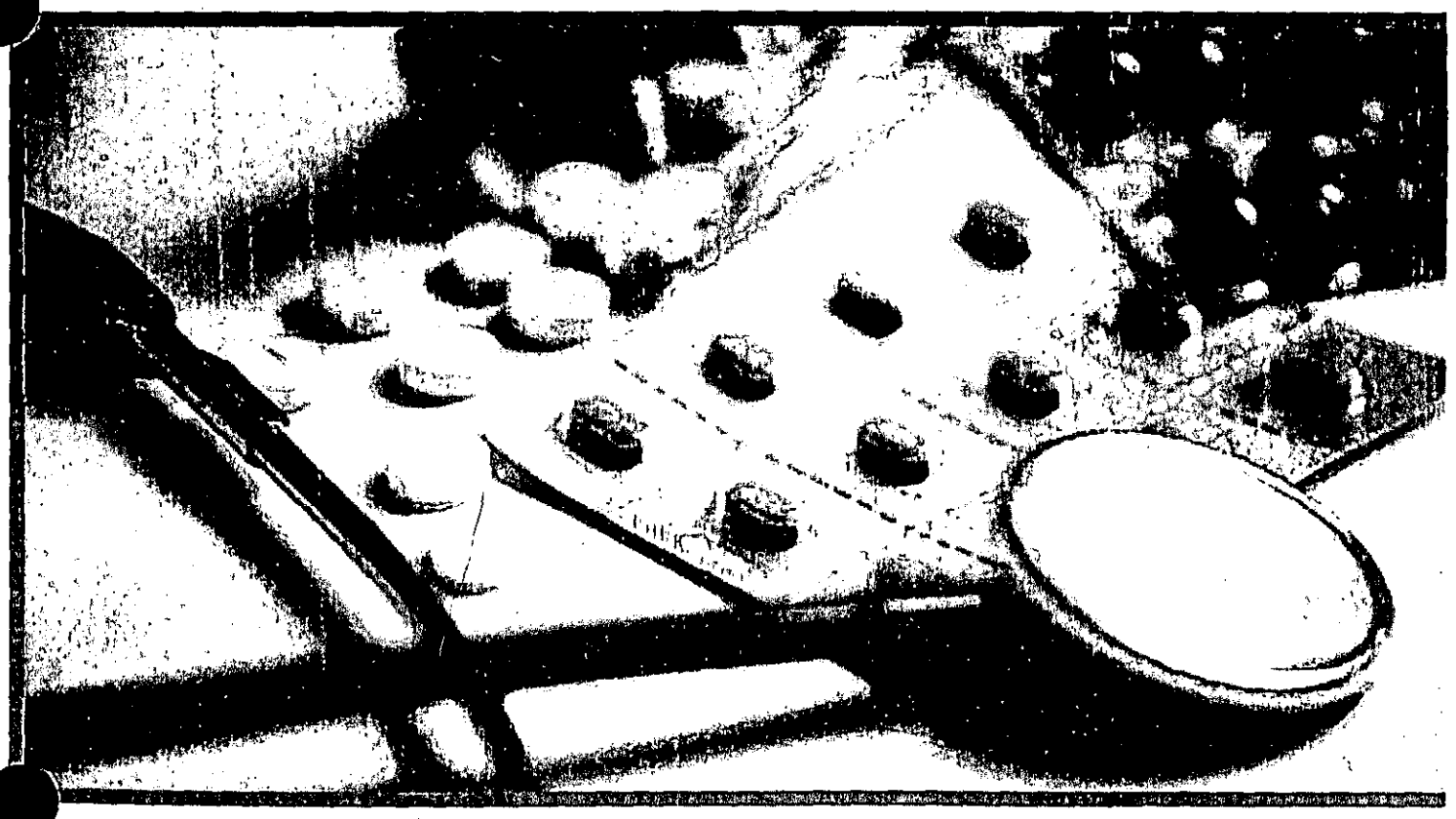
The benefit to consumers from lower prescription drug costs is important, particularly in light of the current negative economic sentiment hitting the United States and North Dakota. It is my opinion that removing the ownership requirements on pharmacies will result in more competition and lower prices for consumers in North Dakota.

Thank you for your time.

Removal of Pharmacy Ownership Restrictions in North Dakota

David T. Flynn, Ph.D.
Director of the Bureau of Business and Economic Research,
University of North Dakota, Grand Forks, North Dakota*

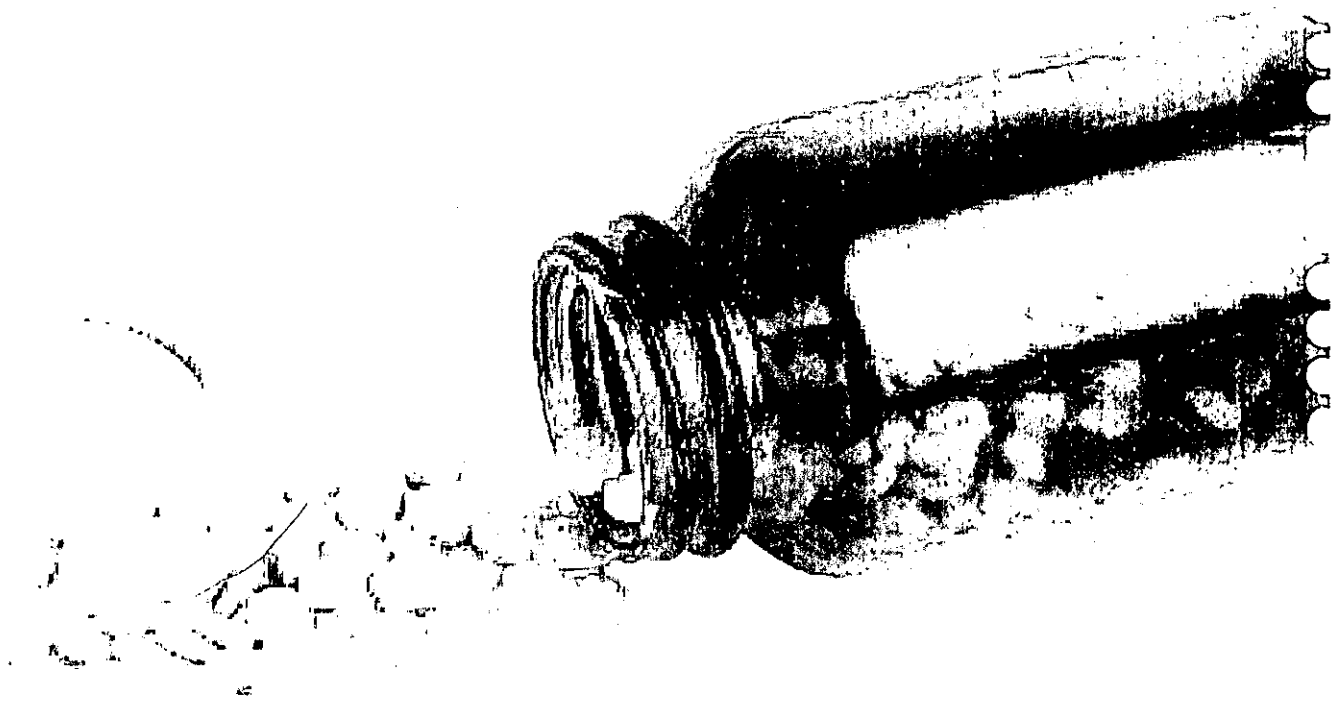
North Dakotans for
Affordable Healthcare



The analysis and opinions contained in this report are those of the author and do not necessarily reflect the opinions of the Bureau of Business & Economic Research, the College of Business & Public Administration, or the University of North Dakota.

About the Author

David T. Flynn, Ph.D. is Director of the Bureau of Business and Economic Research at the University of North Dakotaand serves as the Associate State Director of the North Dakota Small Business Development Center. Dr. Flynn is also the Clow Banking Fellow and an Associate Professor in the Department of Economics, College of Business & Public Administration. He received his Ph.D. from Indiana University and currently resides in Grand Forks with his wife and two children.



Executive Summary

This report estimates the savings to consumers as a result of a change in North Dakota's pharmacy ownership law. The assumption is that after a change in the law corporate owned pharmacies will enter the North Dakota market. The most important result of this entry, confirmed by other organizations, is the savings by consumers, conservatively estimated at more than $2 million.

The estimated savings is further confirmed by a survey of regional chain Thrifty White Drug Stores, Inc., which operates a number of stores in North Dakota and Minnesota. The survey of commonly-prescribed generic and brand name drugs

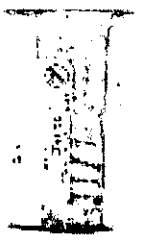
Competition benefits consumers and...the overall economy in North Dakota.

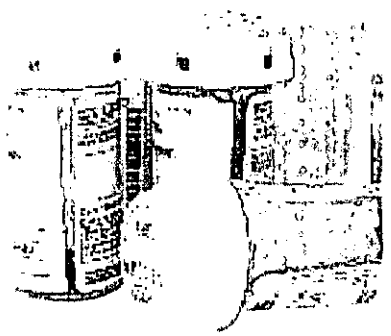
indicates that North Dakotans pay, on average, $7.88 more to fill the same prescription at a White Drug store in North Dakota compared to the price charged to a Minnesotan. On average, White Drug's North Dakota prices are $16.92 higher than Wal-Mart's cash price.

Current salary data for pharmacists and pharmacy technicians is provided as well. With greater competition for jobs in the pharmacy sector, it is expected that salaries of pharmacists and pharmacy technicians will conform more with regional salary trends.

Finally, the economic impact analysis indicates a significant economic benefit to the state. The two scenarios created display this sizable benefit. Under the assumption of all prices faced by consumers equaling discount price data the maximum consumer benefit (scenario 1) generates $46.4 million in additional output through consumer spending and other factors. With the output increase there are also more than 300 jobs created and just under $1.5 million in additional tax revenues. A more conservative and perhaps realistic set of assumptions (scenario 2), consistent with those of other groups, indicates an output increase of over $8 million, a tax collection increase of nearly $350,000 and over 60 new jobs created in the North Dakota economy.

Competition benefits consumers and as a result benefits the overall economy in North Dakota.





Introduction

North Dakotans for Affordable Healthcare (NDAH) seeks a change in pharmacy ownership law in North Dakota, and in so doing would increase competition in North Dakota's pharmacy market. The current situation in North Dakota is that corporate ownership of pharmacies is not allowed, restricting access to corporations such as Wal-Mart, Target, Walgreens and regionally based corporations such as Hugo's (grocery store) and Pamida. This report provides details about the likely savings for North Dakota consumers, the income of pharmacists and pharmacy technicians in North Dakota relative to other states. The study ends with conclusions based on the results of an economic impact analysis describing likely results in North Dakota's economy as a result of a change in pharmacy ownership laws.

Prescription Drug Prices

National Data

The level of prices and inflation are a constant concern in the current US economy and much of the world. Price changes alter the available budget resources for consumers, and when unanticipated fluctuations in prices occur consumer spending plans may need to change drastically, particularly when changes are in areas viewed as having few if any substitutes, such as health care. Anecdotal accounts in newspapers and personal anecdotes provided in past testimony to the interim legislative committee detailed the adverse impacts on low income households, people living on fixed incomes and others, of ever-rising drug prices.

The Bureau of Labor Statistics (BLS) tracks an index value for prescription drug prices as part of their medical care commodities series.[1] Using this index I calculate an annual percentage change from July of 2001 to July of 2008 and a total percentage change over this 7 year period. The percentage change in prescription drug prices over this time period is 24.6%, higher than the overall percentage change in the CPI. Table 1 below displays the one year percentage change in prescription drug prices and compares the rate to the increase in the overall CPI. Figure 1 provides a graphical perspective for the data in Table 1. Both Figure 1 and Table 1 show that the annual percentage changes in prescription drug prices are quite large until the 2006 to 2007 period, in fact they are above the overall increase in prices for the same period. While prices in general fell from 2006 to 2007 we see that drug prices fall by more and that they continue to stay below the general rate of inflation to the end of the analysis. The 2006 to 2007 calculation coincides with the introduction of Wal-Mart's $4 drug plan as well as the Medicare Part D plan introduced by the U.S. government.[2] The increase from 2007 to 2008 is at a lower rate than the general inflation currently rippling through the U.S. economy. The primary culprit for the current increase is higher fuel prices, and the uncertainty surrounding the permanency of this change. Fuel price increases are driving up prices for almost all goods where shipping is an important part of the final retail price, such as food.

[1] The data used come from BLS series CUSR0000SEMA and are seasonally adjusted. The data include all drugs dispensed by prescription and include purchases through mail. These are transaction prices between the pharmacy, the patient, and any third party payer.

[2] It should be noted that Target, Walgreen's and others followed suit soon after Wal-Mart's announcement and continue to do so. The 2008 NCPA Digest sites slow reimbursement under some Medicare Part D plans as a potential source of liquidity and cash flow problems for pharmacies in their analysis.

Figure 1. Annual percentage change in prescription drug prices and overall CPI.

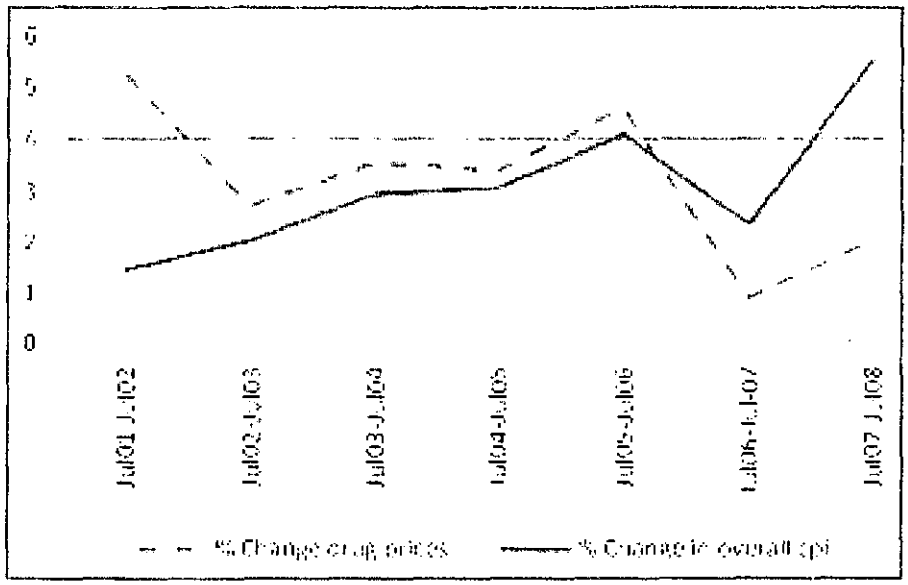


Table 1. Percentage change in prescription drug price index July to July for various years

Period	% change in drug prices	% change in overall cpi
Jul01-Jul02	5.2	1.5
Jul02-Jul03	2.7	2.1
Jul03-Jul04	3.6	2.9
Jul04-Jul05	3.4	3.1
Jul05-Jul06	4.6	4.1
Jul06-Jul-07	0.9	2.44
Jul07-Jul08	2.0	5.5

The precise share of the reduction in medical care commodity inflation attributable to discount retailers offering pharmacy services requires further analysis with more detailed data. Supply and demand factors change constantly, though a contribution on the part of discount provision of medications from retailers cannot be dismissed as a contributing factor. I also provide data for North Dakota and Minnesota White Drug's prices compared with Wal-Mart's in Table 2 below.[1]

[1] For Tables 2 and 3 data supplied by North Dakotan for Affordable Healthcare for period 8/01/2007 through 7/31/2008.

Table 2. Comparison of Wal-Mart prices with North Dakota & Minnesota White Drug's, commonly-prescribed generic and brand name drugs, by volume.

QTY	DRUG	Therapeutic Treatment	Dosage	Wal-Mart's Price	North Dakota White Drug's Price	Minnesota White Drug's Price
#30	HCTZ	Blood Pressure	25mg	4.00	11.89	9.99
#30	Lisinopril	Blood Pressure	20mg	4.00	13.89	13.89
#60	Tramadol	Arthritis/Pain	50mg	4.00	18.79	18.79
#60	Metformin	Diabetes	500mg	4.00	19.99	19.99
#30	Fluoxetine	Mental Health	20mg	4.00	15.19	15.19
#30	Fluoxetine	Mental Health	40mg	4.00	72.09	37.52
#60	Metoprolol	Heart Health	50mg	4.00	22.29	17.39
#30	Pravastatin	Cholesterol	40mg	4.00	15.99	15.99
#30	Cyclobenzaprine	Arthritis/Pain	10mg	4.00	16.09	16.09
#20	SMZ/TMP DS	Antibiotic		4.00	14.19	14.09
#20	Ciprofloxacin	Antibiotic	500mg	4.00	33.49	12.99
#30	Plavix	Heart Health	75mg	147.84	162.79	162.79
#30	Singulair	Asthma/Allergies	10mg	130.68	127.19	127.19
#30	Nexium	Gastrointestinal	40mg	171.72	189.09	159.99
#30	Lipitor	Cholesterol	20mg	126.62	142.69	129.70
#30	Prevacid	Gastrointestinal	30mg	165.46	186.89	157.01
#30	Lipitor	Cholesterol	10mg	88.68	100.09	100.09

North Dakota, Minnesota Data

To demonstrate the regional price differences Table 2 provides a comparison of generic drug prices between Wal-Mart and White Drug's in North Dakota and Minnesota. Wal-Mart's price is significantly lower in many cases.[5]

The average savings North Dakotans would receive from a Wal-Mart pharmacy would be significant, averaging $16.92 per fill. The savings received by Minnesotans from Wal-Mart averages $9.04. Annual savings for users of Lipitor or Prevacid would amount to more than $130 and $250 respectively. The data in Table 2 also indicate lower prices for Minnesotans from White Drugs. North Dakotans pay on average $7.88 more for their prescriptions from the same pharmacy outlet, White Drugs. There are significant savings for North Dakota consumers from changed prices.

Ten of the seventeen drugs listed in table 2 are included on the Wal-Mart $4 list and included in the top 100 generic drugs sold in 2007.

[4] This data also supplied by North Dakotans for Affordable Healthcare for the period 8/1/2007 through 7/31/2008.

[5] Data provided by North Dakotans for Affordable Healthcare based on survey from 8/16/2008 to 8/18/2008 from selected North Dakota White Drug's. Pricing survey reconfirmed with no change in White Drug's North Dakota pricing as of December 8, 2008.

Conclusions

North Dakotans are paying more for prescription medications than Minnesotans. The introduction of new competitors would reduce prices benefitting consumers. Other organizations such as BCBS, NDPERS, and the state Medicaid office agree that a change in the pharmacy ownership law will lower prescription costs to North Dakota consumers.

Relative Income of Pharmacists

Table 3 displays regional figures for employment and annual wage of pharmacists for North Dakota and its bordering states. As can be seen, the wages North Dakota are lower than elsewhere.[6] The appendix contains a table with data for all 50 states and shows that North Dakota is in fact the lowest annual mean wage for the United States. NDSU reports that slightly more than one-third of the pharmacists from their program stay to work in state.[7]

North Dakota ranks 18th in the United States for pay for pharmacy technicians, a surprise given its poor performance for pharmacists.

Table 3. Regional employment of pharmacists, annual mean wage and difference with ND annual mean wage.

State	Employment	Annual mean wage	Difference from ND annual mean wage
Minnesota	4,990	$105,440	$21,730
Montana	1,020	$87,260	$3,550
North Dakota	810	$83,710	----
South Dakota	1,040	$88,650	$4,940
Wyoming	480	$91,320	$7,610

Table 4. Regional employment of pharmacy technicians, annual mean wage and difference with ND annual mean wage.

State	Employment	Annual mean wage	Difference from ND annual mean wage
Minnesota	6,030	$29,360	$890
Montana	850	$28,290	-$180
North Dakota	450	$28,470	----
South Dakota	910	$26,320	-$2,150
Wyoming	430	$29,000	$530

[6] This and other information can be found from the Bureau of Labor Statistics website and the various surveys and databases they track.
[7] Available from NDSU College of Pharmacy, Nursing, and Allied Sciences website. (Accessed 8/20/2008).

Impact Analysis

The significant savings levels represent an opportunity for North Dakota's economy to experience a further buffer against recessionary forces prevalent in other parts of the country. There are two scenarios developed for the impact analysis that incorporate the consumer sector, insurers, and pharmacies. The first scenario, explained in a more complete fashion later, estimates the maximum possible benefit to consumers from a change in pharmacy ownership rules. The other scenario estimates impacts using percentages and ratios from more in line with expected outcomes of a change in ownership rules. For each scenario I report the output and employment and tax impacts for each of the three scenarios and provide a graphical comparison in a later section.

Scenario 1: The task set forth in this scenario is estimating the impact from a change in pharmacy ownership laws such that all prices are now reduced at all pharmacies. The impact would provide the highest level of direct benefit to the consumer and relies on the data provided by BCBS. Table 5 displays estimated expenditures on prescription drugs by BCBS members by location and by type of pharmacy for out-state expenditures. In addition, $124,441 in Medicaid savings, estimated by the North Dakota Department of Human Services, are not detailed in the cost breakdown below but included in the impact analysis.

As mentioned, the first assumption is that the introduction of discount retailer pharmacies results in a reduction of prices such that all prescription drug prices are at the level of Wal-Mart from the BCBS data. The second assumption is that all 80% of out-state prescription drug purchases are repatriated to North Dakota.[10] We do not engage in any changes in consumer behavior here as there are no good estimates of these changes, particularly for groups such as those lacking health insurance.[11]

Table 5. Cost breakdown for prescription drug expenditures.[8]

Area & Store	Total Amount	Consumer share	BCBS share
In-state total cost	$152,212,555.69	$60,885,022.28	$91,327,533.42
Out-state total cost[9]	$50,944,515.85	$20,377,806.34	$30,566,709.51
Wal-Mart total cost	$8,347,921.82	$3,339,168.73	$5,008,753.09
Non-WM	$42,596,594.03	$17,038,637.61	$25,557,956.42

[8] BCBS provided 2006 claims, a sample quarter breakdown expenditure type and average cost figures that allowed for the creation of Table 5. BCBS used a different method to arrive at their savings numbers. Their estimation results in savings for North Dakota consumers as well.

[9] Out-state costs are broken down into Wal-Mart and non-Wal-Mart expenditures. The average cost sharing ratio was provided by BCBS as was the other pieces used to develop the data in this and other scenario tables.

[10] According to the 2000 Census the 15% of workers listing Cass County as their location of employment resided in Clay County, MN. A further 3% of workers resided in another county in Minnesota. We err on the side of caution and use 20% as our estimate of fills that will not return to North Dakota after the removal of ownership restrictions.

[11] Certainly it seems logical to assume an increase in purchases of prescription drugs when the price falls, particularly for those with more limited resources and lacking health insurance. The problem is that there is no definitive estimate of the extent of this change at this time. The Census Bureau estimates there are 69,000 North Dakotans lacking health insurance, more than 10% of the state population.

The resulting savings to North Dakota consumers from the assumption of Wal-Mart average prices is $14,017,029.65, while the share of savings to BCBS is $21,025,544.47. The consumer savings are distributed across income categories according to the Census Bureau's American Community Survey population breakdown by income for North Dakota. Existing pharmacies in North Dakota will incur a retail markup loss under this scenario. A sizable portion of consumer prescription drug prices comes from manufacturing expense, research and development, as well as wholesale markup and transportation costs. The loss to pharmacies is equal to the retail markup on the combined consumer and BCBS amount, $35,042,574.12. In addition, the availability of prescription drugs at lower cost in North Dakota is assumed to attract back a large percentage of prescriptions filled out of state. The amount of funds returning to North Dakota is estimated to be $28,238,701.31.

The output impacts are quite large with a total economic impact in excess of $46 million. Direct impacts are the result of the changes in the North Dakota pharmacy regulations. The indirect changes are the result of business purchases from other businesses and induced amounts are from household spending changes. Insurance and medical services are among the sectors benefitting the most from such a change, though financial services and food service also benefit. There are important employment impacts with insurance and medical services of various types among the chief beneficiaries from the change in law. Benefits are spread around with restaurants, discount retailers, grocery stores and others sharing in the more than 300 jobs created under this scenario.

Table 6. Cost breakdown assuming all prescription drug expenditures are at Wal-Mart average costs.

Area & Store	Total Amount	Consumer share	BCBS share
In-state total cost	$117,169,981.58	$46,867,992.63	$70,301,988.95
Out-state total cost[12]	$35,298,376.64	$14,119,350.65	$21,179,025.98
Wal-Mart total cost	$8,347,921.82	$3,339,168.73	$5,008,753.09
Non-WM	$26,950,454.82	$10,780,181.93	$16,170,272.89

Table 7. Impact results from Scenario 1.

Sector	Impact Amounts			
	Direct	Indirect	Induced	Total
Output Impacts	$33,088,424	$7,959,492	$5,389,799	$46,437,714
Employment Impacts	168.0	75.6	59.4	302.9
Tax Impacts	$988,586	$178,822	$322,133	$1,489,541

[12] Out-state costs are broken down into Wal-Mart and non-Wal-Mart expenditures. The average cost sharing ratio was provided by BCBS as was the other pieces used to develop the data in this and other scenario tables.

Scenario 2: Scenario 2 distributes in-state changes in a pattern similar to that found in the current out of state data. Discount retailers are assumed to gain 15% market share in the North Dakota market. In addition, there is again an assumption that 80% of the current out of state prescription dollars return to pharmacies in North Dakota. Prescriptions filled at corporate-type pharmacies use the reported Wal-Mart total cost and those from other in state pharmacies use the in state cost. The initial figures for this scenario are the same as we see in Table 3 from scenario 1. The adjusted figures based on this scenario are found in Table 8.

The total savings to the consumer sector as a result of this scenario are $2,102,554.45. The pre-margin total negative for the pharmacy sector is $5,256,386.12, though this is offset by the return of $6,678,337.46 from out state fills. As before, Medicaid savings total $124,441.

Despite the more limited assumptions in scenario 2 than those in scenario 1 there are still positive impacts on North Dakota's economy, as seen in table 9. The output impact is just over $8 million. Employment gains equal more than 60 jobs, and tax collections increase by almost $350,000.

Table 8. Cost breakdown under scenario 2.

Area & Store	Total Amount	Consumer share	BCBS share
In-state total cost	$146,956,169.58	$58,782,467.83	$88,173,701.75
In-state non Wal-Mart Pharmacies	$129,380,672.34	$51,752,268.94	$77,628,403.40
In-state non Wal-Mart Pharmacies	$17,575,497.24	$7,030,198.89	$10,545,298.34

Table 9. Impact results from scenario 2.

	Impact Amounts			
Sector	Direct	Indirect	Induced	Total
Output Impacts	$5,685,135	$1,360,535	$1,046,028	$8,091,698
Employment Impacts	36.8	13.0	11.5	61.3
Tax Impacts	$252,531	$33,741	$62,518	$348,790

Comparisons of scenarios

Both scenarios display positive overall benefits for the North Dakota economy from a change in the pharmacy ownership law. Scenario one is meant to provide estimation of the maximum consumer benefit from lower prices while scenario 2 focuses on a more conservative and perhaps realistic outcome of a change in the pharmacy ownership law. Alternative assumptions about the percentage of fills returned to the state and the amount of prescriptions transferred between in-state outlets will change the overall dollar values. Common to both scenarios discussed here are positive output, employment and tax changes. Figure 1 displays side-by-side the impacts for output under both scenarios, while figure 2 provides the same graphical representation for employment and figure 3 shows the tax impacts for the two scenarios.

Figure 1. Output impacts of NDAH scenarios, ($)

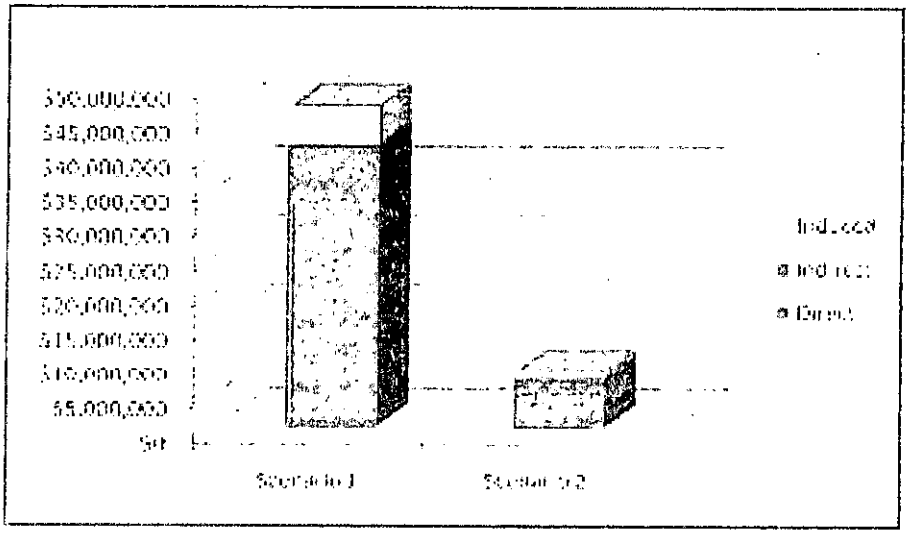


Figure 2. Employment impacts of NDAH scenarios, (# of jobs)

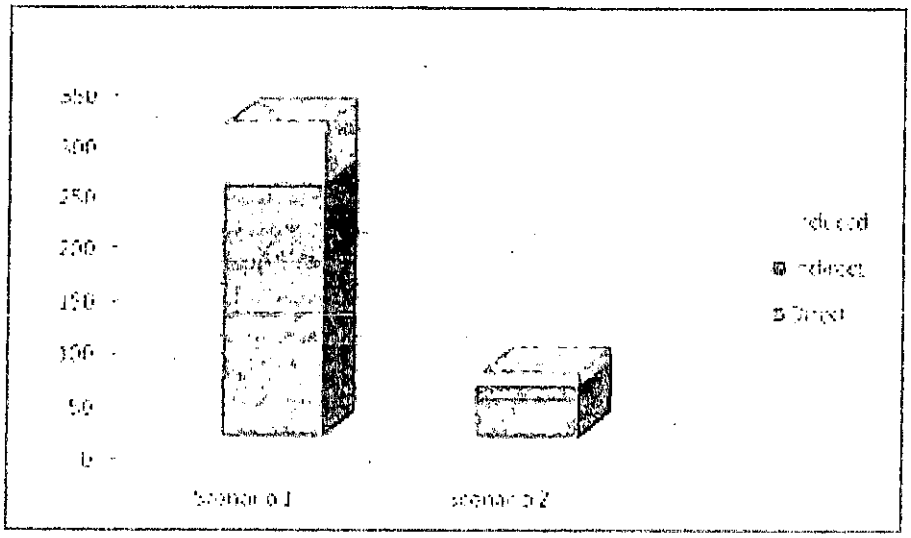
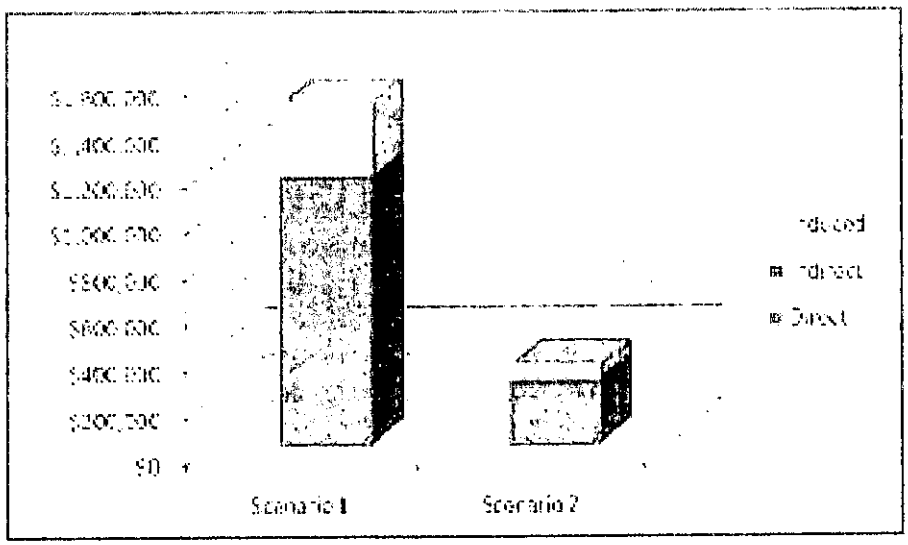


Figure 3. Tax impacts of NDAH scenarios, ($)



Impact Conclusions

Scenario 2 shows that realistic assumptions about changes occurring as a result of the amendment of the law governing pharmacy ownership a significant positive economic impact occurs for the state of North Dakota. The consumer benefit is highest under scenario 1 but it is unlikely that all drug prices would conform to those at discount chains. However, there are reasons to believe the impacts would be larger than those estimated in scenario 2. This information only includes BCBS and Medicaid information, which does not cover everyone in the state. BCBS insures only around 50% of the population of ND. Benefits would likely be larger if those insured under other plans or Medicare Part D were included in this analysis.

Competition benefits consumers.

There is little data regarding the change in spending behavior on prescription drugs after the reduction in price, particularly for those who lack health insurance. Common sense tells us purchases increase, but by how much is unclear. An often overlooked benefit of this would be the increased health of the population at large. The likely result is a healthier population that would be more productive, have fewer sick days, transfer disease less readily, all of which would result in a stronger state economy with a higher gross state product.

Conclusion

Competition benefits consumers. The more competitors exist to supply a product, the higher the supply of the product and, everything else equal, the lower the market price. North Dakota's prescription drug consumers currently face higher prices than they would otherwise due to a restriction on competition in the form of pharmacy ownership laws. Increases in competition are typically followed by improvements in the quality of service. Allowing Wal-Mart, Target, Walgreen's, Hugo's, Pamida, hospitals and others to operate pharmacies raises the potential of increased quantity and quality of pharmacy service and lower prescription drug prices creating significant economic benefits to North Dakotans.

Table 10. United States Employment and Income for Pharmacists by State

State	Employment	Annual mean wage
Alabama	4440	$101,140
Alaska	360	$109,810
Arizona	4940	$97,570
Arkansas	2580	$94,410
California	23030	$112,020
Colorado	4080	$98,570
Connecticut	2820	$101,850
Delaware	780	$93,360
District of Columbia	590	$83,870
Florida	17690	$98,190
Georgia	7530	$98,070
Hawaii	1310	$95,000
Idaho	1410	$99,870
Illinois	9250	$96,730
Indiana	5680	$93,400
Iowa	2820	$89,150
Kansas	2480	$94,130
Kentucky	4000	$103,800
Louisiana	3820	$90,150
Maine	1190	$108,930
Maryland	4640	$94,460
Massachusetts	6780	$88,920
Michigan	8640	$97,640
Minnesota	4990	$105,440
Mississippi	2250	$95,630
Missouri	5360	$98,500
Montana	1020	$87,260
Nebraska	1980	$89,120
Nevada	2240	$99,760
New Hampshire	1140	$102,170
New Jersey	7900	$98,200
New Mexico	1510	$95,980
New York	15310	$97,270
North Carolina	7590	$102,480
North Dakota	810	$83,710
Ohio	11260	$95,750
Oklahoma	3280	$92,210
Oregon	3100	$99,410
Pennsylvania	11810	$89,650
Puerto Rico	1850	$58,740
Rhode Island	1150	$95,500
South Carolina	3950	$98,540
South Dakota	1040	$88,650
Tennessee	6130	$105,280
Texas	17660	$103,820
Utah	1840	$100,440
Vermont	450	$102,100
Virginia	5790	$98,570
Washington	5250	$97,860
West Virginia	1890	$100,080
Wisconsin	5060	$102,910
Wyoming	480	$91,320

Note: Annual wages have been calculated by multiplying the hourly mean wage by 2,080 hours.
Available from the Bureau of Labor Statistics website, www.bls.gov

Table 11. United States Employment and Income for pharmacy technicians by State

State	Employment	Annual mean wage
Alabama	6080	$23,380
Alaska	520	$33,970
Arizona	6440	$28,770
Arkansas	2850	$23,770
California	24540	$35,450
Colorado	3760	$30,580
Connecticut	3120	$30,860
Delaware	1200	$24,830
Florida	21550	$26,940
Georgia	9300	$25,530
Hawaii	1060	$33,150
Idaho	1430	$27,180
Illinois	16000	$26,530
Indiana	7070	$25,990
Iowa	3410	$25,080
Kansas	2530	$25,790
Kentucky	6120	$23,700
Louisiana	4030	$24,830
Maine	1590	$26,010
Maryland	5050	$28,790
Massachusetts	5810	$29,480
Michigan	10470	$27,550
Minnesota	6030	$29,360
Mississippi	2320	$24,080
Missouri	9510	$23,810

State	Employment	Annual mean wage
Montana	850	$28,290
Nebraska	2090	$25,880
Nevada	2210	$31,390
New Hampshire	1180	$26,530
New Jersey	7410	$27,890
New Mexico	1700	$27,480
New York	12790	$28,760
North Carolina	9920	$24,700
North Dakota	450	$28,470
Ohio	12450	$24,980
Oklahoma	4030	$23,970
Oregon	3720	$31,770
Pennsylvania	14740	$25,180
Rhode Island	1140	$30,120
South Carolina	5090	$24,480
South Dakota	910	$26,320
Tennessee	8770	$26,620
Texas	25430	$27,750
Utah	2390	$29,460
Vermont	440	$26,740
Virginia	6920	$26,240
Washington	5370	$34,700
West Virginia	2480	$22,720
Wisconsin	6540	$27,070
Wyoming	430	$29,000

Note: Annual wages have been calculated by multiplying the hourly mean wage by 2,080 hours.
Available from the Bureau of Labor Statistics website, www.bls.gov

Testimony of Dick Hedahl
North Dakota Chamber of Commerce
HB 1440
February 3, 2009

Mr. Chairman and members of the committee, my name is Dick Hedahl and as a member, past director and past chairman I am here today representing the ND Chamber of Commerce, the Voice of North Dakota business. Our organization is an economic and geographical cross section of North Dakota's private sector. We stand in support of HB 1440 and urge a do pass from the committee on this bill.

Our mission statement and legislative policy states "The North Dakota Chamber supports competition in the free market system and believes the supply demand model should hold precedent." Our decision to take a position on this issue was not entered into without a long debate at both the committee and board level. In the end we felt that the Chamber, as the voice of business for North Dakota, has to be consistent in our support of the free market system and capitalism as the best business model to follow.

If I might also add some personal perspectives on this bill: I am president and CEO of Hedahls, Inc. We are a regional auto parts distribution company with 28 locations in four states. I became interested in healthcare in 1991 when our costs skyrocketed for health insurance. We aggressively tackled the issue then and have had good success with our wellness program ever since. I have talked with some of you about our plan in the past. One of the tenants of our plan is a reliance on incentives to help people lead a healthy lifestyle.

The incentives of the free market and capitalism are powerful forces that keep quality high and prices low in our society. The more we can allow access to entry into the market, the more benefit the people of North Dakota will receive from the increased competition. The auto parts business has very few barriers to entry into the market. As a result, I have competitors in every town and from all over the country. This competitive pressure has made my company a much better supplier to my customers. My customers pay less for their auto parts because of this competition. As a local business, of course I would love to have a law that restricted my competitors from selling in my town. But my customers would not be as well served.

This pharmacy bill will allow more distributors of pharmaceuticals to offer their products and services in our state. More suppliers make the competition better. BCBS did a study that indicates this bill will help reduce the costs of healthcare for individuals and businesses. I encourage you to support HB1440.

Thank you for the opportunity to appear before you today in support of HB 1440. I would be happy to answer any questions.

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Walgreens
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Written Testimony on Behalf of

Walgreen Co.

Concerning HB 1440

Removal of the Residency Requirement for the Operation of Pharmacies in North Dakota

Presented to the

State of North Dakota

Industry Business and Labor Committee

Human Services Committee

Bismarck, North Dakota

February 3, 2009

Hal Rosenbluth
Senior Vice President, Walgreen Co.
President, Walgreens Health and Wellness Division
Chairman, Take Care Health Systems
Eight Tower Bridge
161 Washington Street, Suite 1400
Conshohocken, PA 19428
484-351-3208

I sit before you today as both an officer of the Walgreen Company, a rancher from Linton, a taxpayer of land and income taxes, an honorary citizen of North Dakota and a friend of the state.

I would not be here today if I did not truly believe in my testimony, as my friends in North Dakota will always supersede my corporate responsibilities.

My responsibilities include being president of the Health and Wellness division composed of 4,000 healthcare practitioners with a customer care call center employing 90 folks in Fargo, senior vice president of the company, and, as previously mentioned, an executive officer of the country's 40th largest company, which, quite frankly, is synonymous with being a mackerel in the moonlight, its stinks and shines at the same time.

I am here to share my perspective on the issue of the current pharmacy ownership restriction debate from, what I believe to be, a unique perspective.

First, having now spent over 20 years in the state, this goes against everything I have come to love about North Dakota; it protects and benefits the few, while the rest of us suffer the consequences of a less than free market system; it limits freedom of choice for its citizens; it decreases quality of life, and worst yet, increases the cost of healthcare when most can't afford it in the first place.

Why is it that my neighbors and I can choose which sale barn to buy or sell their cattle, contract in advance with a buyer or seller, or even buy and sell over satellite television for that matter? Why can we choose which grain elevator to buy or sell commodities, or where and how to bank our money? And yet, when it comes to pharmacy ownership, a law exists that precludes true competition on service and price.

This makes no sense to me, makes no sense to my friends, and makes no sense for the state. For such a progressive state, where common sense is actually common, I just don't get it.

I've heard that passing this bill will force the closure of small town pharmacies; well, frankly I do not see that argument. We have a great pharmacy in Linton, run by true professionals, and a critical part of the community. Don't think for a moment that I plan to truck sixty miles to Bismarck to get my medications, birthday cards, and Preparation H from Walgreens; it simply is too far and too expensive to do so. With the price of gas fluctuating throughout the year, and the 12 miles per gallon I get on my Ford pickup, it might cost me upwards of $ 40.00 dollars to get an $ 8.00 prescription, a $ 1.00 card, or $ 3.00 to reverse the effect my horse had on me after rounding up cattle; now even a city boy knows that doesn't make any sense.

As to the affect on small town pharmacy profit margins if Walgreens were to open in a large city, I don't quite get it. According to a 2008 study by the National Community Pharmacist Association, independent pharmacies in the west central region of the United States, which of course includes North Dakota, enjoyed higher net income than independent pharmacies anywhere else in America, and pharmacies operating in towns of less than 20,000 residents had higher profit margins than those operating in towns of 20 to 50 thousand residents. Why? Well,

as I see it, the larger the town, the more the competition, the more competition, the lower the prices.

Putting the cost/price equation aside for a moment, the Linton pharmacy doesn't simply dispense medications, it's highly convenient too. Not only does it sell all types of items in the front of the store, I believe it still houses a dry cleaning service, as well. For me, this combination is nirvana considering that virtually each time my family is at the ranch we either break a leg, an arm, a wrist or a rib, we end up purchasing our medications at the Linton pharmacy, buy a new set of crutches, pick up gauze and other OTC products, and, if we choose, dump off our muddy clothes while we're there. You see, when the Rosenbluth's come to town, we don't break horses, they break us; we don't sort cattle, they sort us; and we don't put up fence, we get entangled in it.

If it weren't for the Linton Pharmacy, we'd be cut up, in pain, and hopping around more like rabbits than human beings. So while I hope Walgreens opens a pharmacy in Bismarck, I'm sticking with the Linton Pharmacy, because they've always been there for me, my family, my maladies and my medications.

As for Walgreens, we have the most sophisticated technology system in the industry, tremendous purchasing power, and the same professional pharmacists as those in small and large towns in North Dakota. What does that mean for the citizens of the state that choose to use our services; better prices, a record of pharmacy purchases so when on the road, whether it be Phoenix, Seattle, or anywhere else, our prescription records are available to any Walgreens pharmacy one visits nationwide, ensuring that there are no negative drug interactions whether at home or away; we even provide in store health clinics so when visiting out of state friends or family, North Dakotans can receive medical care without an appointment, access to their pharmacy records, and, if necessary receive customer service from relatives working in Walgreens Fargo Center.

Thank you very much for taking the time to let me visit with you this morning, and thanks for caring about the health and well being of your friends and neighbors. The country can't afford the rising costs of healthcare, and neither can North Dakotans.

Walgreens
The Pharmacy America Trusts • Since 1901™

Written Testimony on Behalf of

Walgreen Co.

Concerning HB 1440

Removal of the Residency Requirement for the Operation of Pharmacies in North Dakota

Presented to the

State of North Dakota

House of Representatives

Industry Business and Labor Committee

Human Services Committee

Bismarck, North Dakota

February 3, 2009

Ron Weinert, R.Ph.
Director, Government Relations
Walgreen Co.
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Chairman Keiser, Chairman Weisz, distinguished members of the Industry, Business and Labor Committee, distinguished members of the Human Services Committee and interested members of the public:

My name is Ron Weinert. I am the Director of Government Relations for the Walgreen Company ("Walgreens"). I have been a pharmacist registered in the state of Illinois for over 25 years. I would like to thank the Committees for allowing Walgreens to present comments in **support** of House Bill 1440. Walgreens operates more than 6,600 stores nationwide, in 49 states and Puerto Rico. In North Dakota, Walgreens operates one store, without a pharmacy.

In June of 1983 I took an oath upon graduating from pharmacy school. On that day I vowed to devote my professional life to the service of all humankind through the profession of pharmacy. I swore to consider the welfare of humanity and relief of human suffering my primary concerns. I promised to apply my knowledge, experience, and skills to the best of my ability to assure optimal drug therapy outcomes for the patients I serve. That same oath bound me to keep abreast of developments and maintain professional competency in my profession of pharmacy and notably to maintain the highest principles of moral, ethical and legal conduct. I pledged to embrace and advocate change in the profession of pharmacy that improves patient care. I took these vows voluntarily with the full realization of the responsibility with which I am entrusted by the public.

That same oath is given to new pharmacists across the country every year. Pharmacists who work for hospitals are not given a different oath than those who work for chain or independent retailers. Each pharmacist has a great responsibility to maintain the highest principles of moral, ethical and legal conduct. As a result, the contention that some pharmacists care more than others is offensive to me. The thought that patients are better served by pharmacists who work for independent companies or employee owned companies is an affront to the profession of pharmacy. I am proud to be a Walgreens pharmacist because my employer does everything in its power to encourage me to be the best pharmacist I can be- with education, technology and career opportunities. Beyond the encouragement of my company, however, I have a professional and moral obligation to serve the public, and that is an obligation that no pharmacist takes lightly-regardless of whose name is on their paycheck.

As a pharmacy company, Walgreens endeavors to provide high quality accessible prescription care to each and every one of our patients. We hire impeccably trained pharmacists who are both knowledgeable and eager to provide counseling. We provide continuing education to our pharmacists free of charge and encourage them to become certified in various technical skills in order to provide quality health care to all of our patients regardless of their condition or ailment.

As a result, Walgreens can provide treatment to all patients; whether they be fighting a common cold, cancer, diabetes or infertility. Because of Walgreens incredible network of retail stores, mail service facilities and expert specialty pharmacists, regardless of their location, we can get every patient the right drug at the right time. In fact, Walgreens mailed over 7100 prescriptions into North Dakota over the last 12 months.

The core of Walgreens' business, however, is retail pharmacy. Walgreens' patients can enjoy a nationwide network of pharmacies available to serve their needs, from Seattle to Florida and from Maine to Hawaii, our patients can obtain refills for their prescriptions anywhere in the country, but not here. Our stores are open seven days a week with evening hours and are open on holidays. We also operate the most 24 hour stores in the country. Thanks to our satellite linked databases, pharmacists in all of our stores can see a patient's prescription records to ensure that each patient gets informed counseling and drug utilization review. Imagine a person becoming ill when on vacation away from home, a Walgreens pharmacist can look at the patient's prescription records to ensure that there are no negative interactions between drugs.

Beyond our outstanding service, Walgreens is also committed to providing affordable prescription care, as evidenced by our Prescription Savings Club. Members in this club can purchase over 400 generic drugs for less than $1 per week for a 90 day supply in addition to discounts on over 5000 medications. Membership in the club also provides discounts in our stores. Recent pricing studies by the Fargo Forum have shown our prices in Moorhead to be lower than any other price surveyed in Fargo.

Walgreens patients receive superior service and superior pricing, but the pharmacy ownership law prevents North Dakotans from receiving either Walgreens' superior service or Walgreens' superior pricing. This is a disservice to North Dakotans. They deserve the ability to choose at which pharmacy they prefer to shop. Let the consumers choose where they desire to shop. Please support House Bill 1440.

Walgreen Co. Comments
Ron Weinert, R.Ph., Director, Government Relations
Comments presented to the North Dakota Industry Business and Labor Committee
Bismarck, North Dakota
February 3, 2009

Roger C.
Fargo, ND 01/26/2009 5:49 PM

There is not much legal grounds for rescinding this law as the ND Supreme Court has already up held it. I would not call the ND Supreme Court shallow. To my knowledge, no one here has answered the question as to why requiring a registered pharmacist to own at least 51% of a pharmacy is a bad thing. There is nothing to stop a big box from opening a pharmacy now. Nothing. To own an electrical contractor business, a Master Electrician must own at least 51% of the business. So really, what is the difference? Is that unconstitutional also? Don't think so. There is a reason for laws like this. I would trust an electrician from a business owned by a Master Electrician over, say an electrician sent out by Wal-Mart, licensed or not. Reading the newspapers and listening to the news, people should be well aware what happens when business go unregulated. It is seemingly little things like rescinding laws such as this that reduces competition because the big companies can then come in and undercut the existing business. With reduced or no competition, prices go up, regardless of the arguments otherwise. The big boxes, read Wal-Mart, sees $$$. No other reason. They don't care about people, it is money, pure and simple. They can make more if they own the pharmacy and the pharmacist. This law needs to stay in place.

Report a Violation

Darrell N.
Fargo, ND 01/26/2009 5:12 PM

Its about time to change this bill. The big problem is the pharmacies in ND are afraid of a little competiton. If they are so stable they should have no problem about the change. Wal-mart or K-Mart are not going to move into your little towns and take your buisness away.

Report a Violation

Wendy H.
Fargo, ND 01/26/2009 2:24 PM

I have been a Wal-Mart pharmacist for almost 10 years. We provide good services to our patients and go the extra mile for them. We counsel, call insurances, call Dr's offices for refills or to change to a medication they can afford. We help them with their Medicare D plans, call Medicare, we have delivered medications to patients, and the list goes on and on. I know my patients and I always find time to say hello to them. So I do have an interest in good customer relations and I have not been imported for my job. I am a ND native and I am proud to be a Wal-Mart pharmacist. In fact, I know of several ND natives who would like to move back to ND, but choose not to make $15.00/hr less than all of the other pharmacists in the nation. Pharmacy is a career for me, not a job. I care about my patients and I have the same ethical and legal obligations as any other pharmacist in ND. ~~In Mr. Dodd's editorial, he suggests that the~~ Wal-Mart production model is all about filling as many prescriptions as we can. I wonder if he has ever worked for a Wal-Mart Pharmacy. The Wal-Mart model is to save people money on there prescriptions and to provide good healthcare services. I have seen the real people who are able to afford their medicines since the implementation of the $4 Drug Plan. I have seen diabetics finally able to afford their medicine, I have seen breast cancer patients finally able to afford the medicine they need to prevent reoccurance, I have witnessed people saving hundreds of dollars every month and they no longer have to choose between eating or their medication. I know that I just made a big difference in those people's lives. I am disgusted by all of the negative comment's about Wal-Mart pharmacists ~~and I am angry that North Dakotans are charged on average more for their prescriptions~~. I personally have nothing to gain from repealing the law. In fact, my pharmacy will actually lose business because we have hundreds of North Dakotans already filling their prescriptions at my pharmacy. ~~I also very much agree with Rick O that this will have very little affect on rural ND pharmacies~~. Most people will not travel 50 miles to save $10.00 on their prescription. If anything, it ~~can~~ will affect urban pharmacies. I want this law repealed because it unfair to North Dakotans.

Report a Violation

Glen P.
Jamestown, ND 01/26/2009 12:16 PM

I would like to correct Mr. Dodd. White Durg is not owned by pharmacists (alone,as his remark portrays) It is an employee owned company of which the majority of employees are not pharmacists.

Report a Violation

Kevin F.

BOARD OF PHARMACY
State of North Dakota

John Hoeven, Governor

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Gayle D. Ziegler, R.Ph.
Fargo
William J. Grosz, Sc.D., R.Ph.
Wahpeton, Treasurer

HOUSE BILL #1440 – Relating to Pharmacy Ownership
TUESDAY – FEBRUARY 3RD, 2009
Heritage Center

Chair Keiser and members of the House Industry Business and Labor Committee, for the record I am Howard C. Anderson, Jr, R.Ph., Executive Director of the North Dakota State Board of Pharmacy. Thank you for the opportunity to speak with you today.

The North Dakota State Board of Pharmacy strongly supports the current law, which we refer to as "the pharmacy control law".

The laws you and your predecessors have passed or sustained, have served North Dakota very well in the area of Pharmacy services. We have 236 pharmacies in ND, 48 of them hospitals, four of which have their own out-patient pharmacy. This means we have 29 per 100,000 people and even without our 18 retail telepharmacies we have almost 26 retail pharmacies per 100,000 people in North Dakota which is way ahead of the 16 in the next closest state. **WHAT A RINGING ENDORSEMENT FOR NORTH DAKOTA'S PHARMACY OWNERSHIP LAW.** We have more competition, more access, more service to North Dakota patients then any other state. Our Pharmacists provide excellent service to the patients of North Dakota. Pharmacy dispensing fees continue to gradually decline, while the cost of the drugs themselves continue to escalate. We have lost a few pharmacies but we have also opened a few. Our most recent additions are in Belcourt, New Town and a Telepharmacy in Towner.

In the 2007 Session HB 1299 was modified to a study. Four years ago the North Dakota Senate defeated a similar bill, SB 2283, by a wide margin. Six years ago HB 1407 received just a few votes. A *Fargo Forum* Article before the 2005 session pointed out that "Medicare costs for prescription drugs in North Dakota are actually lower than almost all other states". In spite of the National advertising from some for a 4 dollar one month supply of generic drugs, per patient, per month costs for prescription drugs are lower in North Dakota BECAUSE pharmacists here provide such a high level of service to their patients. Medications are taken appropriately, with proper counseling and patient information, and generics are dispensed at as high a rate as any place in the country. All this is due to the pharmacists of North Dakota operating under the Laws & Rules, You, as our Legislature have created over the years. This is certainly *NOTHING* to be **ASHAMED** of.

Whenever you want good patient care, and personal attention for the customer, you have to have enough time and enough professionals to provide that care. North Dakota pharmacists have that ability, because of the environment you have created for us. We are the best in the country. PLEASE do not let that slip away.

It is **North Dakota** which is the leader in the country in providing Telepharmacy services to rural areas, and we are working hard to extend telepharmacy to rural hospitals. This is because of what you have allowed. We know that demographics and reimbursement rates are making it more difficult for our pharmacists to maintain services to rural hospitals, and we are not opposed to a reasonable accommodation to allow some different scenarios, which might help that situation, while not jeopardizing the good things we have in North Dakota.

Allow me to review the History of this law for you. NDCC 43-15-35 was passed in 1963 by the North Dakota Legislature with the intention of keeping the professional pharmacist with his/her ethical standards, in control of pharmacies. The Oath of the Professional Pharmacist to keep concern for their patients uppermost in their professional practice contributes significantly to protection of the public's health, welfare and safety.

There have been attempts to legislatively repeal NDCC 43-15-35 in 1975, 1987, 1993, 2003, 2005 and 2007, and court challenges in 1968, 1972 and 1982. In all cases, these attempts were defeated by large margins. We believe that every sitting Governor since 1963 has supported the law.

In 1972, a decision by the North Dakota State Board of Pharmacy to deny a pharmacy license to Snyder's Drug Stores was appealed to the North Dakota District Court and the North Dakota Supreme Court. These courts relied on a 1928 US Supreme Court Decision called *Liggett v.Baldridge* to say the law was unconstitutional. The North Dakota State Board of Pharmacy appealed to the United States Supreme Court and in the case argued by Bismarck Attorney A. William Lucas, the US Supreme Court, by a 9 to 0 opinion reversed the 1928 *Liggett v. Baldridge* decision and upheld the Constitutionality of the North Dakota Law. On remand the North Dakota Supreme Court agreed. Attorney Lucas stated that he believes that this law has been one of the most thoroughly constitutionally and legislatively tested statutes in the North Dakota Century Code.

In the decision, written by Justice William O. Douglas, he stated very clearly, "*those who control the purse strings control the policy*". This has been the basic tenet from the beginning in the North Dakota State Board of Pharmacy's interpretation and application of this law.

Let me explain grandfathering. In 1963, a provision was made to allow pharmacies currently in business to stay in business as long as the ownership of those pharmacies did not change.

Until 1996 the Board of Pharmacy interpreted that to mean retail pharmacies. In 1996, the North Dakota Supreme Court said that it looked to them like hospitals, which had pharmacy permits in 1963, could do at their licensed locations, whatever they wanted to with their pharmacy permit. In 1963 when the law was passed, no one had ever envisioned hospitals would be in the out-patient pharmacy business. Even though legislators in 1963 did not envision hospitals in the out-patient business, many of them who continue to hold their pharmacy permit are in the out-patient

pharmacy business at their hospital's permitted location as grandfathered permit holders.

There are two members on our board who work for North Dakota Hospitals and the have expressed some concern about the inability of hospitals and clinics to provide coordinated care at all locations, but the board has said that they feel strongly that the ownership and control of pharmacies, by pharmacists, has been good for North Dakota and none of them wish to jeopardize what we have, when these issues could be resolved with a leased pharmacy, owned by North Dakota pharmacists working within a business associate agreement to provide coordinated care to the clinic and hospital patients.

There are currently nine *grandfathered* hospital pharmacies in North Dakota out of the total of forty-eight licensed hospitals in the state. In the 2007 Session you added a provision that if a community was losing it's only pharmacy, to allow the hospital in that community to own and operate a retail pharmacy. There have since been three instances where this could have occurred, but hospitals have not chosen to pursue the option.

Within the hospital where the hospital pharmacy is serving their in-patients, there are procedures which link the hospital pharmacist with the Pharmacy and Therapeutics Committee through the Medical Staff to the Board of Directors of the hospital. This allows all policies and procedures of the hospital/healthcare institution to be vetted through these several levels of control. Once we get outside the hospital/healthcare institution in a clinic setting or another location, these requirements do not apply.

The Supreme Court accepted your reasons for our Law in 1973. Today we see work place issues and medication errors headlined in the national pharmacy press. We see pharmacists in some pharmacies that have had to form a union in order to insist that they be allowed a bathroom, lunch or work break during their shifts. This does not happen in North Dakota. The environment you and your predecessors in the Legislature put in place has served North Dakota consumers well.

In North Dakota non pharmacist administrators do not determine how many prescriptions must be filled before there is an additional pharmacist or pharmacy technician to help. Pharmacists make those decisions.

The ownership law is the best opportunity for pharmacists to be masters of their own destiny in the patient's best interest. The ownership law insures that pharmacists who have pledged their oath to uphold healthcare standards and professional ethics determine policy.

North Dakota can serve as a light for the rest of the county. We have the best level of pharmacy services in practice in North Dakota, compared to ANY state.

Remember, "*Those who control the purse strings control the policy*"

We hope you agree and will keep it that way.

Thank you.

CVS CAREMARK

Important Changes to Your Prescription Benefits

December 30, 2008

[redacted]

[redacted]

We are pleased to inform you about an important change to your prescription benefit plan. Starting **January 1, 2009,** you will receive significant savings by getting your long-term medicines, in a 90-day supply, at either a **CVS/pharmacy** retail store or through **CVS Caremark Mail Service** Pharmacy.

Your prescription benefit plan will allow two 30-day fills at a network retail pharmacy. After these two fills you will need 90-day supply prescriptions filled by a local CVS/pharmacy or by CVS Caremark Mail Service. If you fill your long-term prescriptions at another retail pharmacy after two fills, **you will pay a higher copay***.

Choose what is more convenient for you. The copay is the same either way.

At a CVS/pharmacy you may:	With CVS Caremark Mail Service you may:
• Pick-up your long-term medicine directly from the pharmacy at a time that is convenient for you	• Enjoy convenient home delivery
• Enjoy same-day prescription availability	• Receive medicine in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
• Talk face-to-face with a pharmacist	• Talk to a pharmacist by phone

If you currently receive your long-term medicines from CVS/pharmacy or CVS Caremark Mail Service and wish to continue – no action is required. We will contact your doctor and notify you if you are not already on a 90-day prescription.

If you wish to change how you receive your long-term medicines either by switching to CVS/pharmacy or CVS Caremark Mail Service, we'll take care of it for you. We will contact you after your last allowable fill before the copay goes up and contact your doctor to get a 90-day prescription to have filled based on your choice of pharmacy.

Visit www.caremark.com to:

- Learn more about your prescription benefit plan
- Investigate other cost savings opportunities
- Access medicine and health information

If you have questions, please call Customer Care toll-free at **1-866-804-5882.** If you have a hearing impairment and need telecommunications device (TDD) assistance, please dial toll-free 1-800-231-4403. We are ready to make filling long-term prescriptions convenient for you.

Sincerely,

CVS Caremark

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

House Bill 1440 – 51% Pharmacy Ownership Law
House Industry, Business, and Labor Committee
Chairman – Rep. George Keiser
February 3, 2009 – 9:00 a.m.

Chairman Keiser and members of the committee, my name is Mike Schwab, the Executive Vice President of the ND Pharmacists Association. I am here today to provide comments in regards to HB 1440 – the repeal of the current ND 51% pharmacy ownership law

In the interest of time, I would like to briefly touch on some key points that need to be considered when discussing the future of pharmacy in ND.

First, we would like to reiterate some of the main reasons for enacting the law in the first place as outlined by the US Supreme Court.

- One reason for enacting the law was to ensure pharmacists control and have a stake in the health care services they provide to North Dakotan communities.
- Another reason noted by the US Supreme Court was to ensure social accountability was not compromised to the profit motive.
- Last one mentioned, would be to avoid "conflicts of interest" in doctor owned and operated pharmacies.

According to an independent economic study conducted in January of 2009 by the Institute for Local Self-Reliance and The New Rules Project titled "The Benefits of North Dakota's Pharmacy Ownership Law," there are a number of things that need to be seriously considered when looking at the repeal of the current 51% pharmacy ownership law.

Independent data used in the report shows compared to other states, North Dakota has more pharmacies dispersed across rural areas, ensuring, residents have access to these vital health care services. If you analyze the data you will also notice the pharmacies in ND are also uniformly scattered throughout the state allowing optimal service coverage. You will also notice in this report North Dakota has a tremendous amount of access in rural areas where the majority of the population is 50 years or older. Legislators have also

been asking for data on how this will affect rural pharmacies and how big of an issue are we talking about. Again, according to the above mentioned economic report from information gathered in regional states and in ND, the potential impact could be tremendous with 70 pharmacies at risk of closing with the potential repeal of the law. In addition, over 600 jobs lost mainly in rural markets.

We would also like to point out that over half of North Dakota's counties have already been designated as professional shortage areas according to The Center for Rural Health and Policy. Important to note, ND also has 46 communities with only one pharmacy being the sole source of pharmacy services.

We feel it is imperative to discuss the issue of "price" as well. As you know, as an Association we are not allowed to collect information on "price" from individual pharmacies nor are we allowed to recommend a "price" to pharmacies. However, I anticipate there are pharmacists and economists here today that will discuss their personal research and experiences with "price" as it relates to the prescriptions in the ND pharmacy market. With that said, as an Association we offer the following national and economic data as it relates to prescription drug costs collectively in ND. National Association of Chain Drug Stores report, the average national price was $69.91 and in ND, the average price was $65.28.

Every national report and/or study that has been looked at has consistently showed prescription drug costs in ND have been well below the national average. Even the National Association of Chain Drug Stores (chain pharmacies own report) shows prescription drug costs in ND are well below the national average. From Medicaid costs, cash pricing costs, insurance and overall, prescription costs are well below national averages in all of those markets. For the opposition to say prescription drug prices in ND are high is simply not the truth. Prescription drug prices in ND are among the lowest in the country. Economists and pharmacists that are here today will testify to their findings on price and will show comparisons nationally and locally.

As a profession, the pharmacists in ND have been able to do some really amazing things from a "service" perspective. We are not just talking about the short comments that are exchanged when you pick up your prescription. We are talking about the UNIQUE LEVELS OF SERVICE (patient care) the profession of pharmacy has been

able to implement and have been on the cutting edge in doing so. From, bone density testing, to medication therapy management reviews for ND seniors on Medicare Part D, to being the first state to implement a statewide diabetes education program for NDPERS members, to also being the first state to develop Telepharmacy service, the profession of pharmacy in ND has thrived and is a leader in a number of pharmacy services.

Direct Economic Impact

What is the potential economic impact in the ND pharmacy market if the law is to be repealed? We do not have an exact answer to "what will things look like in 3 years, 6 years, 10 years," etc... We do however find information contained in the economic report from the New Rules Project to be eye opening. It was noted that if the law is repealed it could cost the state millions of dollars with a potential loss of over $23 million dollars annually and a further loss in state and local tax receipts.

It further mentioned if the law is repealed, and the market share were to mirror what is happening across the country, there will be a direct economic impact LOSS for ND workers and businesses of over $18 million dollars. Again, those are DIRECT economic losses. It is also noted those economic losses will cause a further reduction in income, sales, and other state and local taxes.

We would also ask this Committee seriously consider what is happening to the pharmacy market nationwide in terms of vertical integration. Economists have been warning of vertical integration concerns in the pharmacy market for a number of years. Basically, we are talking about mergers and/or large pharmacy chains owning and operating publicly traded Pharmacy Benefits Managing companies (PBM's). There is an even bigger concern of late because these large publicly traded companies are forcing plan members to their brick and mortar pharmacies they own and operate and/or a mail order pharmacy which they own and operate. A recent CVS letter to plan members is attached for your view. This will provide you with an exact example of what we are seeing. These kinds of examples are not increasing the competition in the state and sure aren't increasing consumer choice in the state. This trend is alarming in other areas of the country.

Note: CVS owns Caremark a PBM, Walgreens owns Walgreens Health Initiatives a PBM, and Wal-Mart announced in June of 2008 they will start a PBM in 2009/2010.

In closing, we all know there are a number of important facts to consider when looking at this law. This is way bigger than just access to $ 4 prescriptions, which already exist in the state through CVS, independent pharmacies and/or mail order options. We are reassured that you will be thorough in your examination of all the short and long-term systemic effects that could take place with the repeal of the 51% pharmacy ownership law.

I would like to thank you for your time and attention today. I would be happy to try and entertain any questions you might have before I introduce a couple of economists who are here today to testify.

Respectfully Submitted,

Mike

Michael D. Schwab

EVP – ND Pharmacists Association

HOUSE INDUSTRY, BUSINESS AND LABOR AND HOUSE HUMAN SERVICES COMMITTEES
HB 1440
REPRESENTATIVE ARLO SCHMIDT

CHAIRMAN KEISER AND CHAIRMAN WEISZ AND MEMBERS OF THE HOUSE INDUSTRY, BUSINESS AND LABOR AND HOUSE HUMAN SERVICES COMMITTEES.

FOR THE RECORD, MY NAME IS ARLO SCHMIDT. I AM A STATE REPRESENTATIVE FOR DISTRICT SEVEN, WHICH COVERS A LARGE AREA OF NORTH CENTRAL NORTH DAKOTA.

I APPEAR BEFORE YOU TODAY IN OPPOSITION TO HB 1440. MY TESTIMONY COMES FROM MY OWN EXPERIENCE. APPROXIMATELY TWO YEARS AGO MY WIFE MARIAN WAS DIAGNOSED WITH LUKEMIA ALONG WITH DIABETES. MANY OF THE DRUGS SHE NEEDS TO USE ARE RESTRICTED (NO MORE THAN TWO WEEKS SUPPLY).

HERE IS THE LIST OF DRUGS: HYDOXYUREA, LISIVOPRIL, SIMVASTATIN, ATENOLOL, METFORMIN, BISOPROLOL, LYRICA, SERTALINE, AND POTASSIUM CHLORIDE.

HER DOCTOR IS IN BISMARCK AND HER NEXT APPOINTMENT IS THE 12TH OF THIS MONTH. HE DETERMINES THE AMOUNT OF MEDICINE SHE WILL NEED. THE PRESCRIPTION IS THEN FORWARDED TO MADDOCK DRUG STORE WHERE SHE GETS ALL HER MEDICINE LOCALLY. WITHOUT THIS DRUG STORE SHE WOULD HAVE TO TRAVEL 45 MILES, OR 90 MILES ROUND-TRIP, TWICE A MONTH OR A TOTAL OF 180 MILES A MONTH. FOR 12 MONTHS A YEAR AT 180 MILES A MONTH, SHE'LL TRAVEL 2160 MILES A YEAR, PAY $540.00 IN GAS.

IN MADDOCK MARION IS NOT A NUMBER. OUR LOCAL DRUGGIST KNOWS EXACTLY WHAT HER NEEDS ARE. WITH THESE DRUGS MARION DOES LIVE A RELATIVELY NORMAL LIFE, BUT SHE CAN NO LONGER DRIVE AND TAKES OTHER PAIN MEDICINE LIKE ALEVE, ETC. THEY ALSO HAVE A GIFT SHOP, WHERE MARION DID MOST OF HER CHRISTMAS SHOPPING.

FOR MARION, MYSELF AND OTHERS IN MADDOCK AND ALL ACROSS RURAL NORTH DAKOTA, WE BELIEVE THE BEST INTEREST OF OUR CITIZENS CAN BE SERVED BY REJECTING HB 1440.

I URGE A DO NOT PASS ON HB 1440

testimony 5

Dave

TESTIMONY FOR ND HOUSE OF REPRESENTATIVES INDUSTRY, BUSINESS AND LABOR COMMITTEE HEARING, HB 1440, FEBURARY 3RD, 2009.

PROFESSIONAL PHARMACY PRACTICE STANDARDS:

1. BECAUSE OF THE COLLABORATIVE EFFORTS OF ALL INTERESTED PARTIES IN PHARMACY (NDPhA, NDBPh, NDSU College of Phamacy,-ABC'S), PHARMACY IN ND HAS BEEN SHOWN TO BE A NATIONAL LEADER IN DEVELOPING PHARMACY PRACTICE STANDARDS. THE ASSOCIATED PHARACY PRACTICE ACT IN ND BOP RULES DEFINES THIS.
2. "HE WHO CONTROLS THE PURSE STRINGS, CONTROLS THE PRACTICE".
3. EXAMPLES OF NORTH DAKOTA LEADERSHIP IN DEVELOPING PROFESSIONAL PRACTICE STANDARDS:
    A. ND LEAD IN MANDATING PATIENT PROFILES.
    B. ND LEAD IN MANDATING PATIENT CONSULTATION ON PRESCRIPTION DELIVERY TO PATIENTS.
    C. ND LEAD IN DEVELOPING PRACTICE STANDARDS AND INCORPORATION OF PHARMACY TECHNICIANS INTO THE ND BOP PRACTICE ACT. THIS ALLOWED AN EXPANDED ROLE FOR TECHNICIANS WHILE REQUIRING MORE STRINGENT EDUCATIONAL REQUIREMENTS FOR TECHNICIANS. THIS ALLOWS THE PHARMACIST'S TO HAVE MORE TIME TO SPEND WITH THEIR PATIENTS FOR CLININCAL ACTIVITIES.
    D. ND ALSO WAS A LEADER IN DEVLOPING PRESCRIPTIVE AUTHORITY FOR PHARMACISTS. THIS REQUIRES A COLLABORATIVE AGREEMENT WITH A PHYSICIAN AND PRACTICE IN A CLINICAL SETTING.
    E. ND LEAD THE NATION IN DEVELOPING TELEPHARMACY STANDARDS. THIS LEAD TO THE PROVISION OF PHARMACY SERVICES TO PATIENTS IN RURAL AREAS THAT CANNOT SUSTAIN A FULL TIME PHARMACY PRACTICE.
    F. ND PHARMACISTS ARE GIVEN THE AUTHORITY (AFTER PROPER CERTIFICATION) TO GIVE IMMUNIZATIONS TO ADULT PATIENTS. THIS ALLOWS THE PROVISION OF THIS SERVICE TO PATIENTS IN RURAL AREAS THAT DO NOT HAVE ACCESS TO THESE SERVICES LOCALLY.
    G. ND PHARMACISTS WERE #1 IN THE NATION FOR THE DELIVERY OF MTMS FOR MEDICARE PART D PLANS FOR MIRIXA. THERE WERE UNDOUBTEDLY FINANCIAL AND HEALTH RELATED SAVINGS. (A NATIIONAL CHAIN LOCATED IN ND DIDN'T PROVIDE THIS EDUCATION FOR 1 PATIENT)

H. ND PERS DIABETES EDUCATION PROJECT. THE ONLY STATE WIDE NETWORK OF IT'S TYPE IN THE NATION. 200 CERTIFIED PHARMACISTS IN 80 SITES EDUCATING AND MONITORING PATIENTS, ALONG WITH THEIR HEALTH CARE PROVIDERS, TO PROMOTE HEALTH AND WELLNESS. THE PROGRAM IS IN IT'S EARLY STAGES BUT THE RESULTS ARE ALREADY VERY IMPRESSIVE. (A NATIONAL CHAIN LOCATED IN ND HAS CHOSEN TO NOT PROVIDE THESE SERVICES)

ALL OF THESE SERVICES WERE DEVELOPED OR SUPPORTED BY THE PARTIES INVOLVED FOR THE SOLE PURPOSE OF FOCUSING ON THE BETTERMENT OF HEALTH CARE IN ND, WHILE STILL PROVIDING MEDICATIONS AT A VERY COMPETETIVE, AFFORDABLE PRICE.

DAVID OLIG, R.PH.
FARGO, ND

Shane Wendel
Central Pharmacy
4 8th St N
New Rockford, ND 58356

Chairman Keiser and IBL committee members,

Thank you for the opportunity to speak today. I want to address the issue of pharmacy access and the effect this bill will have on rural North Dakota. I have just completed the purchase of my business, Central Pharmacy on January 1st. I want to talk about the pharmacy in New Rockford as it is the only pharmacy in town. Central Pharmacy severs about a 35 mile radius and also provides all the pharmacy services to Lutheran Home of the Good Shepherd which has 80 residents and about 100 employees. We also provide pharmacy services to 4th Corporation Group Home which has 44 residents and 78 employees. Golden Acres in Carrington also gets many services from our pharmacy. They have 60 residents and about 90 employees. I have included letters from all three facilities indicating their support to leave the existing law in place to preserve the cooperation and reliance we have in health care together. Please remember that about 70 other communities exist just like New Rockford that cannot afford to loose this small town health care resource.

North Dakota has much better access to rural pharmacy delivering cost effect prescriptions than our neighbor South Dakota. This is because of the ownership law. Predatory pricing and the perception of low prices that is bought though advertising, kills rural North Dakota pharmacies. The average price of a prescription in my pharmacy in 2008 was about $52. What was Wal-Marts average price of a prescription in 2008? Some are $4 but truly what is it costing consumers for all prescriptions? Wal-Mart will not say, I wonder why? I could sell my prescriptions for 50% less than Wal-Mart and I will still loose prescriptions because they are able to buy the perception of low cost because of the money they spend in advertising. Buying perception of low prices. This bill's support is a prime example of this.

My small business would fail with a 15% decline in my prescription volume and a 30 mile radius of pharmacy access will be gone forever. As many as 70 communities exist just like mine with a very similar story. Small town Main Street we all know has struggled to continue and maintain services the rural farming communities need. This bill will drastically accelerate the consolidating and centralizing of pharmacy services at the expense of access. Travel costs, late treatments, missed doses and lack of drug information are a cost that seems to get no consideration from bill proponents. Rural consumers will always pay the price of centralized services.

North Dakota's population is over 50% rural. Many people have pretty much written off small town North Dakota because we are struggling over time. We must continue to protect and value our rural economies. The 51% ownership law allows rural North Dakota pharmacies a better chance to continue the services we provide at $5 below the

national average for total prescription costs. I ask for your support to protect rural pharmacies to continue to deliver the best pharmacy care and the most affordable prescription drugs.

Thank you

Shane Wendel Pharm.D.

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4TH CORPORATION

Main Office
120 11th Street
New Rockford, ND 58356
701-947-2147 • Fax 701-947-2027

January 30, 2009

Mr. Shane Wendel
Central Pharmacy
4 8th St. N.
New Rockford, ND 58356

Dear Mr. Wendel,

The 4th Corporation Board of Directors would like to express their support of maintaining the 1963 law of 51% pharmacist ownership in North Dakota pharmacies. We see many benefits with having our local pharmacies maintain the ownership status as they currently do.

4th Corporation provides services to 44 people with developmental disabilities and employs 78 staff in Eddy, Foster, Wells, and Ramsey counties. Our consumers and staff all benefit from having the availability of locally owned pharmacies in our hometowns. The local pharmacists know our system, our clientele, our staff, the rules and regulations we must follow in our business, and are always ready to take as much time as is needed to answer any questions we have in their area of expertise. The local pharmacists have also been available to take 'after hours' calls from staff who have questions on medications. Their availability, knowledge, and input is invaluable.

4th Corporation also benefits by having the locally owned pharmacies be part of the small towns we live in. Businesses in the small towns understand the complexities of operating in the smaller communities, and we each support our local businesses and help maintain the smaller communities we have pride and ownership in. As a small town business 4th Corporation has established a Foundation to help support the needs of the people we provide services to, and the support of the locally owned businesses, including the locally owned pharmacies, has been outstanding. It is this 'helping each other' concept which enables us to grow and keep our communities viable and ongoing.

If you have any questions of us that would help you make your decision in this proposed bill, please give us a call. We extend our support in maintaining the current laws regarding 51% ownership by the local pharmacist.

Sincerely,

Bill Starke

Bill Starke,
Board of Directors

Pharmacyownershipsupport.091

LUTHERAN HOME OF THE GOOD SHEPHERD
NEW ROCKFORD, NORTH DAKOTA

16

[redacted]ebruary 2, 2009

Shane Wendel, Pharm. D
Central Pharmacy
4 8th St. N.
New Rockford, North Dakota 58356

Dear Shane,

I am writing this letter to you offering you my support to defeat HB 1440 and HB 1523 relating to the Pharmacy Law and Ownership in North Dakota. The Lutheran Home of the Good Shepherd relies on our pharmacy in New Rockford 24 hours a day for our residents' prescriptions as well as STAT medications. The continous changes in medications happen every day if the larger pharmacies were to come to North Dakota we could lose our pharmacy in our community

I have worked in rural areas for many years and its reassuring to have a pharmacy in the rural town for our staff, physicians and our residents to know they can get their new prescription filled so quickly without worry to travel over 40 miles to pick up their prescriptions or the wait to have them delivered to their homes by mail.

I strongly urge our representatives to vote "no" to HB 1440 and HB 1523 so North Dakota will be able to continue with pharmacy services in the community for our elderly, Lutheran Home of the Good Shepherd residents' and [redacted]er members of the community.

Respectfully submitted,

Ella Gutzke, Administrator

Ella Gutzke, Administrator
Lutheran Home of the Good Shepherd
1226 1st Ave. N
New Rockford, North Dakota 58356
Ph# (701) 947-2944

2/2/2009

Golden Acres Manor

16 1 East Main Street
P.O. Box 261
Carrington, ND 58421-0261

1-30-2008

Dear Members of the House Industry, Business, & Labor Committee:

I am writing to indicate my full support for leaving the current pharmacy ownership law as is.

I serve as the Administrator of a 60 bed Skilled Nursing facility located in Carrington, ND, which employs approximately 90 staff members. A change to the current pharmacy law would negatively impact all of those individuals and the two pharmacies serving them. A change in the law will also be detrimental to the other small, rural community pharmacies in the state, as well as the communities and community members that they serve.

Those rural pharmacies operating throughout the state will see a variety of issues. They will face a financial strain as some customers move toward a cheaper distributor of their medications, which will happen even if that means extended travel as seen by the migration of North Dakotan's filling prescriptions in Canada. They will also be faced with a staffing issue as non-owner pharmacists working as employees in these rural pharmacies begin to seek positions in the large chain type organizations which may be able to offer higher wages, better benefit packages, more flexible schedules, etc.

In addition to the pharmacies and the owners having to deal with many negative issues, the citizens of North Dakota will also be forced to deal with various concerns. The primary concern that will face each citizen will be that they will see a decline in the quality of service – both in medication guidance and general assistance – afforded them during a visit to the pharmacy. This will be due to the large organization's method of operation, which will consist of a push for streamlined, quota driven productivity as a means of limiting staffing and generating larger profits for the company.

None of the above concerns will be of benefit to the state, the economy, the survival of rural business, or the citizens of North Dakota. Nor will these concerns be short-term issues or easy to resolve long-term. The best, and truly only, solution is for the existing pharmacy ownership law to be left in place.

Please consider allowing North Dakota's Pharmacists to continue operating their facilities in the manner that has resulted in a very high level of quality and service, and which will not interrupt the excellent care they provide the customers they serve. Thank you for your consideration.

Sincerely,

Mitchell Page
Administrator

Phone 701-652-3117 Fax 701-652-3118

TOP 25 GENERICS DISPENSED BY RX VOLUME IN 2008 ($20.00 annual fee to join)

MEDICATION	Linson Pharmacy - Fgo	Walgreens Regular Retail Price	Walgreens Rx Savings Club	Wal-Mart Pharmacy
[illegible]ronate 70mg #12	$ 23.80	$ 179.89	$ 24.97	$ 24.00
amlodipine 10mg #90	$ 74.09	$ 167.89	$ 81.97	$ 137.72
amoxicillin 500mg #30	$ 11.17	$ 14.99	$ 9.99	$ 4.00
atenolol 50mg #90	$ 12.85	$ 21.99	$ 9.99	$ 10.00
azithromycin 250mg #6	$ 23.99	$ 43.99	$ 29.99	$ 31.78
cephalexin 500mg #40	$ 14.36	$ 21.99	$ 9.99	$ 43.32
citalopram 20mg #90	$ 18.34	$ 88.29	$ 12.00	$ 10.00
fluoxetine 20mg #90	$ 13.53	$ 41.99	$ 12.00	$ 10.00
fluticasone nasal sp #1	$ 32.58	$ 69.99	$ 52.97	$ 52.36
furosemide 40mg #90	$ 14.08	$ 17.99	$ 9.97	$ 10.00
glyburide 5mg #90	$ 17.64	$ 31.49	$ 10.99	$ 10.00
hctz 25mg #90	$ 12.14	$ 16.99	$ 12.00	$ 10.00
K+ 20meq ER #90	$ 35.22	$ 47.89	$ 21.97	$ 27.46
levothyroxine 75mg #90	$ 17.52	$ 32.89	$ 12.60	$ 10.00
lisinopril 20mg #90	$ 19.13	$ 39.99	$ 12.00	$ 10.00
metformin 500mg #180	$ 16.21	$ 47.89	$ 10.99	$ 10.00
metoprolol 50mg #180	$ 17.45	$ 41.99	$ 12.00	$ 10.00
omeprazole 20mg #90	$ 101.08	$ 227.87	$ 141.97	$ 240.78
pantoprozole 40mg #90	$ 285.75	$ 317.89	$ 291.97	$ 346.54
[illegible]ertraline 100mg #90	$ 17.81	$ 113.59	$ 51.97	$ 61.62
[illegible]vastatin 20mg #90	$ 17.27	$ 113.59	$ 51.97	$ 15.00
[illegible]done 50mg #90	$ 12.69	$ 30.69	$ 12.00	$ 10.00
[illegible]printec #84	$ 42.47	$ 87.89	$ 36.00	$ 27.00
warfarin 5mg #90	$ 27.19	$ 29.99	$ 12.00	$ 10.00
zolpidem 10mg #30	$ 11.21	$ 69.94	$ 39.99	$ 47.72
(drugs shaded this color are not available from Wal-Mart in certain states due to predatory pricing laws)				
TOTALS:	**$ 889.57**	**$ 1,919.58**	**$ 984.26**	**$ 1,179.30**
		$ (1,030.01)	$ (94.69)	$ (289.73)
			10.6% higher	32.6% higher

**The Walgreens and Wal-Mart prices were obtained by calling the pharmacies in Moorhead and Dilworth, M.N.

This is the top 25 generic prescriptions filled by Linson Pharmacy in 2008 by number of Rx's.

Linson Pharmacy prices are cheaper in all categories.

Walgreens DOES NOT BILL THE RX SAVINGS CLUB PRICE TO INSURANCE.

This means that on the above medication list - Linson Pharmacy price to insurance is $1,031.01 less!

Michael Bunn, Pharm. D., a consultant for Pharmacy Healthcare Solutions in Pittsburgh, PA.

(quotes from Mr.Bunn at a January, 2009 conference on Pharmacy Automation and Technology)

"The downside is prescriptions are divided among multiple pharmacies, and there is reduced pharmacist patient interaction."

"[illegible]ou need to compare the business v.s. the professional philosophy and find how those 2 can meet."

"[illegible]ith an enrollment fee program, the discounts are given to enrolled customers only, for traditional chain [illegible]macies, it allows them to capture additional revenues for those who don't participate."

WHAT'S THE REAL TRUTH ABOUT Wal-Mart's $4.00 GENERIC DRUG LIST?

- The January 23rd, 2009 list consists of 342 items
- **There are only 68 different drugs.** For Example, there are 15 different amoxicillins (different strengths, forms, or sizes), 11 different levothyroxine strengths, and nine (9) different warfarin strengths. **These drugs alone account for 10.5% of the entire list.**
- The 68 drugs consist of different sizes. (e.g. 100ml, 150ml, 15gm, 30gm), different strengths (e.g. 1mg, 2mg, 4mg), and different forms of the same drug (e.g. ointment, cream, liquid, tablet) to make up the complete list of 342 items.
- **The list comprises less than 5% of total drugs dispensed in 2008.**
- 25 items are very old drugs with high side effect profiles that are used very little today.
- 70 items are not 30 days supplies; several others are questionable!
- 58 items are asterisked indicating prices may be higher in CA, HI, MN, PA, TN, WI, and WY. ***Are there concerns with predatory pricing?***
- 76 items are marked with a symbol stating prepackaged drugs covered only in unit sizes specified on the Drug List. Does this mean that smaller sizes of the same drug will be priced more expensively? Examples:
  a. hydrocortisone cream 2.5% listed as 30gm. for $4.00. *What about a 20gm. tube that is dispensed?*
  b. silver sulfadiazine cream 1% is listed as 50gm. for $4.00. *What about a 25gm. tube that is dispensed?*

Note of some important restrictions:

- Program pricing may be limited to select manufacturers of a covered drug and is available as long as store supplies in stock at the pharmacy from such manufacturers last. *There are multiple manufacturers of the generics on this list. Does this mean if the Teva generic is on the $4.00 list and the store is out, the same drug from Watson generics is not covered?*
- Not all drugs covered by the $4.00 program are covered by the $10.00 program or all drugs covered by the $9.00 program are covered by the $24.00 program. *How is the patient to know and understand what is covered?*
- Prorated pricing is not available under the Program for prepackaged drugs. *What if the prescriber writes for a smaller size than what is advertized on the drug list? Does the patient pay more for a smaller size or $4.00? How is the patient to know?*
- Prepackaged sizes dispensed in unit sizes not specified on the Drug List may be priced higher, even if equivalent quantities of the drug are available in specified unit sizes. *Is this veiled marketing to charge the patient more at Wal-Mart's discretion? So, a smaller package of the same drug would likely cost more!!*
- *YOU MAY PAY MORE OR LESS THAN THE PROGRAM PRICE, DEPENDING ON THE TERMS OF YOUR INSURANCE PLAN. How can a patient pay more than the Program price if that is what is being billed to insurance????*
- Presciptions must initially be filled in person. Refills must be picked up in store. There are no substitutions or mail orders. *Why must the prescriptions be picked up in person? Is it because they need you to come into the store to make up what they just gave away at a loss on the Program?*
- These Program Details are subject to change **WITHOUT ADVANCED NOTICE.** Changes to these Program Details may be made only in writing. *They can change anything they want in this Program without any advanced notice. One month your drug may be on the list and the next month it is not!!!!!!*

NACDS 2008-2009 Chain Drug Industry Profile - Average Price/Rx by Type of Payment:

			Insurance		
	Cash	**Pt Co-pay + Ins Pymnt**	**Medicaid**	**Overall**
National Average:	$ 54.47	$ 71.00	$ 81.07	$ 69.90
North Dakota:	$ 47.23	$ 67.18	$ 72.94	$ 65.28
Difference	**$ 7.24**	**$ 3.82**	**$ 8.13**	**$ 4.62**
Linson Pharmacy	$ 37.56	$ 59.91	$ 55.09	$ 57.99
Number of Rx's filled:	958,760	7,219,827	468,882	8,647,469
Dollars Saved:	**$ 6,941,422.40**	**$ 27,579,739.14**	**$ 3,812,010.66**	**$ 39,951,306.78**
Linson Pharmacy	$ 16,212,631.60	$ 80,067,881.43	$ 12,181,554.36	$ 102,991,355.70
Geographic region:	**This includes the states of SD,Mn, Wy, Neb, Mont, Kan, Iowa, Wisc.)**			
Regional Average:	$ 52.04	$ 69.95	$ 77.66	$ 68.05
North Dakota:	$ 47.23	$ 67.18	$ 72.94	$ 65.28
Difference:	**$ 4.81**	**$ 2.77**	**$ 4.72**	**$ 2.77**
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Dollars Saved:	**$ 4,611,635.60**	**$ 19,998,920.79**	**$ 2,213,123.04**	**$ 23,953,489.13**
Linson Pharmacy	$ 13,882,845.00	$ 72,487,063.00	$ 10,582,667.00	$ 86,993,538.00

*Linson Pharmacy data is from actual 2007 dispensing of over 73,000 prescriptions
NACDS is the major association for the BIG BOX stores, This is the date being used by "Citizens for Affordable Healthcare".

If you do not want to use the national numbers - look at the geographical numbers.
Almost $24,000,000.00 less in drug price in North Dakota!!
Medicaid/Taxpayer savings of $2,213,123.04!!!!
Insurance Savings: $19,998,920.79 - This is lower co-pays and cost to insurer!!!

Interesting to note: EVEN WITH $4.00 GENERIC PROGRAMS IN OTHER STATES - ND IS $4.81 CHEAPER ON CASH RX'S.
This helps the unisured of N.D.!!!!!

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NACDS 2008-2009 Chain Pharmacy Industry Profile

Table 39

Year	Price Brand Name	Price Overall	Price Generic	Percent Brand Name	Percent Generic	
1990	$ 27.16	$ 22.06	$ 10.29	69.80%	30.20%	
1991	$ 30.11	$ 23.87	$ 10.85	67.60%	32.40%	
1992	$ 33.68	$ 26.33	$ 11.78	66.40%	33.60%	
1993	$ 35.28	$ 26.99	$ 12.82	63.10%	36.90%	
1994	$ 37.37	$ 28.37	$ 14.18	61.20%	38.80%	
1995	$ 40.22	$ 30.01	$ 14.84	59.80%	40.20%	
1996	$ 45.11	$ 32.86	$ 15.71	58.30%	41.70%	
1997	$ 49.55	$ 35.72	$ 16.95	57.60%	42.40%	
1998	$ 53.51	$ 38.43	$ 17.33	58.30%	41.70%	
1999	$ 60.66	$ 42.42	$ 18.16	57.10%	42.90%	
2000	$ 65.29	$ 45.79	$ 19.33	57.60%	42.40%	
2001	$ 69.75	$ 50.06	$ 21.72	59.00%	41.00%	
2002	$ 77.49	$ 55.37	$ 24.89	57.90%	42.10%	
2003	$ 85.57	$ 59.52	$ 27.69	55.00%	45.00%	
2004	$ 91.80	$ 62.64	$ 28.23	54.10%	47.50%	
2005	$ 97.65	$ 63.87	$ 29.21	50.60%	51.30%	
2006	$ 107.48	$ **66.97**	$ **31.39**	46.80%	53.20%	
2007	$ 119.51	$ **69.91**	$ **34.34**	41.80%	**58.20%**	(ND rate 70.45%)

The overall price increase was $69.91 - $66.97 = $2.94 (4.4%)
In N.D. the overall price increase was $65.28 - $64.18 = $1.10 (1.7%)

The generic programs by the "BIG BOX" stores were in place in 2007.
Why was the national price increase greater than N.D.'s????????
The average generic dispensing rate in N.D. for 2007 was 70.45%!!!!
This beats the national average by **12.25%!**
Why?, because the N.D. ownership law puts patients instead of profit 1st!!!

THESE ARE THE NUMBERS FROM THE NATIONAL ASSOC. OF CHAIN DRUG STORES!!!
*This is the primary association for all "Big Box" stores!!!

PHARMACY COMPARISON OF FARGO-WEST FARGO V.S. SIOUX FALLS S.D. - 2009						
THE EFFECTS OF CORPORATE OWNERSHIP						
	Fargo/WF	Sioux Falls, SD				
[redacted]opolitan area population:	123,000	228,000				
Community retail pharmacies:	28	37				
Community retail pharmacies						
with different ownership:	19	12				
(this reflects 1 corporate owner for multiple stores)						
Number of people/pharmacy	**1 per 4,393**	1 per 6,162	**MORE PATIENT ACCESS IN F/WF**			
Number of people per pharmacy						
with different ownership:	**1 per 6,474**	1 per 19,000	**MORE COMPETITION IN F/WF**			
This is the effect corporate ownership has.						
Sioux Falls has 3 chain corporations operating 23 of the pharmacies in the city!					That's 62% of mkt	
This isn't competition - its monopolizing the market!						

OwnershiptestimoneyIBLComm020309 IBL Comm. 02-32-09

Good morning, Chairman Keiser and members of the Industry, Business and Labor Committee. My name is Tony Welder and I have been a pharmacy owner in ND for over 40 years. I am speaking in favor of keeping the pharmacy ownership law intact.

My testimony is going to focus on lawsuits and settlements of some of the big pharmacy chain stores, all published in the national pharmacy trade press. I have not written any of these, but simply gathered the articles for the past few months. I will shorten them here, but have the entire articles attached.

I will finish by explaining why these may be important to ND citizens and how they could possibly affect the fiscal situation in North Dakota.

Rite-Aid was fined 5 million dollars for violating rules to control ingredients for making methamphetamine,

CVS/Caremark was fined 36.7 million dollars for improperly switching Medicaid patients to higher priced drugs. They also paid 38.5 million dollars for unnecessarily driving up prescription costs by encouraging physicians to switch patients to different branded drugs, under guise that the new drugs would save patients and health plans money. This was the second time in a month that the firm paid millions of dollars to settle charges of questionable business practices.

Walgreens paid 35 million dollars for improperly switching drugs to more expensive ones to increase reimbursement from Medicaid.

Wal-Mart was fined 2.866 million dollars to have allegedly dispensed partial bottles of medicine but received full payment from Medicaid. They were also fined 637,000 dollars for failure to keep proper records leading to loss, theft or possible diversion of controlled substances.

Wal-Mart, paid or will pay at least $352,000,000 and possibly up to $640,000,000 to settle 63 class actions lawsuits over claims of employees being forced to work off the clock.

142 CVS/Caremark stores and **112 Rite-Aid stores**, were sued by NY Attorney General Andrew Cuomo for selling more than 600 outdated items, including food and baby formula. Two weeks after an agreement was reached with the attorney general, outdated products were still on their shelves. The California Attorney General found the same pattern.

The most recent event concerning chains is that **Caremark, a Pharmacy Benefit Manager owned by CVS**, is sharing patient records with its retail giant. Patients are getting letters informing them that after two refills of maintenance medications, they must have them filled at a CVS store or by their out of state mail order pharmacy. Local pharmacies are not allowed to fill 90 day supplies.

This kind of activity is reverse economic development, destroys competition, and is financial coercion to drive business out of state.

If those activities occurred here, would ND have the resources and personnel to audit and expose them? Or if not exposed, how much would it affect our Medicaid and health-care budget?

Something to think about: If those kinds of lawsuits were against other out of state businesses such as construction or retail, would any of you here rush to encourage them to do business in this good state?

I am not aware of any of those types of events and lawsuits ever happening in the independent pharmacies of North Dakota.

Thank you for your consideration of the facts.

Rite Aid pays $5M in probe

WASHINGTON (AP) — Pharmacy chain Rite Aid Corp. and subsidiaries in eight states will pay $5 million in penalties for violating rules designed to control key ingredients for methamphetamines.

The Justice Department said Monday that the drugstore operator also has agreed to a new compliance plan with the Drug Enforcement Administration.

Officials said DEA investigation found the company knowingly filled prescriptions for controlled substances pseudophedrine and ephedrine when it knew those prescriptions were not issued for a legitimate medical reason.

Violations were found at Rite Aid pharmacies in California, Kentucky, New Jersey, New York, Maryland, Michigan, Pennsylvania and Virginia.

They got $21 9M

Rite-Aid
$5,000,000
violated
rules for
control of
ingredients
to make meth.
Justice Dept
8 states

News

Rite Aid reduces earnings outlook for quarter, year

CAMP HILL, Pa. — Rite Aid Corp. has announced that its losses for the fourth quarter and full 2008 fiscal year will be much larger due to a noncash accounting charge related to income tax expense. The charge will have no impact on revenues, liquidity or adjusted EBITDA (earnings before interest, taxes, depreciation and amortization), but it will increase Rite Aid's net loss and loss per diluted share.

According to the company, the exact amount of the charge has not been finalized, but it is expected to range between $800 million and $1 billion, or $1.11 to $1.38 per diluted share. The company's previously issued full-year guidance had projected a loss of 27 cents to 31 cents per diluted share. Analysts on average had been expecting Rite Aid to book a full-year loss of 28 cents per share and quarterly red ink of 8 cents per share.

The charge will be recorded as a valuation allowance reducing its deferred tax assets. In fiscal 2006 Rite Aid was able to use a similar income tax valuation allowance to boost its net income by nearly $1.2 billion.

In January the company posted a much bigger than expected third quarter loss as a result of expenses related to its acquisition of more than 1,850 Brooks Eckerd Pharmacy stores from the Jean Coutu Group. As a result, its year-to-date net loss ballooned to $126.8 million.

The company emphasized that its sales estimate of $24.3 billion and its forecast of 2008 adjusted EBITDA ranging between $950 million and $1 billion remain unchanged.

In an unrelated move, Rite Aid launched a consent solicitation on two indentures to eliminate a discrepancy between its debt-incurrence covenant and the lien covenant that exists in the indentures. The proposed amendments do not increase the aggregate amount of debt Rite Aid is allowed to carry.

Plan a catalyst

BENTONVILLE, Ark. — Wal-Mart Stores Inc.'s $4 generics program has saved Americans more than $1 billion since its launch in September 2006, the company's senior vice president and president of health and wellness, John Agwunobi, reported in a recent speech.

In an address to the Council of Teaching Hospitals in New Orleans last month, Agwunobi noted that more than 100 of the discounted drugs are prescribed for heart disease and diabetes.

"While $1 billion in savings

CVS Caremark reaches settlement in lawsuit

WOONSOCKET, R.I. — CVS Caremark Corp. has agreed to pay $36.7 million to settle allegations that it improperly switched customers to a more expensive form of a drug paid for by Medicaid.

The settlement marks the second time in a month that the firm has agreed to pay millions of dollars to settle charges of questionable business practices.

In February CVS Caremark agreed to pay $38.5 million to 28 states to settle claims that its Caremark unit unnecessarily drove up prescription drug costs by encouraging physicians to switch patients to different branded drugs under the guise that the new drugs would save patients and health plans money.

The latest settlement — which was reached in mid-March — stems from a lawsuit filed by a former CVS pharmacist in Illinois in 2003. Since then, 23 states and the federal government have joined the legal action.

According to the lawsuit, between April 1, 1999, and December 31, 2006, CVS pharmacies switched Medicaid patients taking the generic form of the stomach medication Zantac (ranitidine) from tablets to capsules.

Medicaid sets maximum reimbursement prices for the tablet form of the drug but not for capsules, which are more expensive but prescribed less frequently by doctors.

According to the lawsuit, the switch cost taxpayers as much as 400% more than what would have been paid for tablets.

CVS has denied engaging in any wrongful conduct, saying that it purchased and stocked the capsule form of ranitidine in all its stores because the cost was lower than that of the tablets. It denies it dispensed capsules to raise Medicaid reimbursement.

In addition to the $36.7 million CVS Caremark is paying to settle the case, the company will pay $800,000 in investigative costs and other fees.

CVS says it has known about the investigation for several years and notes that the government has also been looking at the way several other drug chains have dispensed ranitidine to Medicaid patients.

Besides its monetary settlement, CVS Caremark has entered into a corporate integrity agreement with the federal Office of the Inspector General.

The Medicaid-bilking allegations against CVS were brought by former CVS pharmacist Bernard Lisitza, who has a history as a whistle-blower.

Previously Lisitza brought legal action against Omnicare Inc., the nation's largest provider of pharmacy services to nursing facilities and assisted-living communities. That case was settled in 2006 for $49.5 million.

Both suits were filed under the False Claims Act, which allows people to file claims alleging fraud against the government and lets them recover a portion of any payments.

The Justice Department says Lisitza received $6.4 million from the Omnicare settlement. His attorney, Michael Behn, recently told *The Wall Street Journal* that Lisitza's share of the CVS settlement will be $4.3 million.

AARP Bulletin today

Walgreens $35,000,000 To More Expensive drugs to increase reimbursement from Medicaid

Walgreen to pay $35 million in drug switching

June 5, 2008 - The Philadelphia Inquirer

By Suzette Parmley

Jun. 5, 2008 (McClatchy-Tribune Regional News delivered by Newstex) --

Walgreen Co. (NYSE:WAG) has agreed to pay $35 million to settle claims that it improperly switched patients' prescription drugs to more expensive ones in order to increase its reimbursement from Medicaid, the U.S. Justice Department announced yesterday.

New Jersey and Pennsylvania will receive part of the money from the case, which was filed by a whistle-blower who sued major pharmacies in two other high-profile cases that netted $87 million in settlements.

Walgreen, of Deerfield, Ill., operates more than 5,000 retail pharmacies throughout the United States. It has about 3,500 employees in the Philadelphia region.

From 2001 to 2005, Walgreen switched the prescriptions for Medicaid patients who were prescribed 150-mg or 300-mg tablets of ulcer-fighting Ranitidine to more expensive capsules; prescriptions for 10-mg or 20-mg capsules of the antidepressant Fluoxetine to more expensive tablets; and prescriptions for 5-mg tablets of the Parkinson's drug Eldepryl to more expensive capsules, according to yesterday's settlement.

The Justice Department said that by switching the prescriptions, Walgreen substantially increased its Medicaid reimbursement while providing no additional medical benefit to the affected patients -- in violation of federal and state regulations.

The suit was filed in 2003 by Bernard Lisitza, a licensed pharmacist in Illinois, on behalf of federal and state governments.

Lisitza, who was temping for another pharmacy and filling some prescriptions for Walgreen's, contended in his suit that the drug-switching programs he observed by Walgreen's were schemes to increase pharmacy profits at taxpayers' expense, and that they resulted in no medical benefit to patients.

Recent generic drug-switching cases by Lisitza resulted in a $37 million settlement earlier this year with CVS (NYSE:CVS) Caremark Corp., owner of CVS pharmacies, and a $50 million settlement in late 2006 with Omnicare Inc. (NYSE:OCR) , the nation's largest pharmacy for nursing homes.

Lisitza's attorney, Michael Behn, said his client was fired after reporting the drug switching at Omnicare and could find only temporary work far from his home in Northbrook, a suburb of Chicago.

"It's one thing to substitute a less-expensive generic for the brand name," Behn said in an interview yesterday from his Chicago office. "It's a different story when a pharmacy is switching to a more expensive drug."

Lisitza will get about $5 million under the Walgreen's settlement. The federal share of the settlement is about $18.6 million.

Forty-six states and Puerto Rico will share about $16.4 million under separate agreements. New Jersey will receive $1.2 million and Pennsylvania about $9,000.

Last month, pharmacy-benefits manager Express Scripts Inc. (NASDAQ:ESRX) , of St. Louis, agreed to pay $9.5 million under an agreement with the attorneys general of 28 states, including Pennsylvania, over switching patients' cholesterol-drug brands to control costs. The attorneys general claimed that the switches resulted in Express Scripts' profiting by getting drugmaker rebates, and that such cost savings were never passed on to consumers.

Walgreen shares closed unchanged yesterday at $36.34 on the New York Stock Exchange.

Contact staff writer Suzette Parmley at 215-854-2594 or sparmley@phillynews.com.

Newstex ID: KRTB-0160-25773021

INSPECTIONS & APPEALS

Steven K. Young, Director

Wal-Mart Medicaid

Wal-Mart Repays Iowa Medicaid Program $8,727.53

DES MOINES, IOWA (December 20, 2004) – Wal-Mart has paid $8,727.53 to Iowa's Medicaid Program to settle allegations under the federal False Claims Act that the company billed the state's medical assistance program for partially-filled prescriptions. The Arkansas-based company is alleged to have dispensed partial or "short" prescriptions due to insufficient stock, but received full payment from the Iowa Medicaid Program. Wal-Mart also paid an additional $2,909.18 to the State as penalty monies.

$2,866,904

US & 49 States

The settlement, part of a nationwide agreement in which Wal-Mart agreed to pay $2,866,904 to the United States and 49 states, covers the time period from January 1, 1990 to December 31, 2000. In addition to the $2.8 million payment, Wal-Mart has reached an agreement with the U.S. Department of Health and Human Services' Office of Inspector General that the company's conduct will be monitored by the government under a four-year corporate integrity agreement.

The Iowa Department of Inspections and Appeals' (DIA) Medicaid Fraud Control Unit assisted with the Wal-Mart investigation in the State of Iowa.

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Drug Topics
The Newsmagazine for Pharmacists

Wal-Mart pays fine for record-keeping violations

Publish date: Jan 8, 2009
By: Alaina Scott, Senior Editor

Wal-Mart Stores Inc., including facilities doing business as Wal-Mart Pharmacy and Sam's Club Pharmacy, has paid the Southern District of Texas a $637,000 fine to resolve numerous alleged record-keeping violations of the Comprehensive Drug Abuse Prevention and Control Act, acting U.S. Attorney Tim Johnson announced recently.

The fine was paid on Dec. 29, 2008. The settlement was finalized yesterday without an admission of liability and without commencement of litigation. "The illegal diversion of controlled substances is a threat to public health and safety," Johnson said. "Today's fine should serve as a reminder to the pharmaceutical industry of its accountability to the public. The public should be reassured by the enforcement efforts of the DEA as well as the industry's general overall compliance."

On July 18, 2006, notices of inspection were issued at five Wal-Mart and Sam's Club Pharmacies in Texas by the DEA Houston Division Office Diversion Group. The notices authorized DEA to conduct controlled substance accountability audits for 20 controlled substances at each location served.

"We take record-keeping very seriously, and we cooperated fully with the U.S. Attorney's Office and the Drug Enforcement Administration during this investigation," a Wal-Mart spokeswoman said. "We continuously review our processes at our pharmacies to ensure they're accurate and in full compliance with the law."

The five pharmacies investigated lacked the required records to prevent diversion of controlled substances, thus violating the Controlled Substances Act (CSA), according to the U.S. Attorney's Office. Specifically, from May 1, 2005 through July 18, 2006, the five facilities negligently failed to make, keep, or furnish records and reports, including invoices of controlled substances, as required by the CSA and its applicable regulations.

The accountability audits did not match the drugs on hand, revealing major overages and shortages in the accountability of controlled substances, and there were missing invoices for controlled substances, all in violation of the CSA, Johnson said. The investigation expanded to other facilities and revealed that several Wal-Mart and Sam's Club pharmacies either did not file or did not file in a timely fashion reports required by statute of loss and/or theft with DEA.

DEA registrants are required to file DEA forms in a timely fashion, reporting suspected thefts or losses of controlled substances. Because of the pharmacies' lack of proper record-keeping, a variety of Schedule II, III, IV and V controlled substances were lost or stolen and possibly diverted.

About the Author

Alaina Scott, Senior Editor

About Alaina Scott, Senior Editor
See more articles by Alaina Scott, Senior Editor

Wal-Mart, $637,000 Fine
Failure to keep proper records
Leading to Loss, theft or
possible diversion of
controlled substances.
U.S. Attorney

panies and the stock market collapse have made for a "disastrous combination," the letter notes.

"Moreover, it does not appear that these concerns will abate any time soon. With consumer spending accounting for 70% of GDP [gross domestic product], it is difficult to foresee an improve[redacted] overall economic growth u[redacted]e consumers regain their footing," the letter adds.

Retailers know from extensive experience with sales tax holidays that they give consumers a big incentive to shop, the letter says. It goes on to suggest three national sales tax holidays

dent and CEO Tracy Mullin.

NRF proposes that tax holidays be held in March, July and October, each lasting 10 days, including two weekends. Tax-free treatment would apply to all tangible goods subject to a state sales tax —ranging from apparel and home furnishings to restaurant dining and automobiles — but would exclude tobacco and alcohol.

The federal government would reimburse the 45 states with sales taxes for the lost revenue and provide the five states without a sales tax (Alaska, Delaware, Montana, New Hampshire and Oregon) revenue approximating the remuneration that would be received by states with similar populations.

State sales tax rates range from 2.9% to 7.25% and add $236 billion a year to the amount consumers pay for goods and services, according to the U.S. Census Bureau. If the taxes were lifted for the three 10-day periods, consumers could save nearly $20 billion, NRF estimates. Based on the 112.4 million U.S. households, the savings would amount to almost $175 for the average family.

Tops Invests in Future

WILLIAMSVILLE, N.Y. — Tops Markets LLC is considering opening seven to 10 new supermarkets as well as investing $150 million in current locations.

The strategy comes about a year after Morgan Stanley Private Equity acquired the 76-store, New York-based grocery chain from Ahold NV for $310 million.

According to Tops, the new location and store renovation plans are part of a plan to strengthen its position as the region's largest supermarket chain.

The plan was launched last fall, when Tops revamped its Olean, N.Y., supermarket from top to bottom, with a renovation of its Hamburg, N.Y., location next on the agenda.

The Hamburg face-lift is slated to cost between $4 million and $5 million, according to Tops chief executive officer Frank Curci. The project is due to be completed in the first quarter of 2009.

Curci says the store improvements, which range from minor touch-ups to multimillion-dollar renovations, will be made over the next five years, with about 60 Tops stores involved. Plans call for new stores to be built in Buffalo, Rochester and some areas extending to the middle of New York.

'c Sells Off n Business

M, Bi-Lo, P&C and Quality Markets banners in four Eastern states. C&S has acquired rights to the intellectual property that allows it to use all but the Big M banner.

"We own the trade names. They will own just the intellectual property," Young says. "Big M Supermarkets will still be a subsidiary of Penn Traffic."

Executives at Keene, N.H.-based C&S say the acquisition of Penn Traffic's wholesale business will bolster their operation.

"[redacted]s a substantial base of i[redacted]ndent wholesale business and views this acquisition as a natural complement to our current business," chariman and CEO Rick Cohen says. "We look forward to further developing the New York, Pennsylvania and eastern Ohio markets as well as leveraging Penn Traffic's proven service model in other regions."

Wal-Mart Settles Class-Action Suit

BENTONVILLE, Ark. — Wal-Mart Stores Inc. has announced that it will pay at least $352 million, and possibly up to $640 million, to settle 63 class-action lawsuits across the nation that claim that the retailer forced employees to work off the clock.

The legal settlement may be the largest ever lawsuit over wage violations, according to some lawyers involved. Wal-Mart made the announcement two weeks after it agreed to pay up to $54.25 million to current and former Wal-Mart employees in Minnesota who claimed that the retailer failed to grant workers full rest breaks and forced hourly employees to work off the clock.

Union critics maintain that the settlements bear out their accusations that the retailer achieves low prices in part by cheating workers. Tom Mars, general counsel and executive vice president of Wal-Mart, dismissed their charge, maintaining that the settlements corrected wage practices of local store managers who acted without authority. "Our policy is to pay associates for every hour worked and to provide rest and meal breaks," he said in a prepared statement.

Frank Azar, a lawyer who has represented Wal-Mart workers in 14 states, said in a statement that the latest settlement was fair to his clients. "We are equally pleased that Wal-Mart has made tremendous strides in wage-and-hour compliance and that it has implemented and that it has agreed to continue to follow state-of-the-art compliance programs so that these improvements will continue into the future."

According to a report in *The New York Times*, the settlements wipe out all but 12 wage lawsuits that are still pending against the company. They also provide a relatively clean slate as the Obama administration enters the White House this month. President-elect Obama has indicated that he intends to make fair-wage enforcement a priority.

The settlements also put an end to what some observers say has been an embarrassing chapter during the tenure of chief executive officer Lee Scott before he turns over his position to Michael Duke in February.

Rite Aid Targets Weight Problems

CAMP HILL, Pa. — Rite Aid Corp. has teamed up with the medical weight-control program Lindora and fitness expert Denise Austin to help customers meet their weight-loss goals for this year.

Working with Lindora, the drug chain has developed the Rite Weight Plan, an online weight-loss program designed to help participants lose as much as 10% of their body weight in just 10 weeks. Customers can enroll in the f[redacted]ogram at www.riteaid.com[redacted]ightplan.

Onc[redacted]rolled, customers receive daily support via e-mail that educates and motivates them to stay focused. A Daily Action Tracker is available to keep track of meals and food intake, with space to record pedometer steps and personal accomplishments. Other features of the program include food recommendations and menus, personalized question-and-answer sessions and interactive Web seminars with Lindora weight-loss experts.

Also part of the program is a free, 16-page weight management guide, available in Rite Aid stores and online. The guide gives examples of simple lifestyle changes that participants can make to look and feel better, hints about what to eat in restaurants, a body mass index calculator and ways to help children develop healthy eating and exercise habits.

The guide also includes 10 tips from Austin for making health and fitness a part of everyday routines, including fitness strategies, nutrition and a 7-minute strength-building routine.

Rite Aid customers can also enter a sweepstakes to win a day with Austin. Four customers and their guests will win a three-day, two-night luxury spa getaway at the Landsdowne Resort in Landsdowne, Va., where they will be treated to lunch, spa treatments and workout sessions with Austin.

Mass Market Retailer 1-12-09

format. The new store features larger fresh departments, expanded organics, signs calling attention to product health benefits, an easier-to-shop layout and lower everyday prices.

SAFEWAY'S $4 GENERICS: After testing the viability of selling $4 generic prescriptions at stores in Dallas and Houston earlier this year, Safeway Inc. has begun offering the service in its stores in the eastern United States and in the Chicago area. The program is being offered at Safeway stores in the District of Columbia, Virginia, Maryland, Delaware, New Jersey and Safeway pharmacies in the Dominick's units in the Chicago area.

WALGREENS SETTLES: Walgreen Co. has agreed to pay $35 million to 42 states and Puerto Rico to settle charges that it overcharged Medicaid by switching dosage forms in filling prescriptions for three generic drugs. The arrangement follows similar settlements with CVS Caremark Corp. earlier this year and with Omnicare Inc. in 2006.

KROGER, UNION AGREE: Kroger Co. has reached a tentative agreement on a new contract with the United Food & Commercial Workers Union Local 700 in Indianapolis. The tentative agreement covers more than 4,200 Kroger associates who work in 60 stores in and around Indianapolis and other parts of Indiana, including Bloomington, Crawfordsville and Kokomo.

Take Turn For Better

NEW YORK — May retail sales were a welcome surprise as consumers spending government rebate checks lifted results at discount stores and warehouse clubs much higher than expected.

Wal-Mart Stores Inc., Costco Wholesale Corp. and BJ's Wholesale Club Inc. posted big gains in sales of consumables, gasoline and off-price apparel as shoppers spent their federal income tax rebates.

Analysts questioned whether the spike from the government checks could be maintained in the face of escalating energy prices and the housing market downturn. But some said the May numbers augured well for discounters, noting that consumers had demonstrated an allegiance to low prices.

"May came in better than expected," says Michael Niemira, chief economist and director of research at the International Council of Shopping Centers. "But it is very clear that consumers are spending in a conservative manner, as the lift largely came from an increase in sales in the wholesale, drug store and discount sectors."

Same-store sales at Wal-Mart Stores Inc. advanced 3.9% (excluding gasoline sales at its Sam's Club division), far exceeding Wall Street's 1.6% projection. The home category generated

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[illegible] Expansion

NEW YORK — Big Lots Inc. chief executive officer Steve Fishman said earlier this month that the closeout retailer is ready to grow and has the potential to expand its store base to 1,800 locations.

"We're highly motivated to open more stores at the right price," Steve Fishman said at a Piper Jaffray & Co. conference in New York.

The proposed growth would increase the size of Big Lots' store base by about one-third.

The company, which specializes in sales of excess inventory, currently operates 1,353 stores in 47 states, with the highest concentration of its stores in California, Texas, Florida and Ohio.

"It's been our opinion that up until recently, the real estate space has been at a premium, and the rent market needed to cool down before we were going to be able to open a significant number of stores profitably," Fishman said, noting that the company has the distribution infrastructure in place to support 1,800 stores.

"We're starting to see more opportunity to open new stores as the commercial real estate market has started to come back to us," he explained. "Additionally, since we take secondary and tertiary locations, the number of store closings or bankruptcy proceedings you hear of from other retailers is starting to loosen up the availability of space."

growth in the United States was slowing, Wal-Mart's share price was stalled and the retailer was being routinely attacked by union-backed activists for its pay and health benefits.

Scott said Wal-Mart's previous woes were due in part to complacency generated by the company's earlier success.

"For several years, we did what we knew worked," Scott said "And we did it well. We grew beyond expectations. Our stock price went up. And we felt good about it. We had every right to. But in time, the world changed. People's expectations of us — and of corporations in general

any sold 192 million.

"Over the life of the product, these bulbs will save our customers nearly $6 billion and keep the equivalent of three coal-fired power plants off the electrical grid," Scott said.

Then there is Wal-Mart's $4 generic drug program, which the company has just extended with a $4 program for generic over-the-counter drugs. Wal-Mart has saved customers in three countries more than $1.1 billion since launching the $4 generics program 20 months ago.

The retailer has also taken a back-to-basics approach with its

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Two Drug Chains Sued Over Outdated Products

NEW YORK — New York Attorney General Andrew Cuomo has sued CVS Caremark Corp. and Rite Aid Corp. for selling expired over-the-counter medicines and food products.

Cuomo says investigators from his office found that 142 CVS stores and 112 Rite Aids across the state were selling out-of-date products, including milk, eggs, baby formula and a wide range of cold medicines, decongestants, allergy treatments and other O-T-Cs.

Investigators report that they were able to purchase more than 600 expired products.

For their part, the drug chains say the findings are cause for concern and are unacceptable.

"We take these allegations very seriously," a spokeswoman for Rite Aid says. "All of the stores mentioned by the attorney general have been told to make sure that there are no longer any outdated products on their shelves. "In addition," she says, "we are checking all of our stores nationwide for expired products, and we are undertaking new training programs to ensure this does not happen again."

According to Cuomo's office, some of the medicines purchased by undercover investigators were more then two years past their expiration dates.

SECTION III: CVS's questionable products and services

Providing "high-quality health and pharmacy services" is a key part of CVS's mission.[85] The quality of CVS's offerings may be dubious in several key areas, however: the company has repeatedly been caught with expired infant formula, out-of-date medicines—often for children and often CVS brand—and other expired products on its shelves. And various products it sells under the CVS brand are outsourced to overseas manufacturers that the FDA rarely inspects, and have been recalled numerous times in recent years because of quality control lapses.

A. Expired drugs, food and infant formula

Attorneys General in New York and California have demanded in the last several months that CVS stop offering expired infant formula, milk and medication for sale. The actions are only the latest in a string of regulators' attempts to protect the public from CVS's pattern of selling out-of-date products. And the pattern extends to Greater Detroit, the Philadelphia area, Greater Boston and several other areas, where surveyors have found expired products for sale at CVS stores. Despite repeated assurances that it will not happen again, CVS seems unable or unwilling to keep expired products off its shelves.

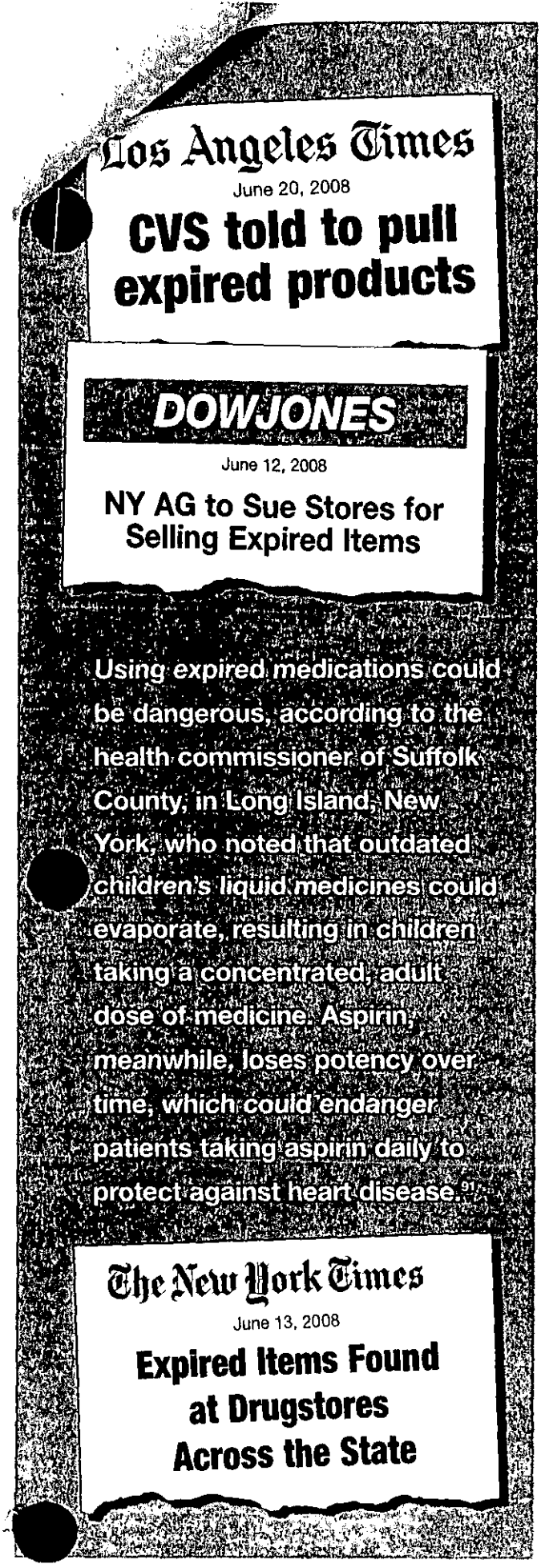
B. New York Attorney General finds expired products at CVS—again

In June, New York State Attorney General Andrew Cuomo took legal action against CVS after undercover investigators found expired products in 142 CVS stores across New York State. Sixty percent of CVS stores his staff visited had expired products on the shelf. "The widespread nature of these violations indicates that CVS maintains an implicit company policy to maximize profits through the selling of expired goods to the public," according to the Attorney General's office.[86]


New York Attorney General Cuomo at press conference about CVS's expired product findings

Investigators found expired products on the shelves in CVS stores in 34 New York State counties, from eastern Long Island to Buffalo and from New York City to Albany. The products included Nuprin brand ibuprofen that was over two years out of date; CVS Junior pain relief that was almost nine months out of date; Enfamil infant formula that had been expired more than 10 months; CVS cough syrup that was over a year outdated; and antifungal cream that was 10 months expired. Cuomo's staff also found expired products for sale at 43 percent of the Rite Aid stores they visited—a lower rate than CVS.

CVS called Cuomo's findings "unacceptable to us," and said, "We will work aggressively to ensure that our review and removal procedures are followed consistently."[87] The chain promised to cooperate with the Attorney General's investigation.[88]



However, a week later, Cuomo's staff found expired products on CVS shelves in the Syracuse area. "It doesn't take a week to pull products off a shelf," Cuomo told a Syracuse newspaper. "And it wasn't supposed to happen in the first place."[89] Then, two weeks after announcing the initial findings, the Attorney General reported that there were still expired products on the shelves in half the stores his staff had checked in follow-up visits. "From my point of view, this suggests that the corporations are not taking responsibility," Cuomo told reporters, as he announced plans to sue to force CVS to remove expired goods from its shelves.[90]

C. CVS violates agreement with New York Attorney General

By selling expired over-the-counter drugs, CVS was breaking an earlier legally binding agreement with the New York Attorney General. In 2003, the Attorney General had caught the chain selling expired drugs, and CVS had signed an "Assurance of Discontinuance" promising to refrain from the practice and institute safeguards to prevent it from recurring. The Attorney General had found expired medications at CVS stores in suburban Westchester County and Manhattan, including CVS children's non-aspirin pain reliever, CVS topical anti-infection ointment and CVS ibuprofen tablets.

CVS paid a civil penalty of $3,500 and agreed to "refrain from selling or offering for sale over-the-counter medicines after the expiration dates listed on the products' packaging" and "institute procedures to ensure that expired over-the-counter medicines will be identified and removed no later than the expiration dates listed on the packaging."[92]

D. California Attorney General finds expired products at CVS

Meanwhile, also in June 2008, California Attorney General Jerry Brown investigated CVS stores in Southern California in response to consumer complaints. His staff found expired products on the shelves at 26 CVS stores in Los Angeles, Orange and San Diego counties. As in New York, the expired goods included infant formula, over-the-counter medicines, milk and eggs. The Attorney General noted that some of the sell-by dates his investigators found on expired products at CVS had been obscured by price tags or other store stickers. "CVS Pharmacy should immediately pull these expired products from its shelves and ensure that these consumer safety violations do not occur again," Brown said.[93]

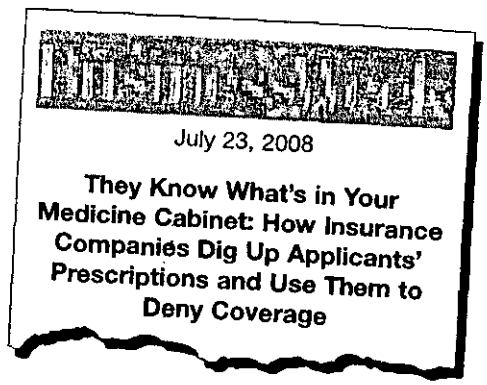
SECTION IV: CVS's failure to protect private information

"We have more information on the consumer and their behavior than anybody else, and we share it with our over-the-counter suppliers. We share it with our pharmacy suppliers."

—CVS Caremark CEO Thomas Ryan[114]

CVS customers trust the company with information about some of their most personal transactions. Consumers may expect that when they leave a CVS store with prescription drugs, over-the-counter medicines and other personal items, it is the end of the transaction. In fact, it is just the beginning.

CVS retains data on your purchases in its computers and analyzes your medical history and buying patterns to design marketing pitches targeted specifically to you. It sells some of its purchase data to "health information companies" that in turn sell the information to drug manufacturers and others for marketing purposes. And CVS has a record of making private information vulnerable to identity theft that has prompted action by three Attorneys General as well as privacy watchdogs.



A. CVS uses your data to sell you more

CVS Caremark has access to more of Americans' most private prescription information than just about anybody. One in two people in the United States now receives prescription or health services from CVS Caremark, and the company's computers contain data on 30 percent of all prescriptions in the United States—over 1.2 billion prescriptions per year.

The company has even more information on its over 50 million ExtraCare card holders, who scan their cards when they shop at CVS in order to get discounts and "extra bucks" redeemable for merchandise at CVS. Nearly two-thirds of CVS's non-pharmacy sales are made with the card. CVS says ExtraCare is the biggest retail loyalty program in the world,[116] and it is growing, partly thanks to the CVS-Caremark merger. The company has recently enrolled 4 million people in ExtraCare by sending cards to people whose pharmacy benefits CVS Caremark administers. The company expects to add another 6 million ExtraCare card holders next year.[116]

CVS uses this intimate knowledge of customers' purchases to "migrate customers from low-value behaviors to higher-value behaviors"[117]—meaning buying more at CVS. As CVS's CEO Thomas Ryan said, "We know the customers who are coming into our store to buy beauty, but aren't buying OTCs [over-the-counter medicines]. ... We know who's coming in for photo, but not using the pharmacy, and we can target [those customers] with special mailings and customized offers."[118]

That could include promoting CVS brand over-the-counter versions of drugs to patients or making "disease-specific" discount offers to patients.[119] For example, a patient with a diabetes drug prescription could start receiving coupons for products that may help diabetics—or even get a pitch for those items on the phone when calling to refill a prescription: "They may get the prescription for diabetes, but there may be eye care or foot care

CVS CAREMARK

Important Changes to Your Prescription Benefits

December 30, 2008

Pt Name
Hidden

We are pleased to inform you about an important change to your prescription benefit plan. Starting **January 1, 2009,** you will receive significant savings by getting your long-term medicines, in a 90-day supply, at either a **CVS/pharmacy** retail store or through **CVS Caremark Mail Service** Pharmacy.

Your prescription benefit plan will allow two 30-day fills at a network retail pharmacy. After these two fills you will need 90-day supply prescriptions filled by a local CVS/pharmacy or by CVS Caremark Mail Service. If you fill your long-term prescriptions at another retail pharmacy after two fills, **you will pay a higher copay***.

Choose what is more convenient for you. The copay is the same either way.

At a CVS/pharmacy you may:	With CVS Caremark Mail Service you may:
• Pick-up your long-term medicine directly from the pharmacy at a time that is convenient for you	• Enjoy convenient home delivery
• Enjoy same-day prescription availability	• Receive medicine in confidential, tamper-resistant and (when necessary) temperature-controlled packaging
• Talk face-to-face with a pharmacist	• Talk to a pharmacist by phone

If you currently receive your long-term medicines from CVS/pharmacy or CVS Caremark Mail Service and wish to continue – no action is required. We will contact your doctor and notify you if you are not already on a 90-day prescription.

If you wish to change how you receive your long-term medicines either by switching to CVS/pharmacy or CVS Caremark Mail Service, we'll take care of it for you. We will contact you after your last allowable fill before the copay goes up and contact your doctor to get a 90-day prescription to have filled based on your choice of pharmacy.

Visit www.caremark.com to:

- Learn more about your prescription benefit plan
- Investigate other cost savings opportunities
- Access medicine and health information

If you have questions, please call Customer Care toll-free at **1-866-804-5882.** If you have a hearing impairment and need telecommunications device (TDD) assistance, please dial toll-free 1-800-231-4403. We are ready to make filling long-term prescriptions convenient for you.

Sincerely,

CVS Caremark

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

5287-005647

2261

Your Personal Prescription Benefit Guide

	Network Retail Pharmacy	CVS/pharmacy	Mail Service Pharmacy
	For immediate and longterm** medicine needs	For immediate and longterm medicine needs	For long-term medicine needs
Up to a 30day supply:	Generic: **$10** Preferred brand: **30% with $20 minimum and $60 maximum** Non-preferred brand: **50% with $30 minimum and $75 maximum**	Generic: **$10** Preferred brand: **30% with $20 minimum and $50 maximum** Non-preferred brand: **$50% with $30 minimum and $75 maximum**	Up to a 90-day supply
Fill limit:	2 for long-term medicines	2 for long-term medicines	
Copay after limit:	Generic: **$20** Preferred brand: **$50** Non-preferred brand: **$70**	Generic: **$20** Preferred brand: **$50** Non-preferred brand: **$70**	Generic: **$20** Preferred brand: **$50** Non-preferred brand: **$70**
84- to 90-day supply	**Not Available**	Generic: **$20** Preferred brand: **50** Non-preferred brand: **$70**	

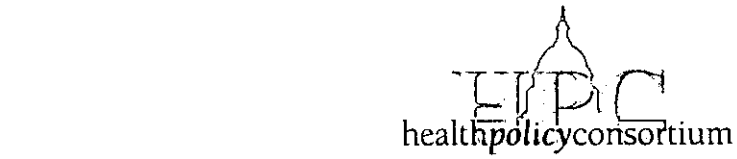
**A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes or high cholesterol.

Have more questions? Contact CVS Caremark:

1. **Customer Care**
   Call toll-free **1-866-804-5882** to speak to a Customer Care representative 24 hours a day, seven days a week.

2. **Caremark.com**
   Caremark.com is a hassle free, round-the-clock way to learn more about your prescription benefit plan, locate a network pharmacy and investigate other cost savings opportunities.

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a [illegible], a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
005647



North Dakota 2009 Legislative Session
House – Industry Business and Labor Committee and
Human Services Committee (Combined Hearing)
Testimony on House Bill 1440
February 3, 2009

Chairman Keiser and Chairman Weisz and Members of the Industry Business and Labor Committee and Human Services Committee:

My name is Beverley Adams and I am the Executive Administrator of the Health Policy Consortium (HPC) which is comprised of the four largest integrated health systems in the State of North Dakota. They are Altru (Grand Forks), MedCenter One (Bismarck), MeritCare (Fargo) and Trinity (Minot). We are in support of HB 1440, which repeals North Dakota Century Code 43-15-35 requirement that retail pharmacies be owed by a 51% majority of pharmacists.

Collectively, the HPC has over 15,000 employees. We provide specialty and sub-specialty care including a substantial amount of pharmacy services in both the hospital and outpatient retail setting. The large hospitals are generally viewed as providing healthcare only to the more urban areas. That is not accurate. The HPC members have larger hospitals in the more urban areas of the State; however, they have clinics throughout the rural areas of the State. For instance, the HPC members provide primary care in the most rural of communities, such as New Town, Cavalier, Wahpeton and Edgeley, North Dakota. The HPC members provide 80% of all healthcare services for the citizens of the State of North Dakota. The HPC members are also the Safety Net health care providers for the more complex medical needs of the citizens of the State. The HPC members provide the more advanced care such as comprehensive trauma centers, orthopedics, cardiology, children's

hospital specialties, neonatology, organ transplants, nephrology, cancer treatments, dermatology and reproductive specialists. These are services that small rural hospitals cannot provide.

The HPC members are also integrated Health Care Systems. This means that we coordinate care among the different specialty services that we provide. Being integrated means that we employ the doctors instead of the doctors being a separate corporate physician group that only has hospital privileges. Numerous studies show that having the physicians integrated and employed by the hospital, is a more cost efficient and higher quality health care model. The four large hospitals integrated their systems before this health care model was popular and despite the fact that the reimbursement system has never rewarded this model of providing care. The current reimbursement system actually punishes this model of care.

The HPC members provide over $100 Million in charity care/community benefit in either the form of bad debt or charity care services each year on behalf of the patients that they serve. This includes providing healthcare services to the more than 60,000 under and uninsured North Dakotans.

The reason the HPC members support a hospital exception to the pharmacy ownership requirement is to extend the ability of these hospitals to provide comprehensive care to patients. As non-profit, mission driven health care facilities, the ability to incorporate pharmaceutical care to the comprehensive patient services already provided simply builds on the integrated efficient and effective model of providing health care.

Currently the health systems employ registered pharmacists in numerous diverse practice areas such as retail, critical care, oncology, pediatrics, cardiology and many other disciplines. Each day the care of patients includes the expertise of the qualified pharmacy staff that we employ. Currently there are times that we are not able to provide retail services to patients when they are in the most need of our care. For instance, a licensed hospital pharmacy which is a Class B pharmacy license, can only fill prescriptions for employees or for patients of the hospital, not patients who walk in for services. For example, one of MeritCare's facilities encompasses a hospital, walk-in clinic, dialysis center and several other services. There is a Class B hospital pharmacy at this location. The pharmacy at this location is permitted by their licensure to only provide pharmacy services to hospital patients and employees, but not to the patients

seen at the walk in clinic if there are retail pharmacies that are open. If a walk-in patient is seen at the hospital pharmacy to fill a prescription, this pharmacy is able to dispense prescriptions and provide consultation to the patient only if they are being discharged from the hospital, or they are an employee or it is late in the evening and retail pharmacies are not open. If a patient is seen as a walk in patient, and it is during normal business hours, the HPC members are not able to process that prescription in any of their Class B permit, hospital pharmacies. The prescriptions being filled for hospital patients or for the walk in patient could be for the exact same prescription, however, in one instance we can fill the prescription and in the other instance with the walk in patient we cannot fill the prescription.

This type of situation is frustrating for both the hospital pharmacist and the patient. Patients do not understand why a hospital pharmacist cannot fill their prescription for them. Under the current law, if a walk in patient comes to a hospital pharmacy and it is an "emergency" which has been defined by the Pharmacy Board as a time when retail pharmacies are not available, then the hospital pharmacy can fill the prescription, but otherwise they are not able to do so. This type of law is not serving the pharmacy profession nor the patients and citizens of this state.

At a time when patients are feeling their worst and simply want to fill their prescription and go home and tend to their ailments, they have to travel to yet another building, blocks away and wait additional time in order to get their prescriptions filled. If hospitals and healthcare systems were able to fill prescriptions, patients would have a choice about whether they want to get their prescriptions filled in the same building where they receive care or whether they wanted to go to another pharmacy. By allowing healthcare facilities to operate under a retail license to fill all prescriptions, the hospitals and clinics could more easily share patient information from the patient's medical chart in order to fill prescriptions more efficiently. Hospital pharmacists would not have to try and call the physician in order to get questions answered or clarification on the patient's medical condition. The retail pharmacist as an employee of the healthcare system, could immediately have access to the patient's medical record.

The rapid care and walk in clinics are becoming more popular health care delivery options. They do not have pharmacy services. If these clinics could operate pharmacies this would provide patients, including young mothers with children the ability to fill prescriptions immediately without

having to travel with small sick children to yet another location to fill a prescription. There is a common sense patient driven reason to allow hospitals and healthcare systems to own and operate a retail pharmacy.

In addition, the creation of a system where retail pharmacists can serve the general public and hospital pharmacists, who cannot, except if it is after hours, has created a division amongst pharmacists and their membership in the pharmacy association. They do not have common interests and there is the perception that somehow hospital pharmacists are less qualified or competent to provide care for the general public. This difference in the types of patients that a retail pharmacist versus a hospital pharmacist can provide care has created a division amongst the professional pharmacists within the State.

No other State has this 51% ownership requirement. In addition, there currently exist numerous exceptions to the 51% requirement.

You know that you have an antiquated law when the exceptions to the rule far exceed the number of pages that it takes to explain the initial law and year after year the exceptions keep growing. There are currently 11 types of permits under the Administrative Code:

1. Retail;
2. Hospital;
3. Home Health Care Pharmacy;
4. Long Term Care Pharmacy;
5. Nuclear pharmacies;
6. Mail Order Pharmacies – exclusively mail order;
7. Out of State Pharmacy;
8. Governmental Agency Pharmacy;
9. Research Pharmacy;
10. Office Practice Pharmacy;
11. Telepharmacy.

Under the North Dakota Century Code: 43-15-35 Subd. 1(e). It simply states that you have to have a permit to operate a pharmacy and meet a number of factors. One of those factors is that the pharmacy is owned by a minimum of 51% by pharmacists. The statute does not restrict this ownership requirement only to retail pharmacies. According to the plain meaning of the Statute, this applies to all pharmacies that exist in the State of North

Dakota unless an exception is created under the Statute. The exceptions under the North Dakota Century Code 43-15-35 Subd. 2 are:

1. Those pharmacies that were operating as a retail pharmacy prior to 1963.
2. A hospital pharmacy filling prescriptions only for their patients. (Says nothing about filling prescriptions for employees or "emergency situations) as stated in the administrative code.
3. A hospital can purchase an existing pharmacy permit if no other pharmacy exists in the community.
4. A post graduate medical residency program.

Exceptions to the 51% ownership requirement under the Administrative Code which are not permitted under North Dakota Statutes include:

1. Hospitals filling prescriptions for employees and in "emergency situations" when the retail pharmacy is closed.
2. Home Health Care pharmacy;
3. Long Term Care Pharmacy;
4. Nuclear pharmacies;
5. Mail Order Pharmacies;
6. Out of State Pharmacies;
7. Governmental Agency Pharmacy
8. Research Pharmacy;
9. Office Practice Pharmacy;
10. Telepharmacy; and
11. Ownership of Pharmacies by the Heirs at Law – ND Admin. Code 61-02-01-09.

Here are the exceptions that are neither authorized under North Dakota law or the North Dakota Administrative Code, but authorized by the Pharmacy Board:

1. A number of variances issued by the Pharmacy Board to operate retail pharmacies which are neither permitted under the Century Code or the Administrative Code:
2. The purchase of pharmacy permits from existing retail pharmacies. Under North Dakota Century Code 43-15-38 Subd. 1 a grandfathered permit expires when the permit holder either discontinues operations or allows the permit to expire. Therefore the permits that CVS is currently

operating under are invalid under law but permitted by the Pharmacy Board.

Currently any pharmacy that is operating contrary to the 4 exceptions set out under the North Dakota Century Code are invalid and need to discontinue operations immediately as they are not allowed under North Dakota law. Right now, the pharmacy board either needs to revoke all improperly granted permits that are in violation of North Dakota law or this legislature needs to repeal the law so that the entities acting outside the scope of North Dakota law, or operating with a permit that is not recognized by North Dakota law, can continue to operate.

The Pharmacy Board acting on behalf of retail pharmacists has acted outside the authority of the law in granting exceptions for the 51% ownership requirement. The Board now comes before you with unclean hands in asking you to uphold the 51% requirement for numerous reasons some patient focused and some self-serving. They simply have no integrity in making this request. The Pharmacy Board is the primary reason this law has so many holes in it that it resembles swiss cheese, but they asking you to ignore the exceptions which are in violation of North Dakota law, in order to continue their unlawful practices. I think that the cartoon in the Forum Editorial on Sunday, February 01, 2009, (Attachment "A") may be a little harsh however, a "Godfather" or "good ole' boys club" type of system comes to mind when looking at the current pharmacy permit process.

In addition to the patient care rationale and the problem with all of the exemptions to support arguments to change the pharmacy law, the hospitals would benefit from the revenues generated from the operation of a retail pharmacy. Numerous hospitals are currently experiencing financial difficulties because of the reimbursement ecosystem in North Dakota that is unbalanced. MeritCare alone is currently reimbursed $25 Million a year less on Medicare patients than surrounding States. In addition MeritCare is earning $30 Million less a year for the patients it serves with private insurance, compared to surrounding States. We are currently looking at rebasing Medicaid, however, at the present time; the large hospitals are being reimbursed 30% below cost on Medicaid patients they treat. If hospitals were allowed to operate retail pharmacies this could be an opportunity to generate some additional revenue to assist with the low medical reimbursement system within the State.

Also, by allowing hospitals to operate retail pharmacies, this also provides another venue for pharmacists in rural areas to sell their pharmacies. It will also allow pharmacy graduates from NDSU who do not want or do not have the capital to operate their own pharmacy, the ability to work as a pharmacist in North Dakota and not have to leave the State.

I appreciate your time this morning. I want to reinforce our support for all of the arguments made this morning to repeal the law. Our thousands of patients would be best-served if this outdated, poorly administered protectionist law is repealed and HB 1440 is passed and signed into law.

Please consider these comments as you deliberate on HB 1440. Chairman Keiser and Chairman Weisz and members of both the Industry Business and Labor Committee and Human Services Committee. I thank you for the time to speak to you today. I am available to answer any questions that you may have at this time.

Published February 01 2009

Forum editorial: Pharmacy law repeal is overdue

North Dakota's pharmacy ownership law is protectionist and distorts the retail pharmaceutical market. It should be repealed by the Legislature.

North Dakota's pharmacy ownership law is protectionist and distorts the retail pharmaceutical market. It should be repealed by the Legislature.

The law requires a registered pharmacist to own 51 percent of a pharmacy. The anachronism has evolved into a security blanket around independent pharmacies that insulates most of them from real market competition. One result is demonstrably higher prices for North Dakota consumers. Another result is constricted opportunity for young pharmacists to work in North Dakota.

The debate has been characterized as a David-and-Goliath struggle, with David the noble small-town druggist and Goliath the soulless big-box chain stores. It's not so simple.

If the independents are the little guys, they are well-funded little guys. They are conducting a coordinated campaign of letters to newspapers and an expensive television ad blitz. North Dakotans for Affordable Health Care has been characterized as Goliath because the organization represents the interests of chain stores, such as Wal-Mart and Walgreen's. Their effort has included visiting newspaper editorial boards and other opinion makers and securing support from business and health care groups.

The debate is emotional because of the state's small-town sensibilities. But when emotional sophistry is removed, the facts emerge: North Dakotans would save millions of dollars if the law were repealed. Several studies have been released, most of them skewed by one side or the other. The one credible study was done by Blue Cross Blue Shield of North Dakota – the health insurer that gets saddled with unnecessarily high drug costs. The study shows that at the low end consumers would save $6.3 million annually, at the high end $14.3 million.

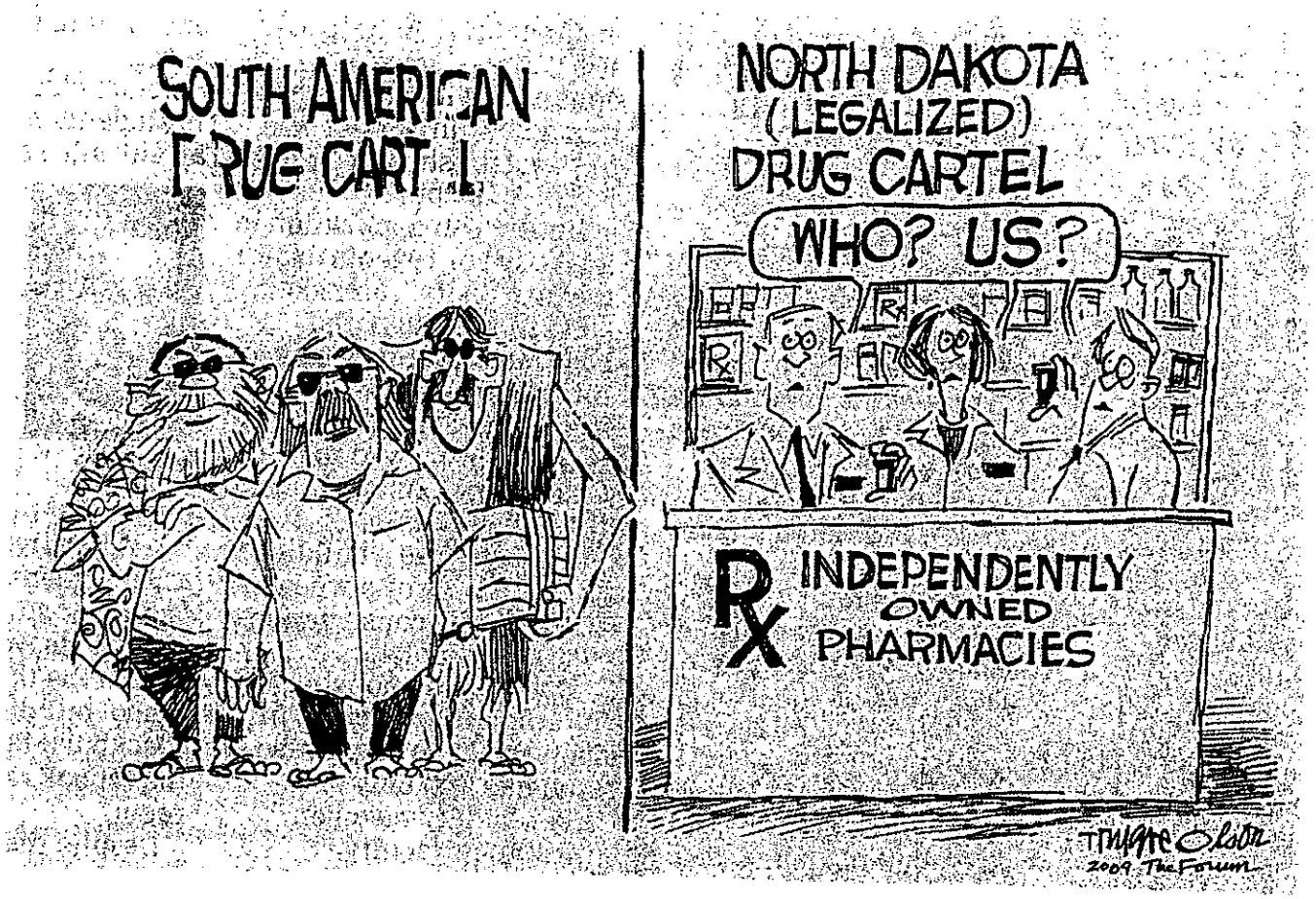
The claim 70 independent drug stores would close is baseless. If Walgreen's opened a pharmacy in Grand Forks, it would not seriously affect a drug store in a small town 90 miles away. But if closer-to-the-city independents closed, wouldn't that circumstance dispel the belief that small-town residents are loyal to their pharmacy?

Most insulting is the suggestion that chain store pharmacists are not service oriented. They are. They take the same oath as independent druggists. They conduct patient informational seminars as part of their employer's requirements. They know their customers and have access to the latest technology to avoid prescription errors. Many in the Midwest were educated at North Dakota State University. They rightfully resent the charge that they are not serving customers well.

Furthermore, repeal of the law would create a minimum of 30

high-paying pharmacy jobs, many to be filled by NDSU graduates.

The ownership law disserves North Dakota consumers, rural hospitals and nursing homes. In effect, it imposes a kind of social engineering tax on North Dakotans – legal extortion – to fund a protection racket. A conservative Legislature that likes to save money and praises the free market should repeal the law.


SOUTH AMERICAN
DRUG CARTEL
NORTH DAKOTA
(LEGALIZED)
DRUG CARTEL
WHO? US?
Rx INDEPENDENTLY OWNED PHARMACIES
TMiller Slater
2009 The Forum

Industrial, Business & Labor Committee

North Dakota Legislative Council
Tuesday, February 3, 2009

Official Testimony of Wendy Harmsen, Pharm.D.

Pharmacy Manager, Dilworth, MN
Wal-Mart Stores, Inc.

Arch Allison
Fargo, ND
North Dakota Market Manager

Ladies and Gentlemen of the committee, my name is Arch Allison, and I am the Wal-Mart Market Manager for North Dakota.

As someone who oversees the overall operations of Wal-Mart stores and supercenters, a market manager does not supervise pharmacies, and the registered pharmacists who serve our customers do not report to operators like me. Rather, our pharmacy operations are organized separately, and, for example, the pharmacist I am about to introduce to you reports to another pharmacist.

For 18 years, North Dakotans have worked for Wal-Mart here. We employ over 3200 employees, and last year, we bought $68 million worth of North Dakota products to sell in our stores. Until recently, the pharmacy law was a disappointment, but not a problem for us. What has changed is the falling wholesale cost of generics, and the $4 generic drug discount plans now available industry wide – except in North Dakota.

In the weeks following the initial announcement of our $4 drug options in Minnesota and South Dakota, we received hundreds of calls every week from North Dakotans, angry that we would not offer them the same benefit. The calls to our stores continue today, though most are coming to realize it is the law that creates this inequity.

When the opportunity came to support North Dakotans for Affordable Healthcare, we felt we had to try to help.

Now, I'd like to introduce another Wal-Mart employee, a dedicated and professional pharmacist, native of Dickinson, Fargo resident, and my friend, Wendy Harmsen, managing pharmacist of the Dilworth Minnesota, Wal-Mart.

Wendy Harmsen, Pharm.D.
Fargo, ND
Wal-Mart Pharmacy Manager, Dilworth, MN

Thank you, Arch, and thank you, members of the committee, for allowing me to share with you today.

Let me begin by saying that I was reluctant to come here today. This debate has created so much disagreement between pharmacists. Many of my colleagues work for independent pharmacies or the Thrifty White chain – we know each other and work with each other every day, despite the state line. Today, I would just like to clarify some misinformation that is out there.

I have heard the argument that as a chain pharmacist, I do not provide the same level of care as an independent pharmacist. The reason I am here today is to defend myself

against this insinuation. I do have time to spend with my patients every day. In fact, we probably do not fill any more prescriptions at my pharmacy than many independent pharmacies do in North Dakota.

My day is spent counseling patients, calling Dr's offices for substitutions to better patient care, calling insurance companies and doing whatever is in the best interest of my patients. I work to assure that they know how to take their medications and what they should expect from taking their medicine. I know my patients. I always take time to say "hello," to them. I know what medications they are taking and why they are taking them.

They know they can ask me questions – whether I am at work or if they run into me away from work, as they often do.

I would like to remind everyone that I hold the same degree, I face the same certifications, and most importantly, I take the same oath of care and responsibility as any other pharmacist.

If you doubt this is true, I invite you today to come to my pharmacy in Dilworth, meet the pharmacists and techs who work for me, and see the patients we serve every day.

To me, pharmacy is a career, not a job. I may work for Wal-Mart, but my job is to take care of my patients.

Safety and Service

Our goal at Wal Mart Pharmacies is to save people money so they can live better. That's what our $4 generic discount prices are about. The drugs on our $4 list account for 40% of all of our fills, represent nearly every major therapeutic category, and include 57 out of the top 100 most commonly prescribed drugs.

However, more than anything else, we strive to provide our customers with safe, friendly, reliable and professional pharmacy services. That's why we hire the best pharmacists from all over the U.S., and recruit new pharmacists from the best schools. In this region, we hire more grads from the NDSU School of Pharmacy than nearly any other.

Every Wal-Mart Pharmacy is managed by a Pharmacy Manager -- who is a registered pharmacist -- and a team of registered pharmacists, as well as pharmacy technicians. As the Pharmacy Manager, I do not report to the manager of the store. Our pharmacy operations are managed separately, and my supervisor, Ray Glaser, is an NDSU grad and Mandan native himself.

To help pharmacists have more time with their patients, and to ensure efficiency and accuracy, we have created our very own software system for our pharmacists. It gives pharmacists access to a huge database and connects them to pharmacists across the country. We call this system of integrated technologies Connexus™.

Connexus™ also improves the working environment for our pharmacists by reducing or eliminating typical stress factors in the prescription filling process. Some of the aspects of the system include:

Touch and Scan Technology - for efficient and accurate check-out
Easy Pay system - to provide better service and workflow
Electronic Imaging – creates a paperless work environment

We are also working with physicians and providers nationwide to increase the use of e-scripts. Our goal is to increase use by 400% this year, resulting in more convenient, efficient, and most importantly, safer prescription fills.

I understand the trepidation some may have for the competitive strength of a company like Wal-Mart. However, please know remember that we only have 12 stores in North Dakota. If this law is changed, we would still operate less than half of the number of North Dakota locations of Thrifty White, the Minnesota chain currently here.

Our stated commitment to help make affordable, quality health care available to all Americans should leave no one out, especially our loyal customers here in North Dakota.

Your Guide to Saving Money on Prescriptions

Low-cost prescriptions make a difference

At Walmart, we don't think you should have to choose between [illegible]ries and the medicines you need. Our $4 prescriptions save [illegible]rican families hundreds of millions of dollars a year.

More $4 prescriptions than ever

Now our $4 price covers hundreds of prescriptions. That includes medicines for a wide range of conditions and diagnosis groups. This list is a quick-reference tool that will help you find the specific medicines you're looking for.

90-Day Prescriptions

Taking a regular prescription? Ask your doctor if you can refill it 3 months at a time. At only $10, our 90-Day prescriptions save you even more than our regular low-cost prescriptions. You save trips to the pharmacy, too.

Revised 1/23/09

	$4 30-Day	$10 90-Day
Allergies & Cold and Flu		
Benzonatate 100mg cap	14	42
Ceron DM syrup	120ml	360ml
C-Phen drops* (30ml bottle)†	1	3
Dex PC syrup*	120ml	360ml
Loratadine 10mg tab	30	90
Promethazine DM syrup	120ml	360ml
Antibiotic Treatments		
[illegible]cillin 125mg/5ml susp (80ml bottle)†	1	3
A[illegible]icillin 125mg/5ml susp (100ml bottle)†	1	3
Amoxicillin 125mg/5ml susp (150ml bottle)†	1	3
Amoxicillin 200mg/5ml susp (50ml bottle)†	1	3
Amoxicillin 200mg/5ml susp* (75ml bottle)†	1	3
Amoxicillin 200mg/5ml susp* (100ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (80ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (100ml bottle)†	1	3
Amoxicillin 250mg/5ml susp (150ml bottle)†	1	3
Amoxicillin 400mg/5ml susp (50ml bottle)†	1	3
Amoxicillin 400mg/5ml susp* (75ml bottle)†	1	3
Amoxicillin 400mg/5ml susp* (100ml bottle)†	1	3
Amoxicillin 250mg cap	30	90
Amoxicillin 500mg cap	30	90
Amoxil 50mg/ml drops* (30ml bottle)†	1	3
Cephalexin 250mg cap	28	84
Cephalexin 500mg cap	30	90
Ciprofloxacin 250mg tab	14	42
Ciprofloxacin 500mg tab	20	60
Doxycycline Hyclate 50mg cap	30	90
Doxycycline Hyclate 100mg cap	20	60
Doxycycline Hyclate 100mg tab	20	60
Erythromycin EC 250mg cap*	28	84
Metronidazole 250mg tab	28	84
Metronidazole 500mg tab	14	42
Penicillin VK 250mg tab	28	84
Penicillin VK 125mg/5ml susp (100ml bottle)†	1	3
Penicillin VK 125mg/5ml susp (200ml bottle)†	1	3
Penicillin VK 250mg/5ml susp (100ml bottle)†	1	3
SMZ-TMP 200mg-40mg/5ml susp.	120ml	360ml
SMZ-TMP 400mg-80mg tab	28	84
SMZ-TMP DS 800mg-160mg tab	20	60
Tetracycline 250mg cap	60	180
Tetracycline 500mg cap	60	180
Arthritis & Pain		
Allopurinol 100mg tab	30	90
Allopurinol 300mg tab	30	90
Baclofen 10mg tab	30	90
Colchicine 0.6mg tab	30	90
Cyclobenzaprine 5mg tab	30	90
Cyclobenzaprine 10mg tab	30	90
Dexamethasone 0.5mg tab	30	90
Dexamethasone 0.75mg tab	12	36

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Prices for some drugs covered by the Prescription Program may be higher and may vary in [illegible] states. Restrictions apply. See Program Details or your Walmart Pharmacist for details.

[illegible]y be higher in CA, HI, MN, MT, PA, TN, WI, and WY.

† Prepackaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

Walmart Save money. Live better. | Sam's Club

Arthritis & Pain (continued)

	$4 30-Day	$10 90-Day
Dexamethasone 4mg tab	6	18
Diclofenac DR 75mg tab	60	180
Ibuprofen 100mg/5ml susp*	120ml	360ml
[illegible]rofen 400mg tab	90	270
Ibuprofen 600mg tab	60	180
Ibuprofen 800mg tab	30	90
Indomethacin 25mg cap*	60	180
Meloxicam 7.5mg tab	30	90
Meloxicam 15mg tab.	30	90
Naproxen 375mg tab*	60	180
Naproxen 500mg tab*	60	180
Piroxicam 20mg cap	30	90
Salsalate 500mg tab.	60	180

Asthma

	$4 30-Day	$10 90-Day
Albuterol 2mg tab	90	270
Albuterol 4mg tab	60	180
Albuterol 2mg/5ml syrup.	120ml	360ml
Albuterol 0.5% nebulizer soln (20ml bottle)†	1	3
Albuterol 0.083% nebulizer soln* (25x3ml vials)†	1	3
[illegible]opium 0.02% nebulizer soln* (25x2.5ml vials)†	1	3

Cholesterol

	$4 30-Day	$10 90-Day
Lovastatin 10mg tab	30	90
Lovastatin 20mg tab*	30	90
Pravastatin 10mg tab	30	90
Pravastatin 20mg tab	30	90
Pravastatin 40mg tab*	30	90

Diabetes

	$4 30-Day	$10 90-Day
Chlorpropamide 100mg tab*	30	90
Glimepiride 1mg tab	30	90
Glimepiride 2mg tab	30	90
Glimepiride 4mg tab	30	90
Glipizide 5mg tab	30	90
Glipizide 10mg tab*	60	180
Glyburide 2.5mg tab	30	90
Glyburide 5mg tab (blue)	30	90
Glyburide 5mg tab (green)	30	90
Glyburide, micronized 3mg tab	30	90
Glyburide, micronized 6mg tab	30	90
Metformin 500mg tab.	60	180
Metformin 850mg tab.	60	180
Metformin 1000mg tab*	60	180
Metformin 500mg ER tab*	60	180

Ear Health

	$4 30-Day	$10 90-Day
Antipyrine/Benzocaine otic (10ml bottle)†	1	3

Fungal Infections

	$4 30-Day	$10 90-Day
Fluconazole 150mg tab	1	3
Nystatin/Triamcin cream (15gm tube)†	1	3
Nystatin/Triamcin cream (30gm tube)†	1	3
Nystatin/Triamcin ointment (15gm tube)†	1	
Nystatin cream (15gm tube)†	1	3
Nystatin cream (30gm tube)†	1	3
Nystatin ointment (15gm tube)†	1	3
Nystatin ointment (30gm tube)†	1	3
Terbinafine 250mg tab*	30	90

Gastrointestinal Health

	$4 30-Day	$10 90-Day
Belladonna Alkaloid/PB tab	60	180
Cimetidine 800mg tab*	30	90
Cytra2 solution	180ml	540ml
Dicyclomine 10mg cap	90	270
Dicyclomine 20mg tab	60	180
Famotidine 20mg tab	60	180
Lactulose syrup	237ml	711ml

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Prices for some drugs covered by the Prescription Program may be higher and may vary in [illegible]tates. Restrictions apply. See Program Details or your Walmart Pharmacist for details.

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[illegible] may be higher in CA, HI, MN, MT, PA, TN, WI, and WY.

† Prepackaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

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Gastrointestinal Health (contined)

Metoclopramide 10mg tab	60	180
Metoclopramide syrup	60ml	180ml
Promethazine 25mg tab*	12	36
[redacted]ethazine plain syrup*	180ml	540ml
[redacted]itidine 150mg tab	60	180
Ranitidine 300mg tab	30	90

	$4 30-Day	$10 90-Day

Glaucoma & Eye Care

Atropine Sulfate 1% op. soln (5ml bottle)†	1	3
Bacitracin op. ointment (3.5gm tube)†	1	3
Erythromycin op. ointment (3.5gm tube)†	1	3
Gentamicin 0.3% op. soln (5ml bottle)†	1	3
Levobunolol 0.5% op soln (5ml bottle)†	1	3
Neomycin/Polymyxin/Dexamethasone 0.1% op. ointment (3.5gm tube)†	1	3
Neomycin/Polymyxin/Dexamethasone 0.1% op. susp (5ml bottle)†	1	3
Pilocarpine 1% op. soln (15ml bottle)†	1	3
Pilocarpine 2% op. soln (15ml bottle)†	1	3
Polymyxin Sulfate/TMP op. soln* (10ml bottle)†	1	3
[redacted]et Sodium 10% op. soln (15ml bottle)†	1	3
[redacted]ol Maleate 0.25% op. soln (5ml bottle)†	1	3
Timolol Maleate 0.5% op soln (5ml bottle)†	1	3
Tobramycin 0.3% op. soln (5ml bottle)†	1	3

	$4 30-Day	$10 90-Day

Heart Health & Blood Pressure

Amiloride-HCTZ 5mg-50mg tab	30	90
Atenolol-Chlorthalidone 50mg-25mg tab	30	90
Atenolol-Chlorthalidone 100mg-25mg tab	30	90
Atenolol 25mg tab	30	90
Atenolol 50mg tab	30	90
Atenolol 100mg tab	30	90
Benazepril 5mg tab	30	90
Benazepril 10mg tab	30	90
Benazepril 20mg tab	30	90
Benazepril 40mg tab	30	90
Bisoprolol-HCTZ 2.5mg-6.25mg tab	30	90
Bisoprolol-HCTZ 5mg-6.25mg tab	30	90
Bisoprolol-HCTZ 10mg-6.25mg tab	30	90
Bumetanide 0.5mg tab	30	90
Bumetanide 1mg tab	30	90
Captopril 12.5mg tab	60	180
Captopril 25mg tab	60	180
Captopril 50mg tab	60	180
Captopril 100mg tab	60	180
Carvedilol 3.125mg tab	60	180
Carvedilol 6.25mg tab	60	180
Carvedilol 12.5mg tab	60	180
Carvedilol 25mg tab*	60	180
Chlorthalidone 25mg tab	30	90
Chlorthalidone 50mg tab	30	90
Clonidine 0.1mg tab	30	90
Clonidine 0.2mg tab	30	90
Digoxin 0.125mg tab	30	90
Digoxin 0.25mg tab	30	90
Diltiazem 30mg tab	60	180
Diltiazem 60mg tab	60	180
Diltiazem 90mg tab*	60	180
Diltiazem 120mg tab	30	90
Doxazosin 1mg tab	30	90
Doxazosin 2mg tab	30	90
Doxazosin 4mg tab	30	90
Doxazosin 8mg tab	30	90
Enalapril-HCTZ 5mg-12.5mg tab	30	90
Enalapril 2.5mg tab	30	90
Enalapril 5mg tab	30	90
Enalapril 10mg tab	30	90
Enalapril 20mg tab	30	90
Furosemide 20mg tab	30	90
Furosemide 40mg tab	30	90
Furosemide 80mg tab	30	90
Guanfacine 1mg tab	30	90
Hydralazine 10mg tab	30	90
Hydralazine 25mg tab	30	90
Hydrochlorothiazide(HCTZ)12.5mg cap*	30	90

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Prices for some drugs covered by the Prescription Program may be higher and may vary in [redacted]tates. Restrictions apply. See Program Details or your Walmart Pharmacist for details.

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[redacted]ay be higher in CA, HI, MN, MT, PA, TN, WI, and WY.

† PE packaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

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Heart Health & Blood Pressure (continued)

Hydrochlorothiazide (HCTZ) 25mg tab	30	90
Hydrochlorothiazide (HCTZ) 50mg tab	30	90
Indapamide 1.25mg tab	30	90
[redacted]pamide 2.5mg tab	30	90
[redacted]sorbide Mononitrate 30mg ER tab	30	90
Isosorbide Mononitrate 60mg ER tab	30	90
Lisinopril-HCTZ 10mg-12.5mg tab	30	90
Lisinopril-HCTZ 20mg-12.5mg tab*	30	90
Lisinopril-HCTZ 20mg-25mg tab*	30	90
Lisinopril 2.5mg tab	30	90
Lisinopril 5mg tab	30	90
Lisinopril 10mg tab	30	90
Lisinopril 20mg tab	30	90
Methyldopa 250mg tab*	60	180
Methyldopa 500mg tab*	30	90
Metoprolol Tartrate 25mg tab	60	180
Metoprolol Tartrate 50mg tab	60	180
Metoprolol Tartrate 100mg tab*	60	180
Nadolol 20mg tab	30	90
Nadolol 40mg tab	30	90
Nitroquick 0.3mg sub tab* (100 count bottle)†	1	3
Nitroquick 0.4mg sub tab* (25 count)†	1	3
[redacted]uick 0.4mg sub tab* (100 count bottle)†	1	3
Pindolol 5mg tab	30	90
Pindolol 10mg tab	30	90
Prazosin HCL 1mg cap	30	90
Prazosin HCL 2mg cap	30	90
Prazosin HCL 5mg cap	30	90
Propranolol 10mg tab	60	180
Propranolol 20mg tab	60	180
Propranolol 40mg tab	60	180
Propranolol 80mg tab	60	180
Sotalol HCL 80mg tab*	30	90
Spironolactone 25mg tab*	30	90
Terazosin 1mg cap	30	90
Terazosin 2mg cap	30	90
Terazosin 5mg cap	30	90
Terazosin 10mg cap	30	90
Triamterene-HCTZ 37.5mg-25mg cap	30	90
Triamterene-HCTZ 37.5mg-25mg tab	30	90
Triamterene-HCTZ 75mg-50mg tab	30	90
Verapamil 80mg tab	30	90
Verapamil 120mg tab	30	90
Warfarin 1mg tab	30	90
Warfarin 2mg tab	30	90
Warfarin 2.5mg tab	30	90
Warfarin 3mg tab	30	90
Warfarin 4mg tab	30	90
Warfarin 5mg tab*	30	90
Warfarin 6mg tab	30	90
Warfarin 7.5mg tab	30	90
Warfarin 10mg tab	30	90

	$4 30-Day	**$10 90-Day**

Mental Health

Amitriptyline 10mg tab	30	90
Amitriptyline 25mg tab	30	90
Amitriptyline 50mg tab	30	90
Amitriptyline 75mg tab	30	90
Amitriptyline 100mg tab	30	90
Benztropine 2mg tab	30	90
Buspirone 5mg tab	60	1
Buspirone 10mg tab*	60	180
Carbamazepine 200mg tab*	60	180
Citalopram 20mg tab	30	90
Citalopram 40mg tab	30	90
Doxepin HCL 10mg cap	30	90
Doxepin HCL 25mg cap	30	90
Doxepin HCL 50mg cap	30	90
Doxepin HCL 75mg cap	30	90
Doxepin HCL 100mg cap	30	90
Fluoxetine 10mg tab*	30	90
Fluoxetine 10mg cap	30	90
Fluoxetine 20mg cap	30	90
Fluoxetine 40mg cap	30	90
Fluphenazine 1mg tab	30	90
Haloperidol 0.5mg tab	30	90

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages. Prices for some drugs covered by the Prescription Program may be higher and may vary in [redacted] states. Restrictions apply. See Program Details or your Walmart Pharmacist for details.

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[redacted] may be higher in CA, HI, MN, MT, PA, TN, WI, and WY.

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Mental Health (continued)

Haloperidol 1mg tab	30	90
Haloperidol 2mg tab	30	90
Haloperidol 5mg tab	30	90
[illegible]um Carbonate 300mg cap*	90	270
[illegible]triptyline 10mg cap	30	90
Nortriptyline 25mg cap	30	90
Paroxetine 10mg tab*	30	90
Paroxetine 20mg tab*	30	90
Prochlorperazine 10mg tab.	30	90
Thioridazine 25mg tab	30	90
Thioridazine 50mg tab	30	90
Thiothixene 2mg cap.	30	90
Trazodone 50mg tab	30	90
Trazodone 100mg tab.	30	90
Trazodone 150mg tab.	30	90
Trihexyphenidyl 2mg tab.	60	180

Skin Conditions

	$4 30-Day	$10 90-Day
Benzoyl Peroxide 4% creamy wash* (170.1ml bottle)†	1	N/A
[illegible]ethasone Dipropionate 0.05% cream [illegible] tube)†	1	3
Betamethasone Dipropionate 0.05% cream (45gm tube)†	1	3
Betamethasone Valerate 0.1% cream (15gm tube)†	1	3
Betamethasone Val. 0.1% cream (45gm tube)†	1	3
Betamethasone Val. 0.1% ointment (15gm tube)†	1	3
Betamethasone Val. 0.1% ointment (45gm tube)†	1	3
Fluocinolone Acet. 0.01% soln (60ml bottle)†	1	3
Fluocinonide 0.05% cream (15gm tube)†	1	3
Fluocinonide 0.05% cream (30gm tube)†	1	3
Gentamicin 0.1% cream (15gm tube)†	1	3
Gentamicin 0.1% ointment (15gm tube)†	1	3
Hydrocortisone 1% cream (28.35-30g tube)†	1	3
Hydrocortisone 2.5% cream (30gm tube)†	1	3
Selenium Sulfide 2.5% lotion* (120ml bottle)†	1	3
Silver Sulfadiazine 1% cream* (50gm tube)†	1	3
Triamcinolone 0.025% cream (15gm tube)†	1	3
Triamcinolone 0.025% cream (80gm tube)†	1	3
Triamcinolone 0.1% cream (15gm tube)†	1	3
Triamcinolone 0.1% cream (80gm tube)†	1	3
Triamcinolone 0.1% ointment (15gm tube)†	1	3
Triamcinolone 0.1% ointment (80gm tube)†	1	3
Triamcinolone 0.5% cream (15gm tube)†	1	3

Thyroid Conditions

	$4 30-Day	$10 90-Day
Levothyroxine 25mcg tab	30	90
Levothyroxine 50mcg tab	30	90
Levothyroxine 75mcg tab	30	90
Levothyroxine 88mcg tab	30	90
Levothyroxine 100mcg tab	30	90
Levothyroxine 112mcg tab	30	90
Levothyroxine 125mcg tab	30	90
Levothyroxine 137mcg tab	30	90
Levothyroxine 150mcg tab	30	90
Levothyroxine 175mcg tab*	30	90
Levothyroxine 200mcg tab*	30	90

Viruses

	$4 30-Day	$10 90-Day
Acyclovir 200mg cap	30	90

Vitamins & Nutritional Health

	$4 30-Day	$10 90-Day
Folic Acid 1mg tab	30	90
Klorcon 8 8mEq ER tab	30	90
Klorcon 10 10mEq ER tab.	30	90
Klorcon M10 10mEq tab.	30	90
Mag 64 64mg tab*	60	180
Magnesium Oxide 400mg tab	30	90
Prenatal Plus qty 30*	30	90
Potassium Chloride 10% liquid	473ml	1419ml
Sodium Fluoride .5mg chewable (120ct bottle) †	1	N/A

Prescription Program includes up to a 30-day supply for $4 and a 90-day supply for $10 of some covered generic drugs at commonly prescribed dosages.
Prices for some drugs covered by the Prescription Program may be higher and may vary in [illegible]tes. Restrictions apply. See Program Details or your Walmart Pharmacist for details.

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[illegible]ay be higher in CA, HI, MN, MT, PA, TN, WI, and WY.
† Prepackaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

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	$4 30-Day	$10 90-Day
Women's Health		
Estradiol 0.5mg tab	30	90
[illegible]radiol 1mg tab	30	90
[illegible]diol 2mg tab	30	90
Estropipate 0.75mg tab	30	90
Estropipate 1.5mg tab*	30	90
MedroxyprogesteroneAcetate 2.5mg tab	30	90
Medroxyprogesterone Acetate 5mg tab	30	90
Medroxyprogesterone Acetate 10mg tab	10	30

	$9 30-Day	$24 90-Day
Women's Health		
Alendronate SOD 35mg tab	4	12
Alendronate SOD 70mg tab	4	12
Clomiphene 50mg tab	5	15
EST Estrogen/Methyl Testost HS tab	30	90
EST Estrogen/Methyl Testost DS tab	30	90
Sprintec 28-day tab*	28	N/A
Tri-Sprintec 28-day tab*	28	N/A
Tamoxifen 10mg tab	60	180
Tamoxifen 20mg tab	30	90

	$4 30-Day	$10 90-Day
Other Medical Conditions		
Chlorhexidine Gluconate 0.12% soln (473ml bottle)†	1	3
Hydrocortisone AC 25mg suppositories	12	36
Isoniazid 300mg tab	30	90
Lidocaine 2% viscous solution (100ml bottle)†	1	3
Megestrol 20mg tab*	30	90
Methylpred 4mg tab	21	63
Methylpred 4mg dose pak (21 tablets)†	1	3
Oxybutynin 5mg tab	60	180
Phenazopyridine 100mg tab	6	18
Phenazopyridine 200mg tab	30	90
Prednisone 2.5mg tab	30	90
Prednisone 5mg tab	30	90
Prednisone 5mg dose pak (21 tablets)†	1	3
Prednisone 5mg dose pak* (48 tablets)†	1	3
Prednisone 10mg tab	30	90
Prednisone 10mg dose pak (21 tablets)†	1	3
Prednisone 10mg dose pak* (48 tablets)†	1	N/A
Prednisone 20mg tab	30	90

Walmart's Prescription Program Details

1. Walmart's Prescription Program (the "Program") is available at all Walmart, Sam's Club and Neighborhood Market pharmacies in the United States ("Walmart Pharmacy"), except in North Dakota.

2. The Program applies only to certain generic drugs at commonly prescribed dosages. You may obtain a list of generic drugs and dosages covered under the Program (the "Drug List") on Walmart.com or at any Walmart Pharmacy. The Drug List may change and also may vary by state. Not all formulations of a drug (for example, enteric-coated, extended or timed release formulations) are covered under the Program.

3. Under the Program, $4 is the price for up to a 30-day supply of certain covered generic drugs at commonly prescribed dosages (the "$4 Program"). $10 is the price of a 90-day supply of certain covered generic drugs at commonly prescribed dosages (the "$10 Program"). Not all drugs covered by the $4 Program are covered by the $10 Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $4 Program and $10 Program are prorated based on the $4 Program price, but will not exceed $10. Prices for quantities greater than a 90-day supply of drugs covered by the $10 Program are prorated based on the $10 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs (such as tubes, vials or bottles), see Section 5.

4. Under the Program, $9 is the price for up to a 30-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$9 Program"). $24 is the price for a 90-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$24 Program"). Not all drugs covered by the $9 Program are covered by the $24 Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $9 Program and $24 Program are prorated based on the $9 Program price, but will not exceed $24. Prices for quantities greater than a 90-day supply of drugs covered by the $24 Program are prorated based on the $24 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs, see Section 5.

5. Prepackaged drugs are covered under the Program only in the unit sizes specified on the Drug List. Prepackaged drugs are dispensed based on the quantities prescribed and unit sizes in stock at the Pharmacy. Unit sizes not specified on the Drug List are not covered under the Program. Multi-unit purchases are charged at a per unit price, based on the price per unit size dispensed, unless otherwise specified. Prepackaged drugs dispensed in unit sizes not specified on the Drug List may be priced higher, even if equivalent quantities of the drug are available in specified unit sizes. Prorated pricing is not available under the Program for prepackaged drugs.

6. Prices of certain drugs covered by the Program may be higher in some states, as noted on the Drug List.

7. Program pricing may be limited to select manufacturers of a covered drug and is available as long as store supplies in stock at the Pharmacy from such manufacturers last.

8. You may pay less or more than the Program price, depending on the terms of your health plan. Prescriber permission may be required to change a 30-day prescription to a 90-day prescription. Certain plans, including government-funded programs, may not cover a 90-day supply.

9. Prescriptions must initially be filled in person. Refills must be picked up in store. There are no substitutions or mail orders.

10. These Program Details are subject to change without advance notice. Changes to these Program Details may be made only in writing.

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Revised 1/23/[illegible]

[illegible]may be higher in CA, HI, MN, MT, PA, TN, WI, and WY.

† Prepackaged drugs are covered only in unit sizes specified on Drug List. See Program Details or your Walmart Pharmacist for details.

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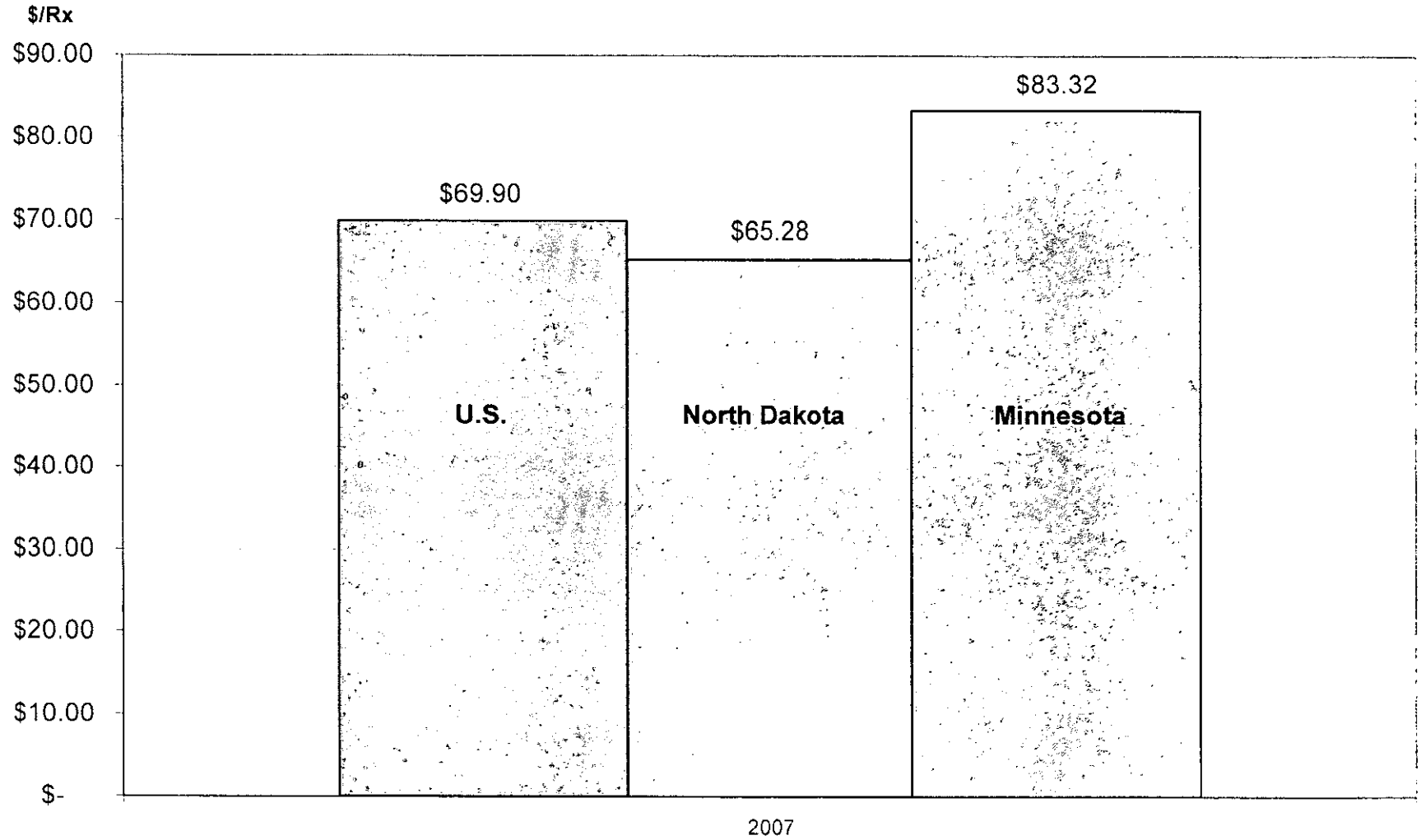
Figure 1.

Average $ per Rx (All Sources) in 2007: U.S., North Dakota & Minnesota



Source: Data as reported in The NACDS Chain Pharmacy Industry Profile, annual editions 1998 to 2008; data from IMS Market View, as reported in Novartis Pharmacy Benefit Report, 1996 to 2001 and NDCHealth (a health care information company), 2002 to 2007.

Figure 2.

Average $ per Rx by State: 2007

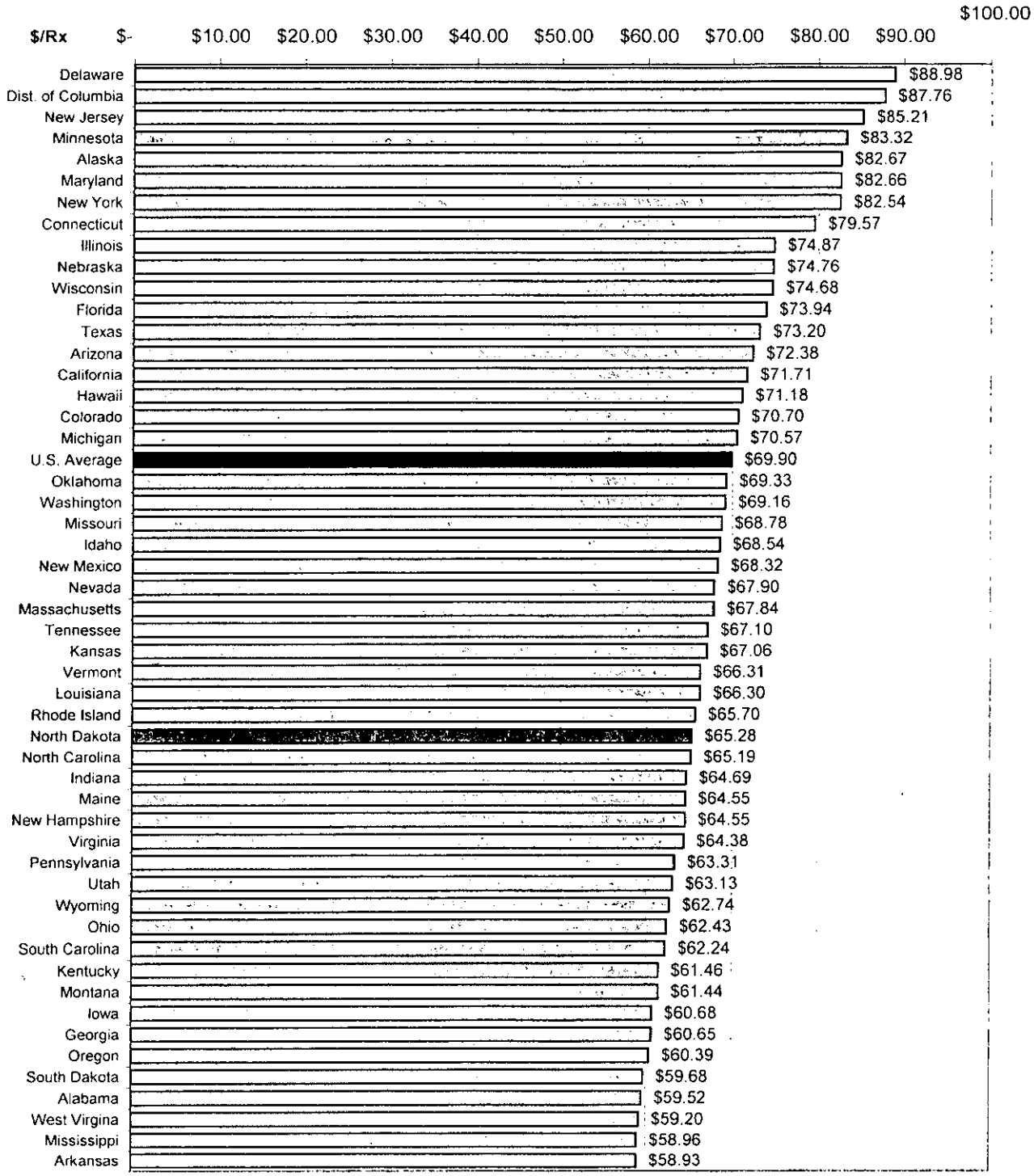
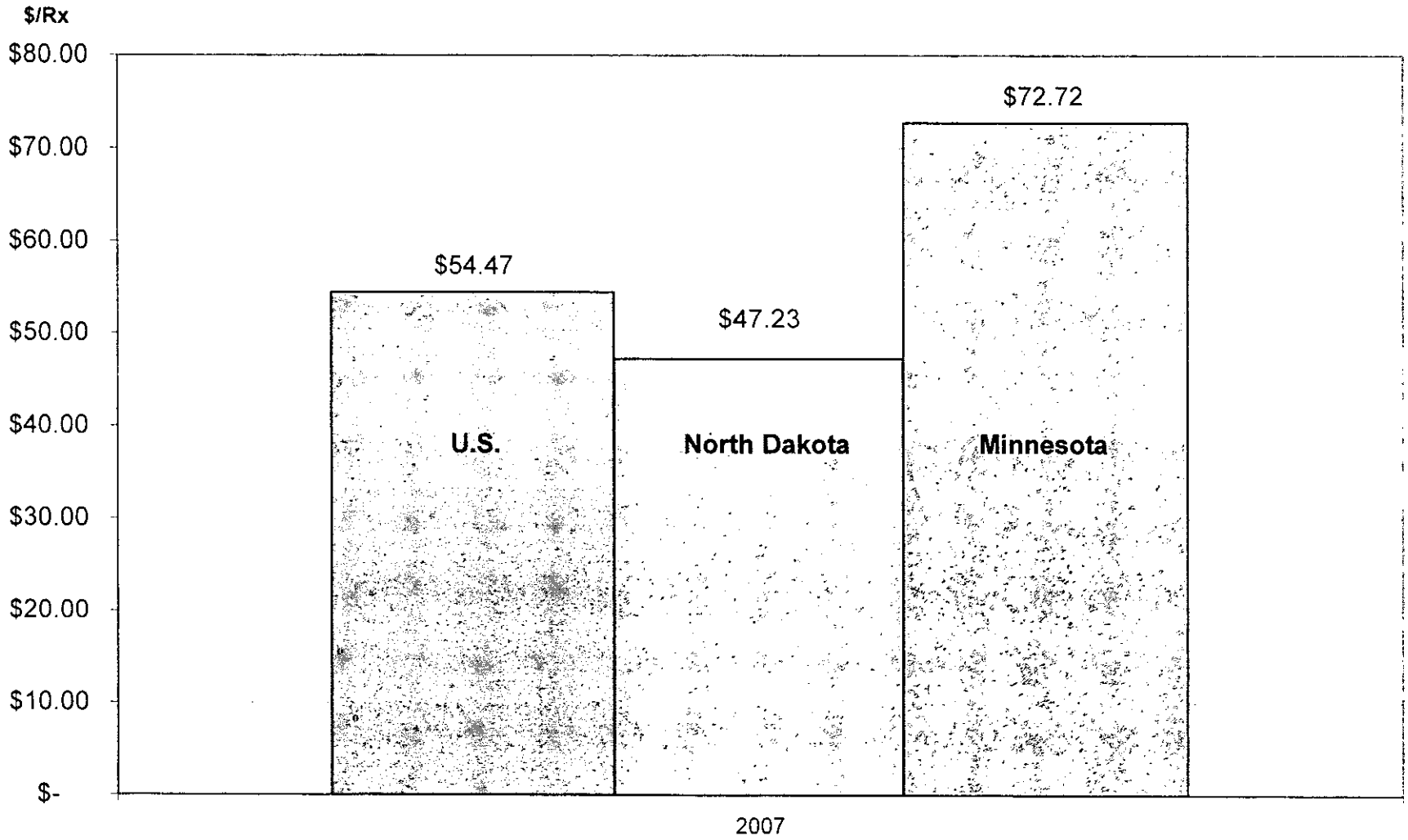


Figure 3.

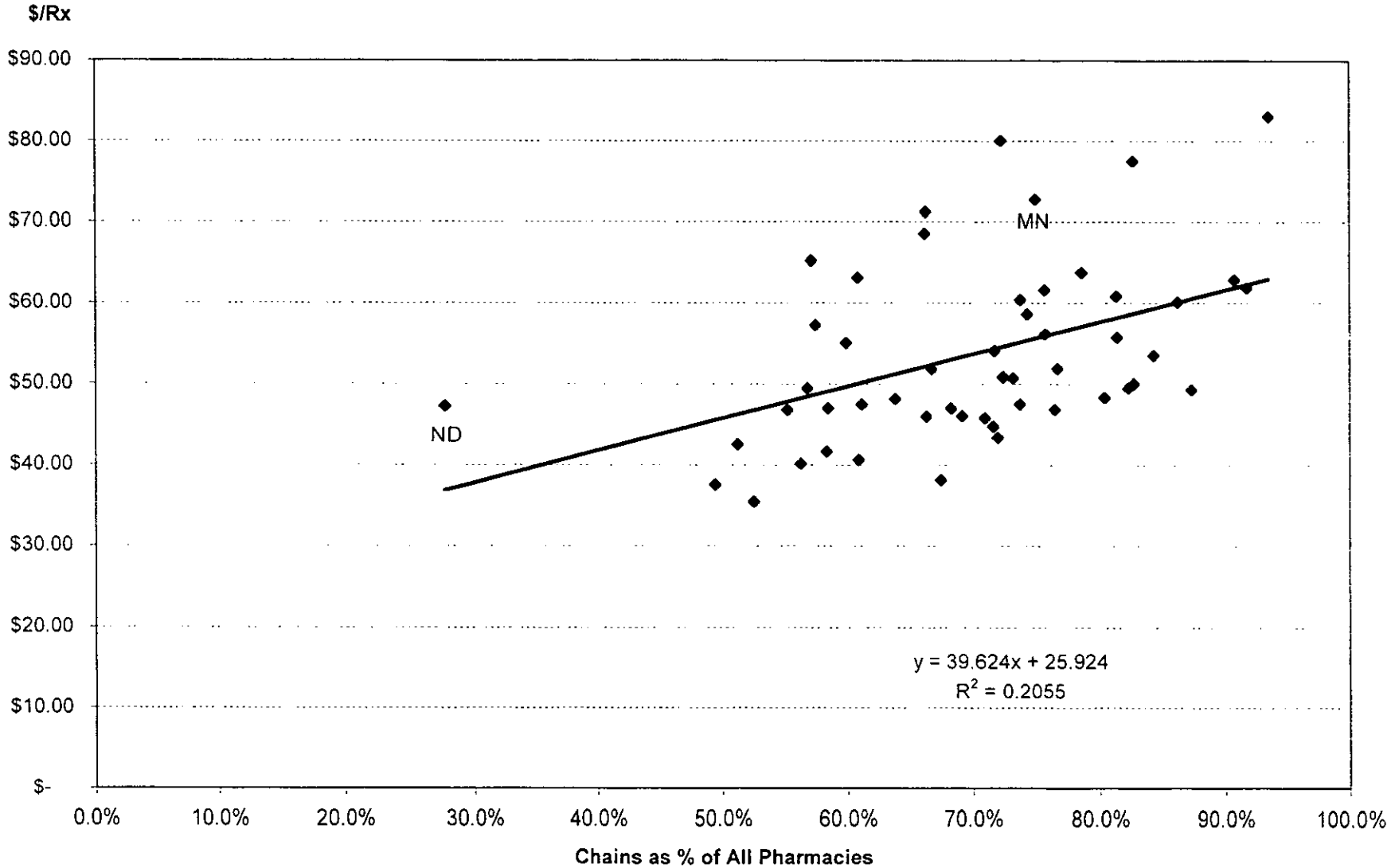
Average $ per Rx (Cash) in 2007: U.S., North Dakota & Minnesota



Source: Data as reported in The NACDS Chain Pharmacy Industry Profile, annual editions 1998 to 2008; data from IMS Market View, as reported in Novartis Pharmacy Benefit Report, 1996 to 2001 and NDCHealth (a health care information company), 2002 to 2007.

Figure 4.

$/Rx for Cash Prescriptions vs. Chains as a % of Pharmacies by State: 2007



Source: Data as reported in The NACDS Chain Pharmacy Industry Profile, annual editions 1998 to 2008; data from IMS Market View, as reported in Novartis Pharmacy Benefit Report, 1996 to 2001 and NDCHealth (a health care information company), 2002 to 2007.

Testimony

House Industry, Business and Labor Committee

Representative George Keiser, Chair

February 3, 2009

Chairman Keiser, committee members, for the record my name is Harvey Hanel and I am the Pharmacy Director for Workforce Safety and Insurance. Before I begin my testimony, I would like to state for the record that WSI has not taken a position on this proposed legislation. I was contacted by Representative Kasper to provide information on what the agency is being billed for generic medications that are filled at Walmart pharmacies outside of North Dakota and how those compare to generic medications that are filled by pharmacies located inside the state.

The spreadsheet that you have before you is the result of that request. Before I get into specifics, I would like to detail how the information on the spreadsheet was derived. The generics are broken into two categories, those that are contained on Walmart's website describing their $4.00 generic program and those generics that, either are not on that list, or those in which the quantity dispensed place them outside of the list. The information on those prescriptions dispensed at a Walmart pharmacy were obtained from the paper invoices which are sent by the third party billing company that Walmart uses for their worker's compensation prescriptions. The time frame studied were prescriptions dispensed between June of 2008 and November of 2008. Copies of the November invoices were located at WSI, the prior months were located

at our pharmacy benefit management (PBM) company. You will note that there are no prescriptions on this spreadsheet from the month of October. That is due to some confusion between the date dispensed and the date these were processed by our PBM. I was using the date dispensed when I made the request, and they used the date that they had processed the prescription into their system. Irrespective of this, I am confident that the data contained in this spreadsheet is representative of the generic medications which are dispensed at these pharmacies.

I would also like to describe the methodology that I used to obtain the comparative prescriptions which were dispensed at an in-state pharmacy. Obviously the medications had to be identical generic medications and they had to have been dispensed by a North Dakota pharmacy. Secondly, the date of service and quantity dispensed had to be within reason. If you would be so kind as to refer to the spreadsheet I will explain this further. Under the $4.00 generic heading you will see that the first prescription listed is Tetracycline 500mg capsules which were dispensed on November 20, 2008. A quantity of 30 capsules were dispensed for a 30 day supply. There were no prescriptions dispensed for this same medication within a reasonable time frame or with a reasonably comparable quantity to make a comparison, hence the N/A which appears the Date of Service column for the comparable North Dakota pharmacy. If you would look at the next prescription on the list, the antibiotic sulfamethoxazole/trimethoprim double strength tablets were dispensed on November 10, 2008. A quantity of six tablets for a three days supply were dispensed. On October 20, 2008 the same

medication was dispensed in a North Dakota pharmacy, but with a quantity of 20 for a ten day supply. While the quantity is not an exact match, a general comparison can be made about the amounts that were billed versus the amounts that were paid can be made. The third prescription on the spreadsheet illustrates a more exact comparison. Thirty cyclobenzaprine 10 mg tablets were dispensed on November 16, 2008 at a Walmart pharmacy with the closest match being a prescription dispensed in a North Dakota pharmacy on November 15th. In the case in which there were several prescriptions for the same medication with the same quantity and the same timeframe, I chose the date of service which most closely matched the date of the prescription being compared. Using this methodology I would like to state that prescriptions which appear under the North Dakota side of the spreadsheet truly represent pharmacy in the state. These came from independent pharmacies, chain pharmacies, clinic pharmacies, pharmacies owned by hospitals, pharmacies in urban areas, pharmacies in rural areas, east, west, south and north. In other words, these were not hand picked.

In the vast majority of the cases, WSI is being billed less from the comparable North Dakota pharmacy than we are from the Walmart pharmacy. Of course amount billed and amount paid are two different things entirely. Our PBM adjudicates these prescriptions based upon our fee schedule. So the amount billed becomes irrelevant to us unless the amount billed is actually less than our fee schedule. In that case the prescription would be paid at the pharmacy's usual and customary price,

in other words it would be paid at the lower amount. This only happened one time during this comparison.

I would be happy to answer any questions that the committee might have.

Harvey Hansel

Walmart $4.00 Generics

Date of Service	Medication	Quantity	Days Supply	Amount Billed	Amount Paid
11/20/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
11/10/2008	SMZ-TMP DS	6	3	$11.78	$5.76
11/6/2008	Cyclobenzaprine 10 mg	30	30	$34.40	$7.00
9/17/2008	Tetracycline 500 mg	30	30	$13.40	$6.60
9/8/2008	Triamcinolone 0.1% Oint	30	7	$6.67	$6.38
9/9/2008	SMZ-TMP DS	6	3	$11.78	$5.76
8/20/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
8/14/2008	SMZ-TMP DS	6	3	$11.78	$5.76
7/18/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
7/17/2008	Amitriptyline 75 mg	30	30	$37.72	$8.58
7/10/2008	SMZ-TMP DS	6	3	$11.78	$5.76
6/21/2008	Ciprofloxacin 500 mg	14	7	$72.76	$6.35
6/19/2008	Amitriptyline 75 mg	30	30	$37.72	$8.58
6/18/2008	Tetracycline 500 mg	30	30	$8.19	$6.60

Comparable ND Pharmacy

Date of Service	Quantity	Days Supply	Amount Billed	Amount Paid
N/A				
10/30/2008	20	10	$ 8.20	$ 7.52
11/15/2008	30	30	$15.55	$7.00
N/A				
7/9/2008	80	8	$ 10.50	$ 9.20
9/22/2008	14	7	$ 8.15	$ 6.76
N/A				
9/22/2008	14	7	$ 8.15	$ 6.76
N/A				
7/17/2008	30	30	$ 21.69	$ 8.58
7/9/2008	10	5	$ 5.50	$ 5.50
7/1/2008	14	7	$ 14.30	$ 6.35
6/19/2008	30	30	$ 10.75	$ 8.58
N/A				

Walmart Regular Generics

Date of Service	Medication	Quantity	Days Supply	Amount Billed	Amount Paid
11/24/2008	Amitriptyline 25 mg	60	30	$ 23.30	$ 7.93
9/19/2008	Hydrocodone/Apap 10-325 mg	360	30	$232.61	$ 76.82
9/19/2008	Zolpidem 10mg	30	30	$129.88	$ 12.88
9/18/2008	Oxycodone/Apap 7.5-325 mg	120	30	$201.72	$ 62.96
9/18/2008	Cyclobenzaprine 10 mg	120	20	$163.19	$ 13.01
9/17/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89
9/15/2008	Tramadol 50 mg	180	30	$155.89	$ 22.01
9/15/2008	Hydrocodone/Apap 5-500 mg	30	15	$ 10.31	$ 6.89
9/13/2008	Hydrocodone/Apap 5-500 mg	15	2	$ 7.66	$ 5.95
9/11/2008	Hydrocodone/Apap 7.5-325 mg	80	6	$ 49.51	$ 31.13
9/4/2008	Cephalexin 500 mg	50	16	$ 66.92	$ 12.35
9/2/2008	Hydrocodone/Apap 10-325 mg	60	10	$ 42.94	$ 16.97

Comparable ND Pharmacy

Date of Service	Quantity	Days Supply	Amount Billed	Amount Paid
11/25/2008	60	30	$ 10.99	$ 7.93
9/19/2008	280	23	$ 203.14	$ 60.86
9/18/2008	30	30	$ 23.15	$ 12.88
N/A				
9/18/2008	120	30	$ 131.66	$ 13.01
9/17/2008	60	30	$ 167.23	$ 12.89
9/12/2008	180	30	$ 70.83	$ 22.01
9/15/2008	30	4	$ 13.05	$ 6.89
9/8/2008	15	3	$ 16.22	$ 5.95
N/A				
9/5/2008	60	30	$ 31.56	$ 13.82
9/3/2008	60	10	$ 19.59	$ 16.97

8/27/2008	Morphine Sulfate ER 60 mg	90	30	$272.80	$ 122.61	8/18/2008	90	30	$ 349.19	$ 122.61
8/27/2008	Morphine Sulfate ER 15 mg	60	30	$ 53.15	$ 29.90	8/28/2008	60	30	$ 91.69	$ 29.90
8/25/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	9/2/2008	68	34	$ 14.85	$ 8.32
8/22/2008	Hydrocodone/Apap 7.5-325 mg	80	6	$ 49.51	$ 31.13	N/A				
8/19/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89	8/22/2008	60	30	$ 167.23	$ 12.89
8/18/2008	Oxycodone/Apap 7.5-325 mg	90	22	$152.80	$ 48.47	N/A				
8/18/2008	Cyclobenzaprine 10 mg	120	20	$163.19	$ 13.01	8/22/2008	120	30	$ 115.95	$ 13.01
8/15/2008	Tramadol 50 mg	180	30	$155.89	$ 22.01	8/12/2008	180	30	$ 155.34	$ 22.01
8/5/2008	Hydrocodone/Apap 5-325 mg	30	3	$ 19.63	$ 12.06	8/5/2008	30	3	$ 18.45	$ 12.06
8/5/2008	Cefadroxil 500 mg	10	5	$ 38.48	$ 19.34	7/28/2008	14	7	$ 73.59	$ 25.08
8/4/2008	Zolpidem 10mg	30	30	$129.88	$ 12.88	8/4/2008	30	30	$ 17.29	$ 12.88
8/3/2008	Hydrocodone/Apap 7.5-500 mg	60	30	$ 28.13	$ 10.39	8/4/2008	60	7	$ 38.40	$ 10.39
7/30/2008	Morphine Sulfate ER 30 mg	60	30	$ 96.51	$ 30.75	7/24/2008	60	30	$ 110.77	$ 30.75
7/30/2008	Morphine Sulfate ER 15 mg	60	30	$ 53.15	$ 29.90	7/24/2008	60	30	$ 59.95	$ 29.90
7/26/2008	Hydrocodone/Apap 10-325 mg	360	30	$232.61	$ 76.82	7/12/2008	280	23	$ 203.14	$ 60.86
7/25/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	7/15/2008	60	30	$ 14.05	$ 7.93
7/24/2008	Cyclobenzaprine 10 mg	40	10	$ 48.65	$ 7.67	7/23/2008	40	10	$ 23.95	$ 7.67
7/20/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89	7/21/2008	60	30	$ 167.23	$ 12.89
7/17/2008	Morphine Sulfate ER 60 mg	30	30	$ 94.26	$ 44.20	7/9/2008	30	30	$ 27.89	$ 17.45
7/17/2008	Oxycodone ER 20 mg	120	30	$410.47	$ 308.35	N/A				
7/17/2008	Oxycodone/Apap 7.5-325 mg	84	28	$143.00	$ 45.57	N/A				
7/17/2008	Oxycodone ER 80 mg	30	30	$324.30	$ 243.73	8/18/2008	24	24	$ 196.99	$ 195.98
7/17/2008	Cyclobenzaprine 10 mg	120	30	$163.19	$ 13.01	7/9/2008	120	30	$ 131.66	$ 13.01
7/10/2008	Morphine Sulfate ER 30 mg	90	30	$142.26	$ 43.63	7/23/2008	90	30	$ 50.49	$ 43.63
6/29/2008	Oxycodone ER 20 mg	180	30	$460.02	$ 460.02	N/A				
6/24/2008	Amitriptyline 50 mg	60	30	$ 37.51	$ 6.99	7/7/2008	60	30	$ 15.44	$ 6.99
6/23/2008	Sertraline 100 mg	60	30	$151.63	$ 12.89	6/23/2008	60	30	$ 185.54	$ 12.89
6/20/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	6/9/2008	60	30	$ 14.05	$ 7.93
6/20/2008	Hydrocodone/Apap 7.5-500 mg	60	30	$ 28.13	$ 10.39	6/17/2008	60	15	$ 23.05	$ 10.39
6/19/2008	Zolpidem 10mg	30	30	$129.88	$ 12.88	6/19/2008	30	30	$ 143.99	$ 12.88
6/19/2008	Oxycodone ER 20 mg	90	30	$309.35	$ 232.51	6/21/2008	90	30	$ 258.40	$ 232.51
6/19/2008	Cyclobenzaprine 10 mg	120	30	$163.18	$ 13.01	6/6/2008	120	30	$ 131.66	$ 23.90
6/15/2008	Tramadol 50 mg	180	30	$155.89	$ 22.01	6/16/2008	180	30	$ 123.95	$ 22.01
6/10/2008	Propoxyphene/Apap 100-650 m	100	16	$ 53.11	$ 15.50	6/25/2008	100	16	$ 34.39	$ 15.50
6/10/2008	Tramadol 50 mg	50	8	$ 42.69	$ 9.73	6/6/2008	50	7	$ 39.39	$ 9.73
6/5/2008	Morphine Sulfate ER 30 mg	90	30	$142.26	$ 43.63	6/27/2008	90	30	$ 50.49	$ 43.63
6/5/2008	Hydrocodone/Apap 10-325 mg	360	30	$232.61	$ 85.71	6/9/2008	280	28	$ 141.55	$ 60.86

February 3, 2009

My name is Maari Larsen Loy, I am opposition to HB1440. I am a pharmacy student at North Dakota State University and a pharmacy intern at Family HealthCare Pharmacy. My parents are farmers in rural Cass County; I graduated from Central Cass High School in Casselton, ND and am a tax-paying home-owner in Fargo. As a student who ***is*** staying in North Dakota to practice pharmacy, I need to know I will practice in a state that supports patient care and enables me to do all I can to serve our patients in North Dakota. I have personally seen how this corporate environment restricts the avenues the pharmacist can pursue to deliver the safest, most cost effective, comprehensive pharmaceutical care to our patients.

1. No one here is talking about the other options that have been developed by North Dakota pharmacists to provide inexpensive alternatives for our patients. We already have another option for affordable healthcare in North Dakota… 340B pharmacies!
    a. Pharmacists within private pharmacies have taken on 340B contracts to help patients. This is at a cost of profit and bottom line and adds to the complication of their business.
    b. This arrangement offers options to health consumers in our ***great state*** and retains an opportunity for excellent pharmaceutical care in our own communities.
2. You may ask, "What is a 340B contracted pharmacy?"
    a. We utilize 340B pricing, a subsidized drug source. The savings are passed on to our underserved low-income patients. The programs we utilize allow our patients access to the full-spectrum of medications, including the newest advancements in medication that aren't on the big box store's $4 list.

3. Corporate entities won't give us "affordable" healthcare. Having a $4 generic does nothing to ensure access to these new, more promising therapies that a 340B pharmacy can provide... because these new drugs are not generic and they're not $4!
4. We have seen the unwillingness of the big box to be an advocate for our patients when our patients approach us for help. This help is needed for the problem originating at the big box. They come to us because the problems weren't solved, the issue wasn't resolved, and the patient is at the end of their rope because the problem was presented as "unfixable." We resolve these very issues on a daily basis.
    a. The big box stores do not offer trouble-shooting or accounts receivables to their patients, and dispense prescriptions with a "pay-it-or-leave-it" approach.

In conclusion, 340B pharmacies are full-service pharmacies that offer another option and dimension of pharmaceutical care, and have institutionalized an attitude of caring and service beyond the conventional business model to our patients in North Dakota.

Thank you for your time and consideration.

Maari L. Loy
1218 3rd St N
Fargo, ND 58102

4 Copies

HB 1440
3-16-09

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Mark

Good Morning

I am Joe Schneider from Dickinson where I reside at a wonderful place called, the Evergreen, it is an assisted living facility where we all have a private room.

I am originally from Napoleon ND in Logan Co. Where I grew up on a farm/ranch in the 30's during the great depression.

We called napoleon, the capital of ND as there were four individuals here in the capital.

Tony Schmidt - Land Comm

Otis Bryant - Workman's Comp

Ben Meier - Sec of State

Also, there was an individual at the Penitentiary who during the winter shoveled snow off of the sidewalks around the capital. So we called Napoleon the capital of ND.

Usually when the Legislator met every odd year we felt in danger of laws that would be passed. While the legislator was in session you could see Al Doer around, he was a Pharmacist from Napoleon who owned his drug store, and that drug store is still there today. It burned down this winter but, the new owner is a Pharmist and will rebuild this spring.

Al Doer was probably instrumental in the passing of HB. 1440. Al owned the store, and local people bought their prescription drugs from him. People who needed prescription medication did not drive to Jamestown, Aberdeen or Bismarck for their medical supplies. Residents along our northern boarder drove to Canada for their medical needs and made other purchases their as well. The repeal of this unfair bill will not endanger small towns in ND, it will provide them with a choice for the purchase of their

medical needs. Free enterprise is still the name of the game. All Doer had a successful business and sold his store and retired.

If we have open and fair competition we will all benefit. There are four other Assisted Living Facilities in Dickinson, If this BILL (HB 1440) is repealed it will save me $176.00 a year this plus all other eligible participants would save them money. I my case I am a veteran of World War II. I could buy my prescriptions through the Veterans administration, but would cost me more. Also I could purchase my needs thur my supplemental insurance and after the deductions would still cost me more.

We seniors could invest what we save for our grandchildren and great grandchildren to provide them with an education ~~for~~ so they can pay or help to pay enormous debt which they will inherit.

Thank you for your attention and help us to repeal this bill.

HOUSE BILL NO. 1440

I am Erica Kallenbach, a pharmacy student who will be graduating in May. I grew up in the rural community of Maddock, ND. I am here today to discuss the importance of maintaining the 1963 pharmacy law which states a pharmacy in North Dakota must be at least 51% owned by a pharmacist and to reject House Bill 1440.

First, I want to discuss why the practice of pharmacy in North Dakota is so appealing to me. All pharmacists want to improve patient care, but what is special about North Dakota is that all pharmacists work TOGETHER to provide better outcomes for their patients by implementing new programs and continually striving to improve existing programs.

A great example is the telepharmacy project that is providing access to rural communities that otherwise would have lost pharmacy services. North Dakota was the pioneer state in this aspect of pharmacy and now there are nine other states that have followed their lead. In North Dakota this teamwork effort has allowed for better patient care. Because pharmacists are actively involved in more than just the patients that walk through their doors, they are not driven to purely make profit. Forty- four rural sites in North Dakota now enjoy pharmacy services that would otherwise not exist were it not for telepharmacy.

The Diabetes Management program is another way pharmacists across the state have worked together to improve patient care. This program is designed to empower and educate diabetic patients to develop and improve the self management of their health in order to improve their overall health, reduce complications and control healthcare costs. Cooperation between North Dakota Pharmacy Service Corporation, NDPhA, ND Board of Pharmacy, College of Pharmacy, and pharmacists throughout the state helped make this program possible.

A major advantage pharmacists in North Dakota have is implementing these programs. The owner of the pharmacy is easily accessible and able to implement these programs. My experience with independent pharmacists in North Dakota is their desire to provide the best possible care for their patients without high regard for profit and time.

My concern is that by allowing corporate owned pharmacies into the state, they may fail to implement new programs which improve patient care, and may cause pharmacies to close, which innovate patient care programs. If independent pharmacies go out of business, these programs will have more difficulty finding their way into practice. An example is that the one corporate chain in North Dakota does not participate in the Diabetes Education program. I want North Dakota to continue to be a leader and innovator in the practice of pharmacy and providing patients with great care.

I believe that all pharmacists conduct themselves in a professional manner, but North Dakota pharmacists have an advantage. Pharmacy owners are known very well by their employees and therefore, are more readily accessible to assist in decision making. Pharmacists are able to meet patient's needs in different ways. For example, while I was on rotations a patient's prescription was going to cost $700.00 and the independent pharmacist allowed this patient to charge this prescription without having a previously established account. Also, I have seen pharmacists price match or adjust for patients in

many different situations. The experience that I have had with larger corporations is that there is no price adjusting, and a patient not capable of paying may have to go without.

I want to discuss jobs in the state and young pharmacists leaving. I have been job searching and looking for employment in North Dakota. Currently there are 20 pharmacy positions listed with North Dakota Job Service. This does not include postings in journals and other newspapers for employment. I found that talking with people there are many wonderful job opportunities in North Dakota. It requires more work to find them versus sitting in a large presentation about a company that does not ask questions about me as a candidate.

While looking for employment I have concerns that jobs and opportunities may be lost, not gained. I think about some pharmacies across the state that may lose their current location and face the choice of moving to a new location or selling to corporations. In pharmacies that employed three or four pharmacists, they may be replaced with two pharmacists that have to handle a higher volume and have a greater risk for errors. The ratio of pharmacists to prescription load is higher for chain pharmacies.

I also want to look at young pharmacists leaving the state. My graduating class consists of 35-40% of nonresidents, which will now be possibly choosing to leave North Dakota and return to the area of the country where they grew up.

As a person that has lived in a small rural community like Maddock, we have fought so hard to keep our facilities open like the clinic, pharmacy, and grocery store to name a few. My concern is that larger corporations coming into North Dakota will shut down rural pharmacies, not just by direct competition, but indirectly by allowing insurance companies to reimburse poorly that rural pharmacy prescription counts would not be able to support the rural pharmacy. Also, insurance/employer groups may inflict penalties on patients that do not choose select pharmacies which may lead to independent pharmacies losing many patients. We have fought to preserve rural communities' access to health care and other necessities. We need to learn from our neighbors to the south and keep fighting to maintain healthcare access for every North Dakota Resident.

I want to keep North Dakota thriving. While on rotations, I have witnessed independent pharmacists giving back to their community in many ways, which include donations to scholarship funds, education, and organization fund raising activities, just to name a few.

Also, I noticed that independent pharmacies get services through North Dakota businesses. They stock local businesses products on their shelves and support local suppliers that serve small businesses in North Dakota. Bigger corporations may have their own warehouses and not use local suppliers, which could cause job loss. I find it disheartening that large corporations can come into North Dakota and harvest huge profits. Then I wonder where that money will go, and if it would be reinvested back into North Dakota's economy to support the state's residence like independent owners do.

I hope you will take into consideration these concerns and not change a law that has helped North Dakotans for over 45 years. I want all residents of North Dakota to have access to healthcare and see North Dakota thrive. Please reject House Bill 1440.

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House IBL Committee
Chairman George Keiser
Hearing – February 3, 2009

My Name is Bob Treitline from Dickinson, ND. I am pharmacist and owner of ND Pharmacy in Dickinson, ND. Thank you and the committee for the opportunity to testify on HB 1440. I have provided a lot of information in the packet that will, I hope, answer some questions and create others I am sure. In this hand out there are copies of Medicare D prescription plans which will show some of the questionable activities of the chain owned PBM's and the disparities between competing pharmacy reimbursements. The Medicare D plan's are the only contracts or prices that are available for not only the profession to view but also the public. If you go to the web site Medicare.gov, you can compare all the plans and all the pharmacies prices in your area or even all over the U.S. In doing a comparison for a patient I stumbled on some interesting statistics. On all the comparisons shown I used this patients same drug list which includes the same drugs, the same strength, and same quantities. My point in showing you these comparisons is to show the ability of the big box stores that own PBM's to control the market place by price and contract. CVS owns Caremark , Wallgreen owns WHI, and I think we can guess that Wal-Mart will own their own PBM in the near future. Now let's look at the attachments and you can see what effect these PBM owned pharmacies have on the market as well as the consumer. Attachment #1 is from CVS Pharmacy in Fargo, ND I will point out the cost to the plan and to the consumer now compare attachment #2 which is from Southpoint Pharmacy in Fargo, ND, again compare the plan costs and the consumer costs. I can't explain the disparity but there is defiantly one there, as you can see. I also compared this same drug profile to the Wallgreen Drug in Moorhead, Mn. Attachment #3 and Foss Drug in Moorhead, Mn. Attachment #4 and again it shows the disparity in that market as well. What is the relationship of CVS to Wallgreen ???

One other comparison and that is the MedicareBlue Rx Plan administered by Prime Therapeutics. See attachment #5 CVS in Fargo, ND and attachment #6 Southpoint Pharmacy in Fargo, ND again we see the disparity. (?????????) As you can see the date of the comparison on the bottom of the page is 1-7-09 . On 1-16-09 Mike Schwab of the NDPSC made a call to Tom Christenson, a pharmacy department person for Blue Cross, and ask why there was such a price and or contract disparity in the North Dakota market. I believe Mr. Christenson did not have an answer for Mr. Schwab. It was interesting to note on 1-19-09 the comparison showed no disparity. (???????????) Was there a relationship with CVS and Blue Cross? In conclusion do we want to expand this type of activity, it will come, with the proposed change. I would ask this committee to vote NO to the repeal of HB 1440. I would entertain any questions from the committee. Thank you.

Bob Treitline

Medicare Part D Plan
Advantage Freedom Plan by Rx America
(Admin. By Caremark/CVS)

Attachment #1
CVS (Fargo,ND)
Amount paid by patient
For 12 months $2,842.57

Attachment #2
Southpoint Phar. (Fargo, ND)
Amount paid by patient
$1,299.62 for 12 months

Difference = $1,542.95

Total drug cost for 12 months
$384.89 X 12 = $4,618.68

Total drug cost for 12 months
$178.88 X 12 = $2,146.56

Difference = $2,472.12

Attachment #3
Wallgreen Drug (Moorhead, Mn)
Amount paid by patient
For 12 months $2,657.38

Attachment #4
Foss Drug (Moorhead, Mn)
Amount paid by patient
$1,308.71 For 12 months.

Difference = $1,348.67

Total drug cost for 12 months
$368.00 X 12 = $4,416.00

Total drug cost for 12 months
$181.04 X 12 = $2,172.48

Difference = $2,243.52

Medicare Part D Plan
MedicareBlue Rx Option #1
Admin. By Prime Therapeutics

Attachment #5
CVS (Fargo, ND)
Amount paid by patient
For 12 months $3,015.66

Attachment #6
Southpoint Pharmacy (Fargo,ND)
Amount paid by patient
$1,077.31 For 12 months

Difference = $1,938.35

Total drug cost for 12 months
$398.15 X 12 = $4,777.80

Total drug cost for 12 months
$216.72 X 12 = $2,600.64

Difference = $2,177.16

Medicare The Official U.S. Government Site for People with Medicare

Medicare Prescription Drug Plan Finder

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ind and Compare Plans

lan Drug Details

Print This Page

he following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary ased on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the harmacy you use.

dvantage Freedom Plan by RxAmerica (S5644-059)

Basic Plan Information

- *Approved by Medicare*
- *This organization has plans available nationwide.*
- Mail Order Available: Yes
- **Lower My Cost Share**

View Pharmacy Network

iew Important Notes and Benefit Summary

Add to My Favorites

Contact Information

221 N. Charles Lindbergh Dr., SLC, UT 84116

Members:
(800) 429-6686

Non-Members:
(800) 429-6686

View plan website

lan Ratings [What is this?]

[Click to view more details on Plan Ratings]

rug Plan Customer Service	★★★ 3 out of 5 stars
lember Complaints and Staying with Drug Plan	★★★ 3 out of 5 stars
lember Experience with Drug Plan	★★ 2 out of 5 stars
rug Pricing and Patient Safety	★★ 2 out of 5 stars

ixed Costs

remium	$33.90 per Month **($406.80 per Year)**
nn ductible	$0.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	Full Year Cost	Cost for the Rest of 2009 (11months)
Annual Drug Costs for Use at Retail Pharmacy	$2,842.57 (CVS PHARMACY)	$2,423.78
Mail Order Pharmacy	$1,313.49	$1,279.59

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]	Restrictions: Prior Authorization [What is this?]	Restrictions: Quantity Limits [What is this?]	Restrictions: Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No	No	No
METFORMIN HCL TAB 500MG	TIER 1	No	No	No
OMEPRAZOLE CAP 20MG	TIER 1	No	No	No
Plavix TAB 75MG	TIER 2	No	No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No	No	No
RAMIPRIL CAP 10MG	TIER 1	No	No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at CVS PHARMACY

Hide Information

Selected Drugs	Full Cost of Drug	Initial Coverage Level (The amount you will pay before your total drug costs reach $2,700 .)	Gap (The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pa after you reach $4,350 i out of pocket costs.)
ALENDRONATE SODIUM TAB 70MG	$63.72	$5.00	$63.72	$3.19
METFORMIN HCL TAB 500MG	$23.59	$5.00	$23.59	$2.40
OMEPRAZOLE CAP 20MG	$108.11	$5.00	$108.11	$5.41
Plavix TAB 75MG	$143.48	$50.22	$143.48	$7.17
PRAVASTATIN SODIUM TAB 20MG	$25.77	$5.00	$25.77	$2.40
RAMIPRIL CAP 10MG	$20.21	$5.00	$20.21	$2.40
Monthly Totals	$384.89	$75.22	$384.89	$22.97

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy

Show Information

My Drugs

Drug Name	Quantity/Days Supply	Original Drug Entry	Actions
ALENDRONATE SODIUM TAB 70MG	4 per Month	ALENDRONATE SODIUM (Generic)	Add Doses / Remov
METFORMIN HCL TAB 500MG	60 per Month	METFORMIN HCL (Generic)	Add Doses / Remov
OMEPRAZOLE CAP 20MG	30 per Month	OMEPRAZOLE (Generic)	Add Doses / Remove
Plavix TAB 75MG	30 per Month	Plavix (Brand)	Add Doses / Remove
PRAVASTATIN SODIUM TAB 20MG	30 per Month	PRAVASTATIN SODIUM (Generic)	Add Doses / Remove
RAMIPRIL CAP 10MG	30 per Month	RAMIPRIL (Generic)	Add Doses / Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity

Update with Lower Cost Generic Drugs

My Pharmacies

Pharmacy	Pharmacy Type	Network Status	
CVS PHARMACY [redacted]		Network Pharmacies	Remove

Total Monthly Cost Estimator for CVS PHARMACY

Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. T pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment amount you would pay during the plan year is less than the full 12 month cost shown.

Costs	$109.12	$109.12	$109.12	$109.12	$109.12	$109.12	$109.12	$403.58	$418.79	$418.79	$418.79	$418.79

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Medicare Prescription Drug Plan Finder

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Plan Drug Details

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The following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary based on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the pharmacy you use.

Advantage Freedom Plan by RxAmerica (S5644-059)

Basic Plan Information

- *Approved by Medicare*
- *This organization has plans available nationwide.*
- Mail Order Available: Yes
- **Lower My Cost Share**
- **View Pharmacy Network**
- **View Important Notes and Benefit Summary**

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Contact Information

221 N. Charles Lindbergh Dr., SLC, UT 84116

Members:
(800) 429-6686

Non-Members:
(800) 429-6686

View plan website

Plan Ratings [What is this?]

[Click to view more details on Plan Ratings]

Drug Plan Customer Service	★★★ 3 out of 5 stars
Member Complaints and Staying with Drug Plan	★★★ 3 out of 5 stars
Member Experience with Drug Plan	★★ 2 out of 5 stars
Drug Pricing and Patient Safety	★★ 2 out of 5 stars

Fixed Costs

Premium	$33.90 per Month **($406.80 per Year)**
Annual Deductible	$0.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	Full Year Cost	Cost for the Rest of 2009 (11months)
Annual Drug Costs if you use a Retail Pharmacy	$1,299.62 (SOUTHPOINTE PHARMACY)	$1,191.31
Mail Order Pharmacy	$1,313.49	$1,279.59

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]	Restrictions: Prior Authorization [What is this?]	Restrictions: Quantity Limits [What is this?]	Restrictions: Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No	No	No
METFORMIN HCL TAB 500MG	TIER 1	No	No	No
OMEPRAZOLE CAP 20MG	TIER 1	No	No	No
Plavix TAB 75MG	TIER 2	No	No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No	No	No
RAMIPRIL CAP 10MG	TIER 1	No	No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at SOUTHPOINTE PHARMACY

Hide Information

Selected Drugs	Full Cost of Drug	Initial Coverage Level (The amount you will pay before your total drug costs reach $2,700 .)	Gap (The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $4,350 in out of pocket costs.)
ALENDRONATE SODIUM TAB 70MG	$7.72	$5.00	$7.72	$2.40
METFORMIN HCL TAB 500MG	$4.94	$4.94	$4.94	$2.40
OMEPRAZOLE CAP 20MG	$9.77	$5.00	$9.77	$2.40
Plavix TAB 75MG	$141.32	$49.46	$141.32	$7.07
PRAVASTATIN SODIUM TAB 20MG	$7.28	$5.00	$7.28	$2.40
RAMIPRIL CAP 10MG	$7.85	$5.00	$7.85	$2.40
Monthly Totals:	$178.88	$74.40	$178.88	$19.07

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy

Show Information

My Drugs

Drug Name	Quantity/Days Supply	Original Drug Entry	Actions
ALENDRONATE SODIUM TAB 70MG	4 per Month	ALENDRONATE SODIUM (Generic)	Add Doses / Remove
METFORMIN HCL TAB 500MG	60 per Month	METFORMIN HCL (Generic)	Add Doses / Remove
OMEPRAZOLE CAP 20MG	30 per Month	OMEPRAZOLE (Generic)	Add Doses / Remove
Plavix TAB 75MG	30 per Month	Plavix (Brand)	Add Doses / Remove
PRAVASTATIN SODIUM TAB 20MG	30 per Month	PRAVASTATIN SODIUM (Generic)	Add Doses / Remove
RAMIPRIL CAP 10MG	30 per Month	RAMIPRIL (Generic)	Add Doses / Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity

Update with Lower Cost Generic Drugs

My Pharmacies

Pharmacy	Pharmacy Type	Network Status	
SOUTHPOINTE PHARMACY 2400 32ND AVE S - FARGO, ND 58103 - (701) 234-9912		Network Pharmacies	Remove

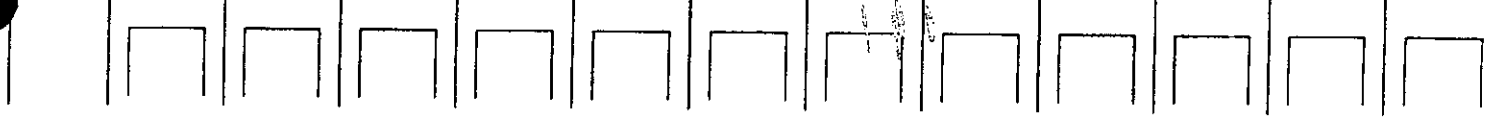
Total Monthly Cost Estimator for SOUTHPOINTE PHARMACY

Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. T pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment i amount you would pay during the plan year is less than the full 12 month cost shown.

Costs	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30	$108.30



Medicare Prescription Drug Plan Finder

Home Help Glossary How Plans Work

<< Back to Choose Plans to Compare

Vea en Español | Use Larger Font | Print

Find and Compare Plans

Plan Drug Details

Print This Page

The following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary based on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the pharmacy you use.

[redacted]

Basic Plan Information

- *Approved by Medicare*
- *This organization has plans available nationwide.*
- Mail Order Available: Yes
- Lower My Cost Share
- View Pharmacy Network
- View Important Notes and Benefit Summary

Add to My Favorites

Contact Information

221 N. Charles Lindbergh Dr., SLC, UT 84116

Members:	Non-Members:
(800) 429-6686	(800) 429-6686

View plan website

Plan Ratings [What is this?]

[Click to view more details on Plan Ratings]

Drug Plan Customer Service	★★★ 3 out of 5 stars
Member Complaints and Staying with Drug Plan	★★★ 3 out of 5 stars
Member Experience with Drug Plan	★★ 2 out of 5 stars
Drug Pricing and Patient Safety	★★ 2 out of 5 stars

Fixed Costs

Premium	$33.90 per Month ($406.80 per Year)
Annual Deductible	$0.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	[redacted]	Cost for the Rest of 2009 (11months)
[redacted]	[redacted]	$2,255.38
Mail Order Pharmacy	$1,313.49	$1,279.59

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]	Prior Authorization [What is this?]	Restrictions: Quantity Limits [What is this?]	Restrictions: Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No	No	No
METFORMIN HCL TAB 500MG	TIER 1	No	No	No
OMEPRAZOLE CAP 20MG	TIER 1	No	No	No
Plavix TAB 75MG	TIER 2	No	No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No	No	No
RAMIPRIL CAP 10MG	TIER 1	No	No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at WALGREEN DRUG STORE

Hide Information

Selected Drugs	Initial Coverage Level (The amount you will pay before your total drug costs reach $2,700 .)	Gap (The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $4,350 in out of pocket costs.)
[redacted]	Full Cost		

ALENDRONATE SODIUM TAB 70MG	$63.21	$5.00	$63.21	$3.16
METFORMIN HCL TAB 500MG	$23.09	$5.00	$23.09	$2.40
OMEPRAZOLE CAP 20MG	$95.16	$5.00	$95.16	$4.76
Plavix TAB 75MG	$141.57	$49.55	$141.57	$7.08
PRAVASTATIN SODIUM TAB 20MG	$25.27	$5.00	$25.27	$2.40
RAMIPRIL CAP 10MG	$19.71	$5.00	$19.71	$2.40
[redacted]	[redacted]	$74.55	$388.00	$22.20

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy Show Information

My Drugs

Drug Name	Quantity/Days Supply		Original Drug Entry	Actions	
ALENDRONATE SODIUM TAB 70MG	4	per Month	ALENDRONATE SODIUM (Generic)	Add Doses	Remove
METFORMIN HCL TAB 500MG	60	per Month	METFORMIN HCL (Generic)	Add Doses	Remove
OMEPRAZOLE CAP 20MG	30	per Month	OMEPRAZOLE (Generic)	Add Doses	Remove
Plavix TAB 75MG	30	per Month	Plavix (Brand)	Add Doses	Remove
PRAVASTATIN SODIUM TAB 20MG	30	per Month	PRAVASTATIN SODIUM (Generic)	Add Doses	Remove
RAMIPRIL CAP 10MG	30	per Month	RAMIPRIL (Generic)	Add Doses	Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity | Update with Lower Cost Generic Drugs

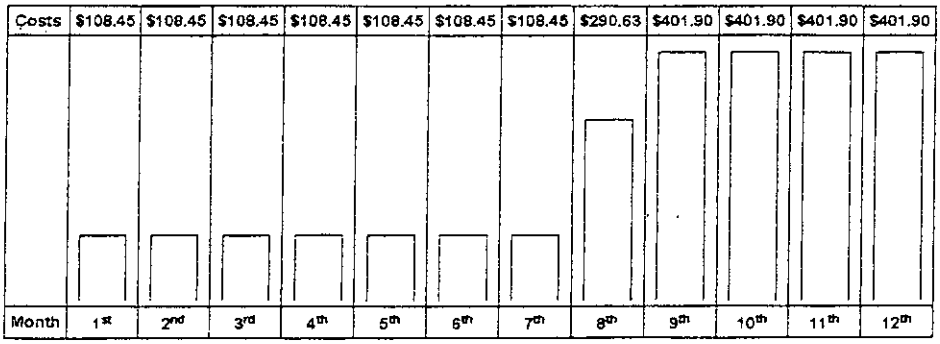
My Pharmacies

Pharmacy	Pharmacy Type	Network Status	
[redacted]		Network Pharmacies	Remove

Total Monthly Cost Estimator for WALGREEN DRUG STORE Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. This information is based on the drugs and/or pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment in 2009 would be for a partial year only, the total amount you would pay during the plan year is less than the full 12 month cost shown.



Show explanation of these costs.

Total Monthly Cost Estimator for Mail Order Pharmacy Show Information

Return To Plan List | Enroll

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Find and Compare Plans

Plan Drug Details

Print This Page

The following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary based on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the pharmacy you use.

Advantage Freedom Plan by RxAmerica (S5644-059)

Basic Plan Information

- *Approved by Medicare*
- *This organization has plans available nationwide.*
- Mail Order Available: Yes
- Lower My Cost Share
- View Pharmacy Network
- View Important Notes and Benefit Summary

Add to My Favorites

Contact Information

221 N. Charles Lindbergh Dr., SLC, UT 84116

Members:	Non-Members:
(800) 429-6686	(800) 429-6685

View plan website

Plan Ratings [What is this?]

[Click to view more details on Plan Ratings]

Drug Plan Customer Service	★★★ 3 out of 5 stars
Member Complaints and Staying with Drug Plan	★★★ 3 out of 5 stars
Member Experience with Drug Plan	★★ 2 out of 5 stars
Drug Pricing and Patient Safety	★★ 2 out of 5 stars

Fixed Costs

Premium	$33.90 per Month ($406.80 per Year)
Annual Deductible	$0.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	Full Year Cost	Cost for the Rest of 2009 (11months)
Annual Drug Costs if you use a Retail Pharmacy	$1,308.71 (FOSS DRUG)	$1,199.65
Mail Order Pharmacy	$1,313.49	$1,279.59

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]		Restrictions: Prior Authorization [What is this?]	Quantity Limits [What is this?]	Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No		No	No
METFORMIN HCL TAB 500MG	TIER 1	No		No	No
OMEPRAZOLE CAP 20MG	TIER 1	No		No	No
Plavix TAB 75MG	TIER 2	No		No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No		No	No
RAMIPRIL CAP 10MG	TIER 1	No		No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at FOSS DRUG

Hide Information

Selected Drugs	Full Cost of Drug	Initial Coverage Level (The amount you will pay before your total drug costs reach $2,700.)	Gap (The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $4,350 in out of pocket costs.)

Attachment #4

ALENDRONATE SODIUM TAB 70MG	$7.72	$5.00	$7.72	$2.40
METFORMIN HCL TAB 500MG	$4.94	$4.94	$4.94	$2.40
OMEPRAZOLE CAP 20MG	$9.77	$5.00	$9.77	$2.40
Plavix TAB 75MG	$143.48	$50.22	$143.48	$7.17
PRAVASTATIN SODIUM TAB 20MG	$7.28	$5.00	$7.28	$2.40
RAMIPRIL CAP 10MG	$7.85	$5.00	$7.85	$2.40
Monthly Totals:	$181.04	$75.16	$181.04	$19.17

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy

Show Information

My Drugs

Drug Name	Quantity/Days Supply	Original Drug Entry	Actions	
ALENDRONATE SODIUM TAB 70MG	4 per Month	ALENDRONATE SODIUM (Generic)	Add Doses	Remove
METFORMIN HCL TAB 500MG	60 per Month	METFORMIN HCL (Generic)	Add Doses	Remove
OMEPRAZOLE CAP 20MG	30 per Month	OMEPRAZOLE (Generic)	Add Doses	Remove
Plavix TAB 75MG	30 per Month	Plavix (Brand)	Add Doses	Remove
PRAVASTATIN SODIUM TAB 20MG	30 per Month	PRAVASTATIN SODIUM (Generic)	Add Doses	Remove
RAMIPRIL CAP 10MG	30 per Month	RAMIPRIL (Generic)	Add Doses	Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity | Update with Lower Cost Generic Drugs

My Pharmacies

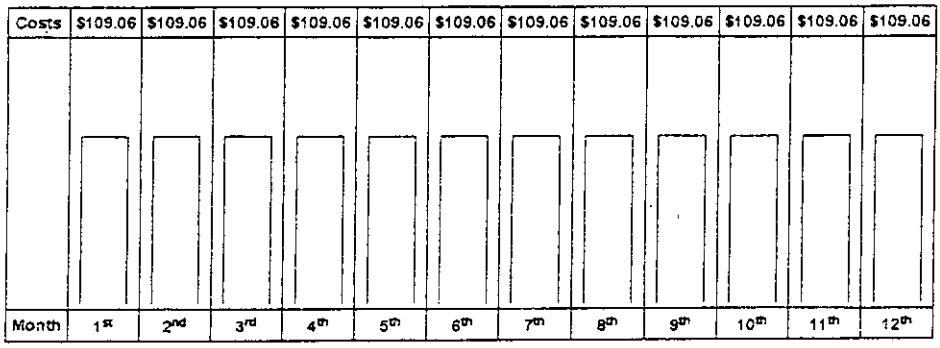
Pharmacy	Pharmacy Type	Network Status	
FOSS DRUG 420 CENTER AVE STE 33 - MOORHEAD, MN 56560 - (218) 236-7400	Long Term Care	Network Pharmacies	Remove

Total Monthly Cost Estimator for FOSS DRUG

Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. This information is based on the drugs and/or pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment in 2009 would be for a partial year only, the total amount you would pay during the plan year is less than the full 12 month cost shown.



Show explanation of these costs.

Total Monthly Cost Estimator for Mail Order Pharmacy

Show Information

Return To Plan List

Enroll

Page Last Updated: 1/5/2009

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Medicare The Official U.S. Government Site for People with Medicare

Medicare Prescription Drug Plan Finder

Find and Compare Plans

Plan Drug Details

Print This Page

The following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary based on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the pharmacy you use.

[redacted]

Basic Plan Information

- *Approved by Medicare*
- Mail Order Available: Yes
- Lower My Cost Share
- View Pharmacy Network
- View Important Notes and Benefit Summary

Add to My Favorites

Contact Information

Customer Service P.O. Box 155845, Fort Worth, TX 76155

Members:
(888) 832-0075
(800) 893-3819(TTY/TDD)

Non-Members:
(866) 434-2037
(866) 456-1550(TTY/TDD)

View plan website

Plan Ratings [What is this?]

[Click to view more details on Plan Ratings]

Drug Plan Customer Service	★★★★ 4 out of 5 stars
Member Complaints and Staying with Drug Plan	★★★★ 4 out of 5 stars
Member Experience with Drug Plan	★★★ 3 out of 5 stars
Drug Pricing and Patient Safety	★★★★ 4 out of 5 stars

Fixed Costs

Premium	$29.70 per Month **($356.40 per Year)**
Annual Deductible	$295.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	[redacted]	Cost for the Rest of 2009 (11months)
[redacted]		$2,587.61
Mail Order Pharmacy	$1,981.13	$1,931.43

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]		Restrictions: Prior Authorization [What is this?]	Restrictions: Quantity Limits [What is this?]	Restrictions: Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No		Yes	No
METFORMIN HCL TAB 500MG	TIER 1	No		No	No
OMEPRAZOLE CAP 20MG	TIER 1	No		Yes	No
Plavix TAB 75MG	TIER 2	No		No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No		Yes	No
RAMIPRIL CAP 10MG	TIER 1	No		No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at CVS PHARMACY

Hide Information

Initial Coverage Level | Gap

Selected Drugs	[redacted]	Deductible (The amount you will pay before your $295 deductible is met.)	(The amount you will pay before your total drug costs reach $2,700 .)	(The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $4,350 in out of pocket costs.)
ALENDRONATE SODIUM TAB 70MG	$63.72	$63.72	$6.37	$63.72	$3.19
METFORMIN HCL TAB 500MG	$23.59	$23.59	$2.36	$23.59	$2.40
OMEPRAZOLE CAP 20MG	$121.62	$121.62	$12.16	$121.62	$6.08
Plavix TAB 75MG	$143.23	$143.23	$31.51	$143.23	$7.16
PRAVASTATIN SODIUM TAB 20MG	$25.77	$25.77	$2.58	$25.77	$2.40
RAMIPRIL CAP 10MG	$20.21	$20.21	$2.02	$20.21	$2.40
[redacted]		$398.15	$57.00	$398.15	$23.63

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy Show Information

My Drugs

Drug Name	Quantity/Days Supply		Original Drug Entry	Actions	
ALENDRONATE SODIUM TAB 70MG	4	per Month	ALENDRONATE SODIUM (Generic)	Add Doses	Remove
METFORMIN HCL TAB 500MG	60	per Month	METFORMIN HCL (Generic)	Add Doses	Remove
OMEPRAZOLE CAP 20MG	30	per Month	OMEPRAZOLE (Generic)	Add Doses	Remove
Plavix TAB 75MG	30	per Month	Plavix (Brand)	Add Doses	Remove
PRAVASTATIN SODIUM TAB 20MG	30	per Month	PRAVASTATIN SODIUM (Generic)	Add Doses	Remove
RAMIPRIL CAP 10MG	30	per Month	RAMIPRIL (Generic)	Add Doses	Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity | Update with Lower Cost Generic Drugs

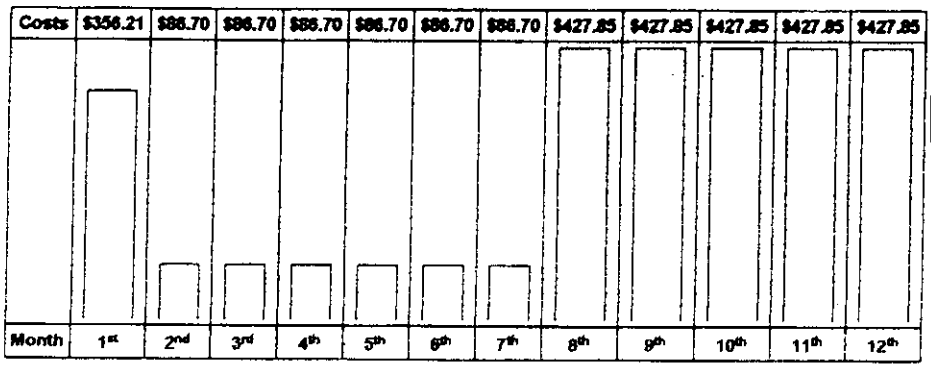
My Pharmacies

Pharmacy	Pharmacy Type	Network Status	
[redacted]		Network Pharmacies	Remove

Total Monthly Cost Estimator for CVS PHARMACY Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. This information is based on the drugs and/or pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment in 2009 would be for a partial year only, the total amount you would pay during the plan year is less than the full 12 month cost shown.



Legend:
Month(s) used to calculate the cost for the rest of the year
Month(s) used to calculate the total annual drug cost

Show explanation of these costs.

Total Monthly Cost Estimator for Mail Order Pharmacy Show Information

Return To Plan List | Enroll

Find and Compare Plans

Plan Drug Details

Print This Page

The following is a summary of the plan's drug coverage. The drug costs displayed are only estimates and actual costs may vary based on the specific quantity, strength and/or dosage of the drug, the order in which you buy your prescriptions, and the pharmacy you use.

MedicareBlue Rx Option 1 (S5743-001)

Basic Plan Information

- *Approved by Medicare.*
- Mail Order Available: Yes
- **Lower My Cost Share**
- **View Pharmacy Network**
- **View Important Notes and Benefit Summary**

Add to My Favorites

Contact Information

Customer Service P O Box 155845, Fort Worth, TX 76155

Members:	Non-Members:
(888) 832-0075	(866) 434-2037
(800) 693-3819(TTY/TDD)	(866) 456-1550(TTY/TDD)

View plan website

Plan Ratings [What is this?]

[Click to view more details on Plan Ratings]

Drug Plan Customer Service	★★★★ 4 out of 5 stars
Member Complaints and Staying with Drug Plan	★★★★ 4 out of 5 stars
Member Experience with Drug Plan	★★★ 3 out of 5 stars
Drug Pricing and Patient Safety	★★★★ 4 out of 5 stars

Fixed Costs

Premium	$29.70 per Month ($356.40 per Year)
Annual Deductible	$295.00

Annual Drug Costs (Including Premium) for Retail Pharmacy vs. Mail Order

Pharmacy Type	Full Year Cost	Cost for the Rest of 2009 (11 months)
Annual Drug Costs if you use a Retail Pharmacy	$1,077.31 (SOUTHPOINTE PHARMACY)	$1,008.26
Mail Order Pharmacy	$1,961.13	$1,931.43

Drug Coverage Information

Selected Drugs	Tier (Formulary Status) [What is this?]		Restrictions: Prior Authorization [What is this?]	Restrictions: Quantity Limits [What is this?]	Restrictions: Step Therapy [What is this?]
ALENDRONATE SODIUM TAB 70MG	TIER 1	No		Yes	No
METFORMIN HCL TAB 500MG	TIER 1	No		No	No
OMEPRAZOLE CAP 20MG	TIER 1	No		Yes	No
Plavix TAB 75MG	TIER 2	No		No	No
PRAVASTATIN SODIUM TAB 20MG	TIER 1	No		Yes	No
RAMIPRIL CAP 10MG	TIER 1	No		No	No

Add or Remove Drugs | Update Dosage/Quantity

Monthly Drug Cost Details at SOUTHPOINTE PHARMACY

Hide Information

Selected Drugs	Full Cost of Drug	Initial Coverage Level: Deductible (The amount you will pay before your $295 deductible is met.)	Initial Coverage Level (The amount you will pay before your total drug costs reach $2,700.)	Gap (The amount you will pay after you reach $2,700 in full drug costs, but before you reach $4,350 in out of pocket costs.)	Catastrophic (The amount you will pay after you reach $4,350 in out of pocket costs.)
ALENDRONATE SODIUM TAB 70MG	$12.46	$12.46	$1.25	$12.46	$2.40
METFORMIN HCL TAB 500MG	$11.20	$11.20	$1.12	$11.20	$2.40
OMEPRAZOLE CAP 20MG	$18.85	$18.85	$1.89	$18.85	$2.40
Plavix TAB 75MG	$147.31	$147.31	$32.41	$147.31	$7.37
PRAVASTATIN SODIUM TAB 20MG	$14.05	$14.05	$1.41	$14.05	$2.40
RAMIPRIL CAP 10MG	$12.85	$12.85	$1.29	$12.85	$2.40
Monthly Totals:	$216.72	$216.72	$39.35	$216.72	$19.37

Your actual costs at the pharmacy may vary slightly.

Monthly Drug Cost Details at Mail Order Pharmacy

Show Information

My Drugs

Drug Name	Quantity/Days Supply		Original Drug Entry	Actions	
ALENDRONATE SODIUM TAB 70MG	4	per Month	ALENDRONATE SODIUM (Generic)	Add Doses	Remove
METFORMIN HCL TAB 500MG	60	per Month	METFORMIN HCL (Generic)	Add Doses	Remove
OMEPRAZOLE CAP 20MG	30	per Month	OMEPRAZOLE (Generic)	Add Doses	Remove
Plavix TAB 75MG	30	per Month	Plavix (Brand)	Add Doses	Remove
PRAVASTATIN SODIUM TAB 20MG	30	per Month	PRAVASTATIN SODIUM (Generic)	Add Doses	Remove
RAMIPRIL CAP 10MG	30	per Month	RAMIPRIL (Generic)	Add Doses	Remove

Add More Drugs | Print My Drug List | Update Dosage/Quantity | Update with Lower Cost Generic Drugs

My Pharmacies

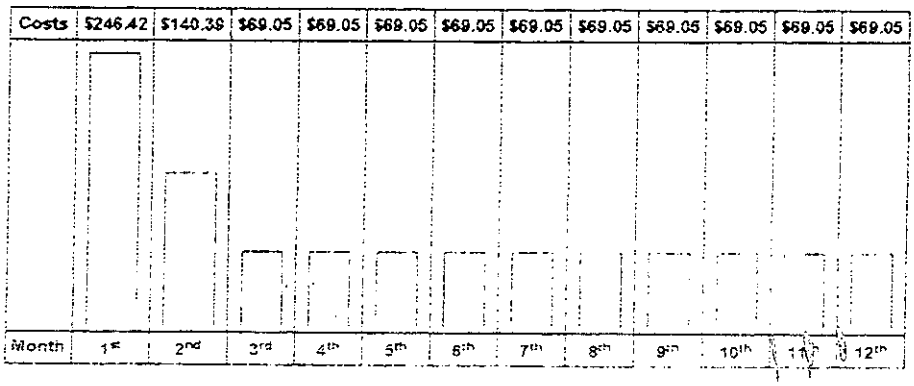
Pharmacy	Pharmacy Type	Network Status	
[redacted]		Network Pharmacies	Remove

Total Monthly Cost Estimator for SOUTHPOINTE PHARMACY

Hide Information

This bar graph depicts an estimate of your monthly prescription drug costs, including any applicable premiums for this plan. This information is based on the drugs and/or pharmacies you selected. Actual costs may vary.

If you were to enroll in this plan today, your enrollment would be effective on the February 1, 2009. Because your enrollment in 2009 would be for a partial year only, the total amount you would pay during the plan year is less than the full 12 month cost shown.



Show explanation of these costs

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Testimony for HB 1440

Honorable Members of the Industry, Business, & Labor Committee,

I would like to present you with an example of how valuable a pharmacist can be in helping a patient improve his or her treatment outcomes. To protect her privacy, I will refer to this patient as "Marie". Marie is a 59 year old woman with type-2 diabetes. When Marie enrolled in the ND Diabetes Medication Management program, she decided to choose our pharmacy because her pharmacy was not a participating provider. For our first meeting, I asked Marie to bring in all her medications. I found she was getting some meds from a local pharmacy in town, some from a mail order pharmacy, some OTC products, and some as samples from the doctor.

Problem 1: Marie was taking Metformin ER 3000mg/day (from out-of-state mail order pharmacy). Maximum recommended dose is 2000mg/day. **Dangerous overdose** was not caught by mail order pharmacy--potentially very harmful to patient. Plus, patient and insurance company were repeatedly paying for higher quantity of tablets and more expensive dosage form than was necessary. I called her doctor and got this switched to an appropriate strength and dosage form. **Cost savings of $109/90 days to insurance and $18/90 days for Marie.**

Problem 2: Marie was taking Aceon, a very expensive blood pressure medicine. Every 90 days, Marie paid $100.94 and her insurance paid $75.93 for Aceon. (This was being filled at a local pharmacy in town.) I called the doctor and got it switched to Lisinopril, a drug with the same effects, but available in generic. Now Marie pays $6.73/90 days and her insurance pays $9.77/90 days. My intervention had an overall **cost savings of $641.48/year.** That's a lot of money for someone on a very tight budget. Marie was very happy!

Problem 3: Marie was very concerned about being able to afford all her medicine. I worked with another patient-focused, independently-owned pharmacy in town to track down the name of a drug rep for Ascensia test strips. I was able to find coupons that covered the entire cost of Marie's diabetic test strips. This saved another $15/90 days for Marie.

These are just the top three ways that I helped Marie during our first meeting. Over the next three months, I met with Marie two more times. In that time, I was able to eliminate 8 unnecessary medications (another cost savings of $75-100/month) and start 3 new appropriate meds. Marie's blood pressure has come down 30 points, significantly reducing her risk for heart attack, stroke, and long term complications with her diabetes and blood pressure. Slowly, but surely, Marie has begun an exercise program and has lost 7 pounds. Plus, **Marie and her insurance company are saving nearly $200 every month.**

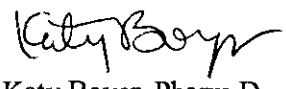
Were these efforts profitable for me? Certainly not. Keep in mind, up until our first meeting, she had never filled a single prescription at my pharmacy. Even so, I spent hours going through Marie's health history, obtaining and reviewing lab values, blood pressure data and blood sugar readings. I worked with her and her doctor to review current treatment plans and set goals for the future. All of the changes I recommended actually lowered the reimbursement to the pharmacy. I didn't do this for my own benefits. I did this to help my patient. Now, Marie is one of my regular patients. I enjoy working with her and seeing the **positive results** we have achieved.

This is only **one** example. As well-trained professionals, we have opportunities every single day to step in and make a difference for **our patients**. Sometimes, all it takes is a phone call to the doctor to suggest a less expensive alternate treatment. A patient's co-pay can drop by $50 to $150 with one phone call. The key to success in this process is having pharmacy management/ownership that supports these types of programs and interventions.

Representatives of the House, please represent my voice and keep ND pharmacies **locally owned** and operated. Please allow all ND pharmacists to **continue** to **provide our patients** with the low-cost, high-quality care that they deserve. Show your constituents how much you **value their health** by keeping the pharmacy ownership law in place.

Thank you for your time in reading this testimony. Please contact me if you have any questions.

Sincerely,



Katy Boyer, Pharm.D.
3623 Harrison St S
Fargo ND 58104
701-367-5205

Chairman Keiser and members of the IBL committee thank you for your attention today. My name is Crystal Toman. I am a registered pharmacist practicing in a retail pharmacy in North Dakota and I'm here to speak in support of keeping the ownership law.

Upon graduation from college, I had a number of opportunities, but chose to stay in ND for a number of reasons. First of all, I was born and raised here and enjoy being close to my family. Also, I had gone to the University of Mary prior to NDSU and really liked Bismarck, so I wanted to live and work here. A very important part of my decision was the variety of responsibilities I could have as a retail pharmacist in ND compared to other states or at least in an independent pharmacy as opposed to a chain. I have much more freedom and opportunity to use the information I learned in pharmacy school. My job is not focused on filling as many prescriptions as possible. I am able to develop a relationship with the patients and provide a wider variety of services. We often work with patients to get more affordable medications for them. This may include using a generic if one is available or using therapeutic substitution. For example, if a patient brings us a prescription for a brand name drug which has no available generic and the patient cannot afford it, we will contact the physician to see if they will change it to another similar drug that is available in a generic form, which can save the patient a great deal of money. It may also include working with physicians to get medications for patients that are covered under their insurance plan.

The pharmacy I work at has a compounding lab where we can customize medications for patients when a commercial product will not work or is not appropriate for them.

We are encouraged to provide MTM or medication therapy management services to our patients. Basically, we address any therapeutic problems a patient may have such as a problem with a medication, a medical condition that is not being treated, or a possible therapeutic substitution as mentioned earlier. This allows us to use our clinical skills on a regular basis. We are also providers of the diabetes management program developed with ND PERS. Through this program, I've been able to consult with patients and address problems and concerns they have or issues they may not even be aware of. One of the women actually didn't have a meter of her own and just used her husband's, but I was able to get her a free meter. She was very grateful. This simple task was very rewarding for the patient and myself.

As much as insurance billing problems can be frustrating, I appreciate the fact that I can take the time I need with patients and also am able to make sure patients receive their medications and deal with the insurance issue later. Overall, the variety of services and having time to talk to patients allows me to use my education in the best way I see fit.

Many of my pharmacist friends and relatives work in chain pharmacies, so I've been asked "why don't you move to MN, you could make more money". Well, I probably could make more money, but in comparison, I'm not sure I'd be ahead considering the cost of living. Also, money isn't everything. There is a lot to be said about job satisfaction.

I'm not saying that my friends aren't satisfied with their jobs, but in general I'd say I am more satisfied with my job than they are with theirs. It's nice to practice in a setting where my performance has a direct effect on the success of the business. That motivates me. It's also nice to have a pharmacist making the business and professional

practice decisions because they understand the intricate details of our job and have a sense of what will work well both for the staff and to provide the best service to our patients. In my mind, the patient is the most important part of my job and I wouldn't want it any other way. I could work in many different settings, but I chose a retail pharmacy in ND because it is both professionally and personally rewarding and that is something I can be proud of. Thank you.

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Ross Ebel
Testimony on Behalf of SB 1440

In January of 2207, my wife and I took a cruise off the coast of Baja California and New Mexico. When we arrived in Los Angeles, my wife misplaced one of the carry on bags - the bag with her prescription drugs, one of which was her blood pressure medicine.

As a registered nurse, she knew that she could not continue on our vacation without those meds. We stayed overnight on the Queen Mary and we were told there was a Walmart located within in short distance. So off to Walmart we went.

She spoke with a pharmacist and they called her pharmacy in North Dakota and requested a copy of the prescription drugs and asked for permission to supply my wife with a months worth of her prescription drugs.

When my wife went to the area to pay, she was so amazed at the total cost and she questioned the staff whether they had the correct meds or amounts of medication because the total bill was so much less than what she is accustomed to paying in North Dakota.

The pharmacist laughed and said, "That was because she was from the state of North Dakota."

She told him in jest that she would fly down every three months to buy her medicine because the price she payed in California was more than a fourth less than what she pays her in North Dakota.

Yes of course we realize we got only one months supply and it was still that much less!

Isn't it time all North Dakotans have the benefit of lower prescription drug prices -- not just those of us who go on vacation

31 HB 1440
3-16-09

To Whom It May Concern:

My name is Ramona Danks, I am a pharmacy student at NDSU and a citizen of North Dakota, born and raised. I grew up in Bismarck and have strong roots in the Badlands of western North Dakota.

I have been studying pharmacy and practicing as an intern in ND for the last four years. What I have learned is that ND has something special…a practice of pharmacy that is the top of the line. I plan to stay here and practice and would be very disappointed if HB 1440 were to pass. We are providing patients with services in even the most rural areas. Telepharmacy has helped ND pharmacy stay in communities that would have lost services otherwise. Pharmacists in this state are now doing more than we ever have before, medication therapy management has the ability to save consumers more than just a few cents on a prescription, it can prevent unneeded medications, hospitalizations, and improve quality of life. Pharmacists can immunize, in ND a pharmacist has the ability to work with a physician and even prescribe some medications, saving doctor's visits and money for the patient.

Those seeking to repeal the 51% ownership law say they will provide better patient access at cheaper prices, I say this. We already are getting the job done. This is about more than the cost of prescription drugs, pharmacy is a medical practice…those pharmacists here in ND realize the value of their services is more than just the cost of drugs. It is being a trusted source of information, advice, and when they can be, a lifesaver.

I have had opportunities to network with pharmacists and pharmacy students from all over the country over the last several years. When I tell these people about the ownership law, they think it is incredible that we have such a say in how we practice in the state and that we have been able to keep it that way for so long when the pressures from big business can be so overwhelming.

Why are we different? We have a proud work ethic all our own. That is why the practice of pharmacy in ND is so different. We set our own standards and the people of this state should take nothing less. In my humble opinion, I feel this law is not about saving patients money, it's about making money from patients.

Lets send a message to all huge corporate pharmacies by voting no on HB 1440. There is no law that prevents chain pharmacies from practicing in ND if they play by our rules.

Sincerely,

Ramona M. Danks

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NORTH DAKOTA
Farmers Union

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Jamestown ND 58401
800-366-8331 • 701-252-2341
www.ndfu.org

February 3, 2009

HB 1440
Joint Hearing Of House Human Services Committee and House Industry, Business and Labor Committee

HB 1440 would repeal the current North Dakota Pharmacy Ownership Law which states a licensed North Dakota pharmacist must own at least 51% of any pharmacy in North Dakota. This law is being challenged by national chain stores that want to operate pharmacies in the state. North Dakota Farmers Union agrees with the report released by the Institute for Local Self- Reliance that found repealing the law will cost the state millions of dollars in annual economic activity, reduce the number of pharmacies in rural areas and lessen the overall quality of pharmacy services in the state. According to the study, 70 pharmacies would be at risk of closing, leaving people North Dakotans with limited choices for filling their prescription needs.

Rural access is important to our organization. At a time when many rural citizens have to drive many miles to purchase basics for their families, the main street pharmacy has remained the heart of many communities. North Dakota pharmacists not only serve our communities, they are a large part of the communities in which they live. If we allow this law to be repealed, the North Dakota way of life in terms of healthcare will be fundamentally altered, and not for the best.

Finally, discussion has centered around "cheaper drugs will be available through national chain stores if they are allowed to have pharmacies". Not only have prescription drugs been found to be less expensive in our state, but these stores are already allowed to have pharmacies. Requiring a pharmacist to own 51% of the operation means the service remains locally owned, which benefits the state's citizens and its economy. You need to ask who really profits by changing the law and who will be hurt.

North Dakota Farmers Union urges a "do not pass" on HB 1440. Thank you.

TESTIMONY
H.B. #1440
TOM WOODMANSEE
NORTH DAKOTA GROCERS ASSOCIATION

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The Board of Directors of the North Dakota Grocers Association does **OPPOSE** the passage of H.B. #1440 as it is written. With many of our grocery retailers now providing lease space for pharmacies, we do not believe it is necessary to change North Dakota law simply because a select few "large" retailers do not like it.

The opportunity exits now for any retailer to have a pharmacy simply by leasing out the space. There are other reasons they are not doing so and only those retailers can answer that question.

The vast majority of North Dakota's pharmacies are locally owned and the average prescription drug prices in North Dakota are still among the lowest in the country. Passage of this bill **will have** an impact on main street business and especially in our rural areas.

Mr. Chairman and members of the House Industry Business & Labor Committee, NDGA does hope you will recommend a **DO NOT Pass on H.B. #1440**.

Thank you for allowing me to submit testimony on H.B. #1440.

Chairman, Rep. Keiser, members of the House Industry, Business and Labor Committee. I am June Enget of Powers Lake, ND and I appear before you today representing the residents of the City of Powers Lake. Along with a copy of my presentation I have included a copy of the signatures of those who are in opposition to the passage of House Bill 1440. The original of signatures is with the copy for the clerk.

The requirement for local pharmacy ownership as crafted by our forefathers is unique. Let us remember we as a state are also unique in the fact that we have a State owned Mill and Elevator and a State owned Bank. These two entities have been helpful to the economy of North Dakota. Do we need to be like everyone else?

The city of Powers Lake is 26 miles from a hospital, clinic or pharmacy at either Tioga or Stanley. The clinic at Tioga provides the city with the services of a Doctor or Physicians Assistant 3 to 4 days a week. If any patient needs a prescription filled immediately it is called in to the Tioga Drug. The pharmacists then find courier services to deliver the medication back to Powers Lake the same day. It is a service we enjoy and appreciate.

If the Drug Stores in either Tioga or Stanley should close our citizens would have to travel 75 miles to either Williston or Minot to fill their prescription. The elderly of our community do not always transportation to go that distance so that would pose a problem for them.

Passage of this Bill will hurt our small town locally owned Drug Stores/Pharmacies. So I respectfully ask your committee to give this a DO NOT PASS RECOMMENDATION.

Thank you.

WE, THE UNDERSIGNED AS RESIDENTS OF THE CITY OF POWERS LAKE, NORTH DAKOTA AND VOTERS IN THAT PRECINCT, DO OPPOSE THE PASSAGE OF HB 1440. WE ASK THE INDUSTRY, BUSINESS AND LABOR COMMITTEE TO GIVE THIS A DO NOT PASS RECOMMENDATION.

NAME	ADDRESS
1. Isabelle Breding	305 4th Ave E Powers Lake N.D.
2. Vern Durward	100 4th Ave E Powers Lake N.D.
3. Louise Rystedt	301 Main St. Powers Lake N.D.
4. Annie Torgerson	305 1st Ave E. Powers Lake, N.D.
5. [illegible] Jensen	Powers Lake [illegible]
6. Margaret C. Holmen	310 Peterson St. Powers Lake, N.D.
7. [illegible] Sem	303 Noland St Powers Lake
8. [illegible] Van Berkom	209 Garness Powers Lake ND
9. Howard Holte	105 Noland Powers Lake, ND
10 Lorraine Helwig	102 - 3rd ave W Powers Lake
11. [illegible]	217 Main St. Powers Lake, N.D
12. Ardyce Enget	208 1st Ave E. Powers Lake N.D. 5877[illegible]
13. [illegible]	403 Railroad Ave Powers Lake ND 5877[illegible]
14. [illegible]	403 Railroad Ave Powers Lake N.D 58773
15. Chandra Rystedt	508 E Hillcrest Powers Lake ND 587[illegible]
16. [illegible]	309 Leduc Street Powers Lake N.D. 587[illegible]
17. [illegible] Helwig	102 7th ave. Powers Lake
18. Cheryl L Rose	100 4th Ave. W Powers Lake N.D.
19. Kari Enget	301 Peterson St Powers Lake ND 58773
20. June G. Enget	301 Peterson St. Powers Lake ND 58773
21. Benny Fredrickson	305 Garness St. Powers Lake ND 58773

22. Diana K. Stoefhaus — 402 Ueland Street ND 58773
23. David M. Sullivan — 404 Ueland Street ND 58773
24. Darrell Carlson — Box 307 Powers Lake N. Dak 58773

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NORTH DAKOTA RETAIL ASSOCIATION

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Testimony HB 1440

February 3, 2009 – House Industry, Business and Labor Committee

Chairman Keiser and members of the House Industry, Business and Labor Committee:

For the record, my name is Mike Rud. I'm the President of the North Dakota Retail Association. NDRA's 400 members and thousands of employees strongly **OPPOSE** H.B. 1440. We submit testimony recommending a **"DO NOT PASS"** on this bill.

Our groups agree with a new report released by the Institute for Local Self- Reliance that repealing the law will cost the state millions of dollars in annual economic activity, reduce the number of pharmacies in rural areas and lessen the overall quality of pharmacy services in the state.

The opportunity for the big box stores to set up pharmacies in their shops already exists. All the big box has to do is rent out the space. This current law seems to be working fine in North Dakota grocery stores where pharmacies have opened businesses. In fact, most grocery stores have seen increased traffic because of the "pharmacy" presence. I know of a Fargo grocery store where the health and beauty aids section has seen a 35% increase in sales since the pharmacy opened.

The question needs to be asked by every Legislator, "Why isn't the current system workable for the big box operations?" Only those folks can supply the real answer to this question.

NDRA believes passage of this bill will have a major negative impact on main street North Dakota in rural areas. The local pharmacy tends to be the anchor store on rural

main streets. If it is forced to close what will happen to the local restaurants or the hardware, department, and grocery stores which all share the same traffic?

NDRA believes if the State of North Dakota is going to promote rural economic development it must uphold the current pharmacy ownership law.

Mr. Chairman and committee members, NDRA urges a "**DO NOT PASS**" recommendation on H.B. 1440.

Thank you for your time and consideration.

Testimony

Terri Torgerson, Max, ND

HB 1440

As a current pharmacy student and having worked in a rural independent pharmacy for the past 10 years, I feel that HB1440 would be disastrous to all rural and many independent pharmacies and their customers.

My belief is by letting HB1440 pass rural pharmacies in ND will no longer be able to survive, leaving consumers without access to pharmacy services. I currently reside in central ND and my local pharmacy is in Garrison, ND. The pharmacy serves not only the city of Garrison, but also the surrounding area including: Max, Douglas, Ryder, Benedict, Parshall, Coleharbor, WhiteShield, and Riverdale totaling over 1500 patients. My concern is where will these consumers go for pharmaceutical services once their rural pharmacy is closed? They will have to drive 50 to 75 miles to the nearest pharmacy located in Minot or Bismarck. Once they are leaving a town for one service they will be shopping out-of-town for other services, producing a domino effect on our small towns. At first the pharmacy will close, next the hardware store, then the local grocery store, etc.

Our local pharmacy also serves 2 nursing homes and the hospital in Garrison. Patients have the right to choose their own pharmacy. Many times in the past we have received admits past our normal business hours, but our pharmacist will come down and fill their prescriptions afterhours making sure that the patient has their medications. With the closing of the local pharmacy the resident will need to wait until the next day or later for their medications. Pharmaceutical care will be affected.

To me as an interning pharmacist and future pharmacist of this great state of ND, this law helps preserve the outstanding pharmacy care that we see today. I hope to be able to practice in a rural pharmacy setting upon graduation and remain a resident of North Dakota.

February 2, 2009

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To: North Dakota House of Representatives: Industry, Labor, and Business Committee

My name is Brandie Hagert, and I am a third year student pharmacist at North Dakota State University in Fargo, ND. I currently live near Emerado, ND. I wanted to state in my own personal opinion that I am in strong opposition to the Bill H.B.1440. According to the American Society of Consultant Pharmacists, "Every dollar spent on drugs in the ambulatory setting, roughly $2.00 is spent on treatment of drug related morbidity and mortality." The Ashville Project had assessed the outcomes of the involvement of pharmacists in Medication Therapy Management (MTM) services, educating patients, and drug reviews which showed pharmacist involvement decreased health care costs in the long run. I do not want the ND 51% ownership law repealed due to the fact it will have a significant impact on the future of the pharmacy profession in the wonderful state of North Dakota. The role of the pharmacist is changing and the future of pharmacy is including Medication Therapy Management (MTM) services, disease prevention programs, personalized medicine, and educating patients which will decrease health care costs for patients long term.

I worked at a big box store the summer after my first year in the pharmacy program and I can tell you first hand that that store focused on the number of prescriptions filled, not patient care. Management stated to me that I should encourage those waiting for their medications to "shop around" while waiting. A number of times, the staff was told that our numbers were low compared to the other stores within the region and we needed to increase the numbers. Also, on a few separate occasions I was told I was spending too much time with the customers while helping them with the over the counter medications, and to stay behind the counter to focus on filling prescriptions. On many occasions, the pharmacists did not get their morning, afternoon, or lunch breaks and did not have adequate time to counsel patients. What I took away from this experience was the example of how I did not want to practice pharmacy.

I will be graduating from the pharmacy program in little over a year and plan to practice pharmacy in the rural areas in North Dakota. If this law is repealed, then I will be limited in the quality of care that I can provide patients. The system in which the big corporations operate in the pharmacy field is focused on the number of prescriptions filled and the pharmacist does not have adequate time to spend with the patients. The future of pharmacy is not about how many prescriptions can be filled in a day, but about educating patients, reviewing their medications to see if they are effective and/or necessary, reviewing if the medications are taken correctly, disease prevention, and MTM services. Pharmacists, student pharmacists, and other health care providers take an oath to provide the best patient care and to protect our patients. District managers, regional managers, and CEO's of the big box stores do not take that oath (unless they themselves were a health care professional). So how would anyone expect them to put patient care and safety as their number one priority? Why haven't the big chain stores been more involved with providing MTM services, prevention programs, and patient education in our region? They have the funds and skills to provide these services, but they have not participated in these services compared to the independent pharmacy owners within our region. If this law is repealed, it will be a step backward and not a step forward in the health care system in North Dakota.

I thank you for your time and appreciate your attention on this important matter.

Thank you,

Brandie Hagert

Brandie Hagert
948 27th St NE Emerado, ND 58228

4404 9th Ave. Cir. S. #202
Fargo, ND 58103-7017
February 2, 2009

To whom this may concern:

In that my wife and I were unable to appear in person and testify in favor of House Bill #1440, please enter the remarks that I was going to share before the committee as written testimony.
We could not appear due to illness.

Thank you,
Clarence F. Olson

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February 3, 2009

Mr. Chairman Keiser, Mr. Chairman Weisz and members of the Human Services and Industry, Business and Labor Committees:

Thank you for the opportunity for my wife and I to appear before you today and let you know why we believe House Bill 1440 should be enacted. My name is Clarence Olson, and this is my wife Debbie, but please call me Rick. We live in Fargo, and are here today as concerned residents of North Dakota. I grew up in rural North Dakota, Rugby, to be exact. My wife grew up on a farm near Hatton, N.D. Her family subsequently left their farm and moved into the city of Hatton. Accordingly, we absolutely sympathize with the challenges that rural communities face today.

We are not here representing anyone but ourselves. I would like to point out for the record and the purposes of complete disclosure that my wife is employed by Wal-Mart in Fargo as an associate. The fact she works for Wal-Mart has no bearing on our appearance here today. I am employed by SkyWest Airlines, which does business here in North Dakota as United Express. I am an agent at the Hector International Airport in Fargo. Neither of us are here today representing our respective employers.

We believe the bill that the committees are considering today, House Bill 1440, must be adopted. When this Legislative Assembly enacted the present law which requires a pharmacy to be at least 51 percent owned by a licensed pharmacist some 40 years ago, the neighborhood drug store with the soda fountain was on the way out. The law was originally enacted to forbid doctors from being able to sell prescription medications. It has since been used as a tool by which drug store owners in our rural areas of the state in particular have been shielded from competition. In essence, a government-protected monopoly was put into place. Quite unintentionally, I'm sure. However, in our opinion, a monopoly nevertheless exists.

Let us give you a little bit about our personal reasons why we would like to see House Bill 1440 become the law of North Dakota. My wife is an asthmatic as well as a leukemia patient. Thankfully, her form of leukemia is a chronic kind which is easily controlled with a daily oral medication, and it is not imminently life-threatening. The medication she takes for her leukemia is called Gleevec. Without insurance, this medication would cost us some $3,000 a month for a 30 day supply of the drug. Who's got that kind of money laying around? Not us, that's for sure. We are your typical working class couple who works hard and struggles to make a living.

We are very fortunate that my wife has very good medical and prescription drug insurance coverage which has thus far allowed us to purchase this medication for my wife with little if no out of pocket costs. I take a couple of prescription drugs for my high blood pressure. We have found that we can obtain our prescriptions over in Moorhead, Minnesota, just across the river at a substantial cost savings than if we were to fill the same prescriptions in a local pharmacy in Fargo.

Those who are most likely to benefit if this law is changed are people who have limited incomes and people such as our senior citizens, many of whom are on fixed incomes. If stores such as Target and Wal-Mart are allowed to operate their own pharmacies in their stores across the state; the people of North Dakota would accordingly have access to the widely-advertised generic prescription drug discount offers that those and other retailers offer. We've all seen these advertised at one time or another. With the way things are set up in North Dakota right now, these discount drug programs are not available; and the people of our state are being deprived of the option of obtaining their medications at the lower costs that are being advertised.

We would like to point out that no one who has been involved in this debate, to the best of our knowledge, is saying that anyone should stop patronizing their local hometown businesses. Many rural pharmacy owners in particular have voiced concerns that their businesses will suffer if this bill becomes law. We really fail to see any significant impact upon them at all. Very little if any impact.

The small town pharmacies all have a loyal clientele who in all likelihood won't drive 60 miles just to save $10 on their prescriptions. Areas of the state where we might see increased competition of pharmacies if House Bill 1440 becomes law would be in the larger cities. Bismarck/Mandan, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, Valley City, Wahpeton and Williston, for example.

Another concern that some people have raised is that in many rural communities of our state, the pharmacist is the only health professional available for miles because of satellite clinics and such. That will not change if this bill becomes law. These pharmacists will still be available for their customers.

In addition, it is our belief that the health and safety of the general public will not be put at risk whatsoever if House Bill 1440 becomes law. If places like Target and Wal-Mart get the green light to offer pharmacy services in their stores, those and other pharmacy companies will be required to follow exactly the same laws and regulations that all pharmacies and pharmacists must follow and are set forth in the North Dakota Century Code. We have obtained our prescription medications from the Walgreens pharmacy across the river in Moorhead, and have experienced no problems whatsoever.

It's likely that you've read articles in the various print media and seen numerous stories on television about the big chain store companies. We probably don't need to tell you that there is a lot of misinformation floating around about the big box companies. In particular, retailers such as Target and Wal-Mart from what we've seen bend over backwards to be good neighbors in the communities they serve.

When our fellow North Dakotans spend their money in the big box stores, their money isn't simply going out of state to Minneapolis or to Bentonville, Arkansas and it's gone forever. It is our understanding that Target and Wal-Mart reinvest millions of dollars each and every year right back into the communities they serve through many different philanthropic activities. These include, but are not limited to, providing college scholarships to students in need and making significant donations to local charitable organizations.

So, to sum up our remarks, to us this is not a Walgreens issue nor is it a Wal-Mart issue. This is a people issue. With the economy the way it is today, we as the consumers need to find every avenue at our means to save money.

We leave you with this simple thought. It is not a horrible thing to embrace competition and change. Rather, we as the people of North Dakota need to embrace competition and change because, believe it or not; we feel that legislation such as House Bill 1440 if it is enacted, will help to make North Dakota an even better place to live, work and raise our families.

We'll be glad to answer any questions that the members of the committees may have. Thank you once again for the opportunity to appear before you today.

Sincerely,

Clarence F. Olson

Clarence F. (Rick) Olson
4404 9th Avenue Cir S Apt 202
Fargo, ND 58103-7017
(701) 364-3822

NDHA
North Dakota Healthcare Association

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Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on House Bill 1440
Joint Hearing: House Industry, Business and Labor and
House Human Services Committees
February 3, 2009

Mr. Chairman and committee members. My name is Arnold Thomas. I am President of the North Dakota Healthcare Association.

You've heard a lot of testimony today. Let me summarize what you need to take away from this hearing:

1. The College of Pharmacy does not have separate tracks for students who intend to work in rural ND, or in a hospital pharmacy, or in a big box pharmacy. They are all trained the same.

2. The Board of Pharmacy does not license pharmacists differently based on whether they work in rural ND, or in a hospital pharmacy, or in a big box pharmacy. They are all licensed the same.

3. If the good people of your respective districts believe that the price and service they receive from their local pharmacy is of value to them, they will continue to support that local business. They do not need the ND Legislative Assembly ordering them do that.

4. If the good people of your respective districts believe that it is to their benefit to take their prescription business elsewhere --that is capitalism -- and they do not need the ND Legislative Assembly preventing them from exercising that decision.

5. This issue is not about training --or licensing --or quality. It's about turf protection. For over fifty years, you have chosen to favor one business model over all others. You have said that the majority ownership of a pharmacy must be in the hands of a pharmacist. Forty-nine other states have opted instead to let their citizens determine where they will conduct business.

It is time that the ND Legislative Assembly begins to trust the good judgment of ND citizens.

I respectfully ask you for a DO Pass to repeal this archaic and protectionist law.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

4/0

February 2, 2009

Representative Keiser:

Please share this information with the committees working on the HB 1440.

Attached is a petition with signatures from many of our citizens in and around Napoleon that strongly feel that we should NOT change the pharmacy law. Our concern is that larger corporations can and will try to sell prescription drugs at a lower cost, forcing our small drug store to endure hardship.

It wasn't too long ago when our local drug store had a fire and burned down, while the building was still on fire, community members were busy get a different building empty in order for our pharmacist to set up and operate as quickly as possible. The pharmacist herself did everything possible to ensure that we did not have interrupted services. How many large corporations have a drug store in a small town would do something like that? Do you honestly believe they would continue service after a fire? Chances are, they would not rebuild, and force every citizen in Napoleon to seek elsewhere for their prescriptions.

Some say that changing the law would not affect small town pharmacies, but can you guarantee that? We, the citizens of Napoleon do not want to take that chance.

Vote Do Not Pass on the HB 1440 and please pass this message on to all those in the committee so they too can make the right choice.

Lisa Beine

Lisa Beine, Administrator

Napoleon Care Center

Napoleon, ND

RURAL PHARMACIES NEED YOUR HELP!!

Help keep our pharmacy local. Sign below if you are against changing the pharmacy law.
Promote the "Do Not Pass" for House Bill 1440

1. Lois Beyer, Napoleon
2. Charlotte M. Young, Napoleon
3. Cathey K. Schade Nap.
4. Alvina Pet, Napoleon
5. Eunice Nelson, Napoleon
6. Leo L. Gross Nap
7. Mary Sitter, Nap.
8. Priscilla Schmeidler - Napoleon
9. Helen Schmidt Nap
10. Christine A. Schwanebeck Nap
11. Rose Hildebrand Nap
12. Jenny M. Weigel - Nap
13. Alvin Hoffman Dawson
14. Rick Marquis Napoleon
15. Andrew Schneider Napoleon
16. Laura Henry Napoleon
17. Alvina Hamel Napoleon ND 58561
18. Lois Scherr Napoleon Box 255
19. Charleen Weigel Kintyre
20. Charlotte J. Glatt Napoleon
21. Marvin Groll Napoleon
22. Clemens Braun Napoleon
23. Lance Weigel Napoleon
24. Paul Haeger Napoleon
25. Elmer Nergy Napoleon ND
26. Paul P. Becker Nap
27. Robert A. Sperle Napoleon ND
28. Harold A. Kuhn Napoleon ND
29. Thomas Aberle
30. Glenn Glatt
31. James Sperle Napoleon ND Box 324 Cole B
32. Eileen Ritter Napoleon ND
33. Betty Braun 514 Broadway Napoleon ND
34. Dale Lee Napoleon
35. Lorraine Piatz 418 Main ave Napoleon ND 58561
36. Water & Wastewater 5794 N. Hwy 6 3 Napoleon
37. Joanne Kuntz
38. Joanne Glatt, Napoleon, N.D.
39. Donita Schmaltz Napoleon ND
40. Stephanie Kuhn Napoleon, ND
41. Janet Herold Napoleon, ND 58561
42. Missy Hildebrand Napoleon, ND 58561
43. Loren Lang Napoleon, ND 58561
44. Janet Boyer 74 Broadway, Napoleon ND 58561 7072 25th Ave S.E.
45. Ron Schmaltz Napoleon
46. Charles Gohl 2821 72nd St SE Napoleon ND
47. Brenda Johnson - Kintyre
48. Mary Young - NAPOLEON
49. Julie Becker Napoleon
50. Dan Pfeifle Napoleon N.D.

Walda E Rogers, Napoleon

RURAL PHARMACIES NEED YOUR HELP!!

Help keep our pharmacy local. Sign below if you are against changing the pharmacy law.
Promote the "Do Not Pass" for House Bill 1440

51. Willis P. Pist, Nap
52. Irene Kramer Napoleon N.D.
53. Mavis Wolf Napoleon
54. Ina Wenger Napoleon
55. Alicia Becker Wisker
56. Dawn Wippenberg Napoleon
57. Ellen Moser, Napoleon Napoleon ND
58. Norman Klepper, Napoleon, ND
59. Connie Rust Napoleon, ND
60. Roy N. Rodlund NAPOLEON N.D.
61. Jean L Lang Napoleon ND
62. Kaitlyn Gruneich Napoleon ND
63. Anthony Gruneich Napoleon N.D.
64. Lucille Zimmerman
65. Eileen Geisler Napoleon
66. Marcella Lee Napoleon
67. Leo Unser Napoleon ND
68. Gladys Margaret Napoleon ND
69. Duane Rodlund Napoleon N.D.
70. Lee Roehrich Napoleon
71. Ronnie Schlecht NAPOLEON ND
72. [illegible] Napoleon, ND
73. Robyn VanSickle Napoleon
74. Todd VanSickle Napoleon
75. Dave Baumgarten Hazelton
76. Jane H. Schweiser Nap.
77. Deborah Wentz Napoleon
78. Ruth W [illegible] Napoleon
79. Magdalen Kaiser
70. [illegible]
81. Alvina Kempert Napoleon
82. Ida A. Hillebrand Napoleon ND
83. Hilland Kramer, Dawson, N.D.
84. Marvin Wolf Napoleon
85. Marie Schmidt Napoleon
86. Dawn Kniper, Napoleon
87. Marcella Zorn Napoleon ND
88. Viola Heiden Dawson N.D.
89. Alma Kaul Napoleon
90. Lucille F Schlosser Nap.
91. Debra Harrison-Napoleon
92. Elizabeth Schatz Napoleon ND
93. Cynthia L Doll Napoleon ND
94. Irene A. Klepper Napoleon
95. [illegible] Napoleon
96. Lonnie Dorn Napoleon
97. John J Unser Napoleon ND
98. Belva Fox Napoleon ND
99. Jane Silbernagel Napoleon ND
100. Florence Wangler Kenmare ND

RURAL PHARMACIES NEED YOUR HELP!!

Help keep our pharmacy local. Sign below if you are against changing the pharmacy law.
Promote the "Do Not Pass" for House Bill 1440

101. Carol Mock Napoleon ND
102. Cari West Wishek ND
103. Florence Eberle Napoleon ND
104. Marie Westmiller Nap 58561
105. Marian Weigel Kintyre
106. Alois J. Weigel Napoleon ND
107. Troy Penn Streeter
108. Charlotte Roemmich Nap
109. Ottilia Piatz Napoleon ND
110. Diana Dewald Napoleon ND
111. Julie A Kuhn Napoleon ND
112. Lisa Rinnells
113. Michelle Vetter Kintyre ND
114. [illegible] Napoleon ND
115. Ken Fetty Napoleon.
116. Lorraine Reis Napoleon ND
117. Chas Weigel Kintyre ND
118. Irene Estes Lehr N D
119. Patricia Becher Napoleon ND
120. Geri Kunz Napoleon ND 58561
121. Mary Norman Napoleon ND
122. Bev Klyve
123. Leo E Schneider Kintyre ND
124. Tammy Wald Napoleon ND
125. Susan Klempel
126. Robert Sprague Napoleon ND 58561
127. Coleen Piatz 617 3rd St W Napoleon ND 58561
128. Mary Christman 418 3rd St West Napoleon ND 58561
129. Debra Rau Streeter ND 58483
130. Esther Pfaffle 6381 Highway 3 Napoleon ND 58561
131. Kathie Meier 235 5th St East Napoleon ND 58561
132. Paul P Becker 212 3rd St East Napoleon ND 58561
133. Kevin [illegible] 620 Ave B-W Napoleon ND 58561
134. Connie Reile
135. Susan R. Wall Napoleon ND 5794 Highway 3
136. Tom Klatt 2992 T3 Rd. St SE. 58561 Napoleon N. D. 58561
137. Loretta Haas 114 Third Street E. Napoleon, ND
138. Lea Wirt 6425 20th Ave SE Kintyre, ND 58549
139. Norma Wentz 424-3rd St. E.
140. Raymond Schmidt 411 ave D. E. Napoleon ND
141. Bernard D. Mierau 417 Main, Napoleon, N.D.
142. Dawn Kahn 1891 35th Ave E. Napoleon ND
143. Kaltza B Schmidt Napoleon
144. Rose Horner 218 4th E Napoleon 58561
145. [illegible] Kintyre
146. Ann Marie Mock Kintyre, ND 180 Market St W
147. Mary Weigel Napoleon N. D.
148. [illegible] Lahm Steele N D
149. Rose Dahl Napoleon N. D
150. Ann Sperle Napoleon

RURAL PHARMACIES NEED YOUR HELP!!

Help keep our pharmacy local. Sign below if you are against changing the pharmacy law.
Promote the "Do Not Pass" for House Bill 1440

151. Robyn Miller - Braddock
152. [illegible] Napoleon ND
153. [illegible] Napoleon N.D.
154. [illegible]
155. [illegible]
156. [illegible]
157. [illegible] Napoleon ND
158. [illegible] Napoleon ND
159. [illegible] Napoleon ND
160. [illegible] Napoleon ND
161. [illegible] Napoleon ND
162. [illegible] Napoleon ND
163. [illegible] Napoleon ND
164. [illegible] Nap. ND
165. [illegible] Nap. N.D.
166. [illegible] Nap.
167. [illegible]
168. [illegible] ND
169. [illegible]
170. [illegible] Napoleon, ND
171. [illegible] Napoleon ND
172. [illegible] Dawson
173. [illegible] Napoleon
174.
175.
176.
177.
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Walmart $4.00 Generics

Date of Service	Medication	Quantity	Days Supply	Amount Billed	Amount Paid
11/20/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
11/10/2008	SMZ-TMP DS	6	3	$11.78	$5.76
11/6/2008	Cyclobenzaprine 10 mg	30	30	$34.40	$7.00
9/17/2008	Tetracycline 500 mg	30	30	$13.40	$6.60
9/8/2008	Triamcinolone 0.1% Oint	30	7	$6.67	$6.38
9/9/2008	SMZ-TMP DS	6	3	$11.78	$5.76
8/20/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
8/14/2008	SMZ-TMP DS	6	3	$11.78	$5.76
7/18/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
7/17/2008	Amitriptyline 75 mg	30	30	$37.72	$8.58
7/10/2008	SMZ-TMP DS	6	3	$11.78	$5.76
6/21/2008	Ciprofloxacin 500 mg	14	7	$72.76	$6.35
6/19/2008	Amitriptyline 75 mg	30	30	$37.72	$8.58
6/18/2008	Tetracycline 500 mg	30	30	$8.19	$6.60
Total Cost of Identical Prescriptons				$182.60	$30.51
Average Cost of Identical Prescriptions				$45.65	$7.63

Comparable ND Pharmacy

Date of Service	Quantity	Days Supply	Amount Billed	Amount Paid
N/A				
10/30/2008	20	10	$ 8.20	$ 7.52
11/15/2008	30	30	$15.55	$7.00
N/A				
7/9/2008	80	8	$ 10.50	$ 9.20
9/22/2008	14	7	$ 8.15	$ 6.76
N/A				
9/22/2008	14	7	$ 8.15	$ 6.76
N/A				
7/17/2008	30	30	$ 21.69	$ 8.58
7/9/2008	10	5	$ 5.50	$ 5.50
7/1/2008	14	7	$ 14.30	$ 6.35
6/19/2008	30	30	$ 10.75	$ 8.58
N/A				
			$62.29	$30.51
			$15.57	$7.63

Walmart Regular Generics

Date of Service	Medication	Quantity	Days Supply	Amount Billed	Amount Paid
11/24/2008	Amitriptyline 25 mg	60	30	$ 23.30	$ 7.93
9/19/2008	Hydrocodone/Apap 10-325 mg	360	30	$ 232.61	$ 76.82
9/19/2008	Zolpidem 10mg	30	30	$ 129.88	$ 12.88
9/18/2008	Oxycodone/Apap 7.5-325 mg	120	30	$ 201.72	$ 62.96
9/18/2008	Cyclobenzaprine 10 mg	120	20	$ 163.19	$ 13.01
9/17/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89
9/15/2008	Tramadol 50 mg	180	30	$ 155.89	$ 22.01
9/15/2008	Hydrocodone/Apap 5-500 mg	30	15	$ 10.31	$ 6.89

Comparable ND Pharmacy

Date of Service	Quantity	Days Supply	Amount Billed	Amount Paid
11/25/2008	60	30	$ 10.99	$ 7.93
9/19/2008	280	23	$ 203.14	$ 60.86
9/18/2008	30	30	$ 23.15	$ 12.88
N/A				
9/18/2008	120	30	$ 131.66	$ 13.01
9/17/2008	60	30	$ 167.23	$ 12.89
9/12/2008	180	30	$ 70.83	$ 22.01
9/15/2008	30	4	$ 13.05	$ 6.89

9/13/2008	Hydrocodone/Apap 5-500 mg	15	2	$ 7.66	$ 5.95	9/8/2008	15	3	$ 16.22	$ 5.95
9/11/2008	Hydrocodone/Apap 7.5-325 mg	80	6	$ 49.51	$ 31.13	N/A				
9/4/2008	Cephalexin 500 mg	50	16	$ 66.92	$ 12.35	9/5/2008	60	30	$ 31.56	$ 13.82
9/2/2008	Hydrocodone/Apap 10-325 mg	60	10	$ 42.94	$ 16.97	9/3/2008	60	10	$ 19.59	$ 16.97
8/27/2008	Morphine Sulfate ER 60 mg	90	30	$ 272.80	$ 122.61	8/18/2008	90	30	$ 349.19	$ 122.61
8/27/2008	Morphine Sulfate ER 15 mg	60	30	$ 53.15	$ 29.90	8/28/2008	60	30	$ 91.69	$ 29.90
8/25/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	9/2/2008	68	34	$ 14.85	$ 8.32
8/22/2008	Hydrocodone/Apap 7.5-325 mg	80	6	$ 49.51	$ 31.13	N/A				
8/19/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89	8/22/2008	60	30	$ 167.23	$ 12.89
8/18/2008	Oxycodone/Apap 7.5-325 mg	90	22	$ 152.80	$ 48.47	N/A				
8/18/2008	Cyclobenzaprine 10 mg	120	20	$ 163.19	$ 13.01	8/22/2008	120	30	$ 115.95	$ 13.01
8/15/2008	Tramadol 50 mg	180	30	$ 155.89	$ 22.01	8/12/2008	180	30	$ 155.34	$ 22.01
8/5/2008	Hydrocodone/Apap 5-325 mg	30	3	$ 19.63	$ 12.06	8/5/2008	30	3	$ 18.45	$ 12.06
8/5/2008	Cefadroxil 500 mg	10	5	$ 38.48	$ 19.34	7/28/2008	14	7	$ 73.59	$ 25.08
8/4/2008	Zolpidem 10mg	30	30	$ 129.88	$ 12.88	8/4/2008	30	30	$ 17.29	$ 12.88
8/3/2008	Hydrocodone/Apap 7.5-500 mg	60	30	$ 28.13	$ 10.39	8/4/2008	60	7	$ 38.40	$ 10.39
7/30/2008	Morphine Sulfate ER 30 mg	60	30	$ 96.51	$ 30.75	7/24/2008	60	30	$ 110.77	$ 30.75
7/30/2008	Morphine Sulfate ER 15 mg	60	30	$ 53.15	$ 29.90	7/24/2008	60	30	$ 59.95	$ 29.90
7/26/2008	Hydrocodone/Apap 10-325 mg	360	30	$ 232.61	$ 76.82	7/12/2008	280	23	$ 203.14	$ 60.86
7/25/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	7/15/2008	60	30	$ 14.05	$ 7.93
7/24/2008	Cyclobenzaprine 10 mg	40	10	$ 48.65	$ 7.67	7/23/2008	40	10	$ 23.95	$ 7.67
7/20/2008	Sertraline 100 mg	60	30	$ 92.98	$ 12.89	7/21/2008	60	30	$ 167.23	$ 12.89
7/17/2008	Morphine Sulfate ER 60 mg	30	30	$ 94.26	$ 44.20	7/9/2008	30	30	$ 27.89	$ 17.45
7/17/2008	Oxycodone ER 20 mg	120	30	$ 410.47	$ 308.35	N/A				
7/17/2008	Oxycodone/Apap 7.5-325 mg	84	28	$ 143.00	$ 45.57	N/A				
7/17/2008	Oxycodone ER 80 mg	30	30	$ 324.30	$ 243.73	8/18/2008	24	24	$ 196.99	$ 195.98
7/17/2008	Cyclobenzaprine 10 mg	120	30	$ 163.19	$ 13.01	7/9/2008	120	30	$ 131.66	$ 13.01
7/10/2008	Morphine Sulfate ER 30 mg	90	30	$ 142.26	$ 43.63	7/23/2008	90	30	$ 50.49	$ 43.63
6/29/2008	Oxycodone ER 20 mg	180	30	$ 460.02	$ 460.02	N/A				
6/24/2008	Amitriptyline 50 mg	60	30	$ 37.51	$ 6.99	7/7/2008	60	30	$ 15.44	$ 6.99
6/23/2008	Sertraline 100 mg	60	30	$ 151.63	$ 12.89	6/23/2008	60	30	$ 185.54	$ 12.89
6/20/2008	Amitriptyline 25 mg	60	30	$ 23.29	$ 7.93	6/9/2008	60	30	$ 14.05	$ 7.93
6/20/2008	Hydrocodone/Apap 7.5-500 mg	60	30	$ 28.13	$ 10.39	6/17/2008	60	15	$ 23.05	$ 10.39
6/19/2008	Zolpidem 10mg	30	30	$ 129.88	$ 12.88	6/19/2008	30	30	$ 143.99	$ 12.88
6/19/2008	Oxycodone ER 20 mg	90	30	$ 309.35	$ 232.51	6/21/2008	90	30	$ 258.40	$ 232.51
6/19/2008	Cyclobenzaprine 10 mg	120	30	$ 163.18	$ 13.01	6/6/2008	120	30	$ 131.66	$ 23.90
6/15/2008	Tramadol 50 mg	180	30	$ 155.89	$ 22.01	6/16/2008	180	30	$ 123.95	$ 22.01

6/10/2008	Propoxyphene/Apap 100-650 m	100	16	$	53.11	$	15.50	6/25/2008	100	16	$ 34.39	$ 15.50
6/10/2008	Tramadol 50 mg	50	8	$	42.69	$	9.73	6/6/2008	50	7	$ 39.39	$ 9.73
6/5/2008	Morphine Sulfate ER 30 mg	90	30	$	142.26	$	43.63	6/27/2008	90	30	$ 50.49	$ 43.63
6/5/2008	Hydrocodone/Apap 10-325 mg	360	30	$	232.61	$	85.71	6/9/2008	280	28	$ 141.55	$ 60.86
Total Cost of Identical Prescriptons				$	3,493.01	$	911.73				$ 3,012.60	$ 895.87
Average Cost of Identical Prescriptions				$	99.80	$	26.05				$ 86.07	$ 25.60

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board

FROM: Bryan

DATE: **November 15, 2007**

SUBJECT: **NDPERS Prescription Drugs Update**

The NDPERS Health Plan cost sharing for prescription drugs for the 07-09 biennium is:

Prescription Formulary Generic Drug			
- Copayment	$5	$5	$5
- Co-Insurance	15%	15%	15%
Prescription Formulary Brand-Name Drug			
- Copayment	$20	$20	$20
- Co-Insurance	25%	25%	25%
Prescription Non-Formulary Drug			
- Copayment	$25	$25	$25
- Co-Insurance	50%	50%	50%

The data for the latest year (7/2006 – 6/2007) shows the average charge for a generic drug at $47.56 and the average charge for a brand name drug at $165.38 per script. The average amount the NDPERS Health Plan paid was $18.75 for a generic and $90.26 for a brand name. There were 495,474 prescriptions during this period. Note that the Medicare part-D claims are no longer processed through the BCBS/Prime system. The NDPERS generic utilization for this period was at 57%.

The new mail order pharmacy had 450 claims for this period (1/10th of 1% of the total). Members that are using the mail order option are getting higher cost drugs. The average charges and paid amounts for mail order were:

	Charges	Paid
Generic:	$128.90	$140.39
Brand:	$623.46	$358.11

The top five mail order drugs were:

GENNAME	Frequency	Percent	Cumulative Frequency	Cumulative Percent
PROTONIX	21	4.83	21	4.83
ADVAIR DISKUS	16	3.68	37	8.51
AVONEX	16	3.68	53	12.18
CRESTOR	16	3.68	69	15.86
METFORMIN HCL	14	3.22	83	19.08

The top ten drugs for the NDPERS Prescription Drug Plan were:

GENNAME	Frequency	Percent	Cumulative Frequency	Cumulative Percent
LIPITOR	2637	2.01	2637	2.01
LISINOPRIL	2336	1.78	4973	3.79
HYDROCODONE/ACETAMINOPHEN	2304	1.75	7277	5.54
LEVOTHYROXINE SODIUM	2161	1.65	9438	7.19
AZITHROMYCIN	2051	1.56	11489	8.75
AMOXICILLIN	2015	1.53	13504	10.28
HYDROCHLOROTHIAZIDE	2012	1.53	15516	11.82
FLUOXETINE HCL	1730	1.32	17246	13.13
METFORMIN HCL	1705	1.30	18951	14.43
SERTRALINE HCL	1597	1.22	20548	15.65

Some retail stores like Wal-Mart and Target are now offering a 30-day supply of over 360 mostly generic drugs for $4. This offer is for in-store purchases only except for stores in North Dakota and is not available by mail order. Since this is lower than the NDPERS copayment, these offers would save money for both the NDPERS Health Plan and its members. The following is an analysis from BCBS.

I took a look at NDPERS 2nd Quarter 2007 utilization. I would estimate that NDPERS would have saved approximately $240,000 if all $4 qualifying generics were filled at Wal-Mart stores. Members would have saved about the same amount in cost sharing.

For this to actually occur is another matter. The $4 generic program applies only to prescriptions filled in less than 34 day supplies and picked up in person at a Wal-Mart store. There are no participating Wal-Mart stores in North Dakota. Only about $7,000 of the savings noted above is attributable to NDPERS members with an out-of-state zipcode.

Tom Christensen, PhD, RPh
Director of Pharmacy Management

If you have any questions or would like to see any other information, I will be available at the NDPERS Board meeting.

BlueCross BlueShield of North Dakota

An independent licensee of the Blue Cross & Blue Shield Association

Consulting Services Unit
4510 13th Avenue South
Fargo, North Dakota 58121-0001

(701) 282-1444

Memorandum

TO: Sparb Collins, NDPERS

FROM: Larry Brooks, BCBSND

DATE: January 8, 2008

SUBJECT: Wal-Mart Drugs

Through an e-mail dated December 10, 2007, you asked the effect on premiums if the Wal-Mart Drug Plan was available in North Dakota. Specifically, how much of a reduction in premiums would be associated with this option.

After reviewing this situation with our Actuarial Department, we would expect savings to NDPERS to be no more than 0.1% to 0.3% of premium, depending on the design of the benefit (for instance, who pays the $4, if members have a choice, impact on areas without a Wal-Mart, impact of 90-day prescriptions, and so on).

Rob Scheiring of our Actuarial Department will be attending the January 17 Board meeting to address any additional questions you might have.

3

Mr. Chairman and Committee Members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota.

An editorial appearing in The Forum on January 11, 2009 notes that the legislative debate over North Dakota's pharmacy ownership law "will be one of the most contentious and emotional in years." The editorial correctly calls for setting emotion aside.

One issue that often gets obscured in emotional rhetoric is the cost-saving potential of repealing the pharmacy ownership law. Much of the evidence, on both sides of the issue, is anecdotal and speculative. Since Blue Cross Blue Shield of North Dakota (BCBSND) and its members purchase pharmaceuticals in nearly every state we have some perspective on cost.

BCBSND's pharmacy provider network is comprised of nearly every pharmacy in North Dakota and over 50,000 additional pharmacies throughout the country. Each of these pharmacies is contracted to specific reimbursement rates (discounts) on brand and generic medications. Regardless of pharmacy location, approximately 99% of brand name medication claims are paid at the pharmacy's contracted rate.

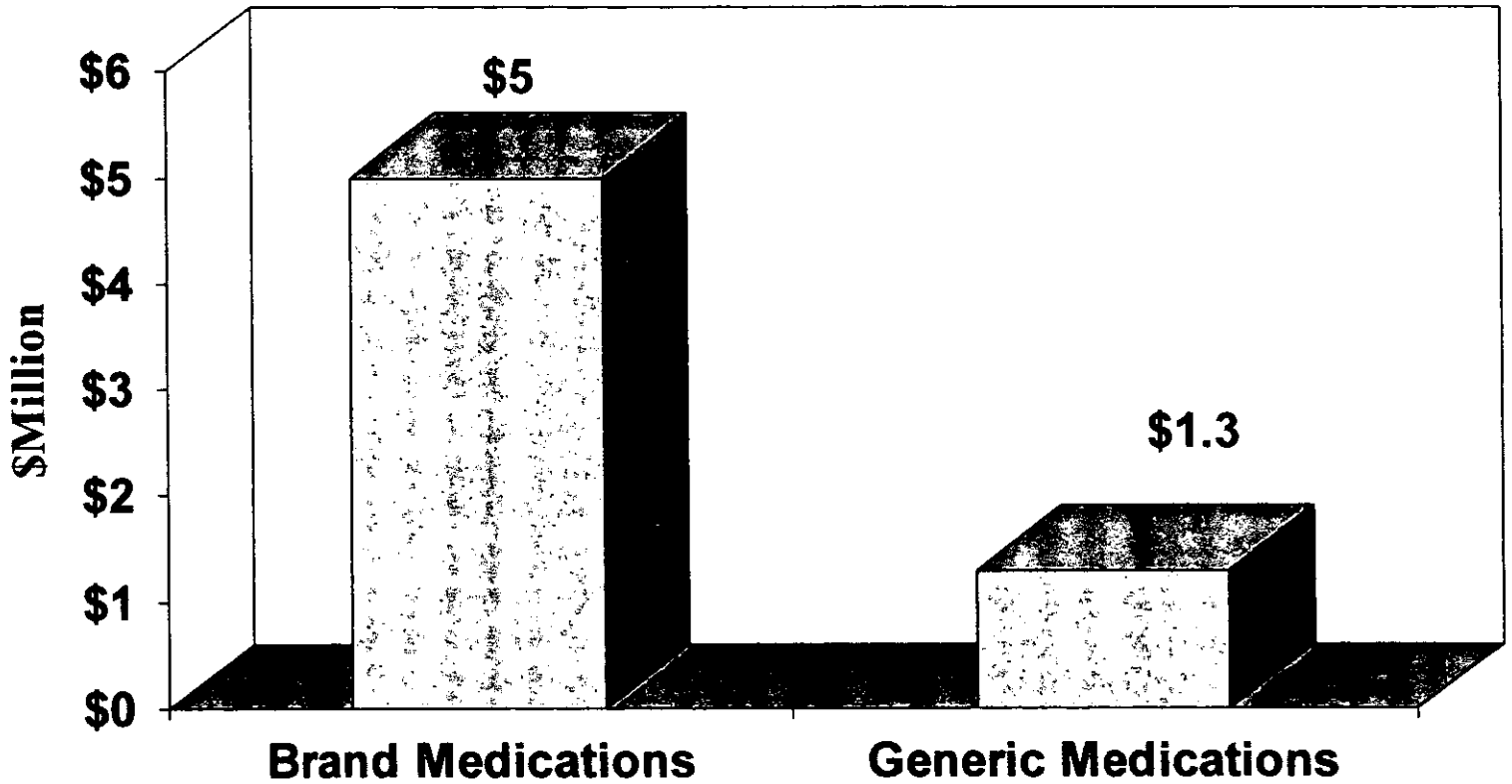
The average discount on brand medications is approximately three percent greater in the out-of-state pharmacies than it is in North Dakota pharmacies. In 2008, BCBSND and its members spent over $160 million on brand medications in North Dakota. If repeal of the pharmacy ownership law were to result in discounts within North Dakota similar to those existing in the out-of-state pharmacies it could lead to cost savings of approximately $5 million annually. Nearly 40% of these savings would accrue to directly to BCBSND members through reduced cost sharing.

Another difference between North Dakota and the out-of-state pharmacy market is the existence of $4 generic medication programs made popular by Wal-Mart. In 2008, approximately $8.5 million could have been saved if all generic medication claims eligible for the Wal-Mart program had been paid under the Wal-Mart guidelines. Out-of-state claim experience during the same period indicates the actual market penetration of $4 generic medication programs to be approximately 15 percent. If repeal of the pharmacy ownership law resulted in similar market penetration in North Dakota, annual savings could be as much as $1.3 million. Approximately half of these saving would accrue directly to our members in reduced cost sharing.

Although BCBSND can produce hard statistics based on millions of pharmacy claims much of potential cost impact of repealing the pharmacy ownership law remains speculative. This is because the true impact of repealing the pharmacy ownership law will depend on the consumer behavior of North Dakotans. Should the pharmacy ownership law be repealed and new pharmacy businesses enter the state, BCBSND will continue to contract with all pharmacies and seek the best discounts for our members. BCBSND will also continue to take measures to support rural pharmacies and maintain access to pharmacy services in rural areas. We believe that our members and all North

Dakotans will continue to make their best personal choice in pharmacy services. Repeal of the pharmacy ownership law will allow them to do so.

BCBSND projected cost reductions from ownership repeal



Assumptions

- National insured market discounts on brand drugs

Assumptions

- Widespread availability of $4 generic programs
- 15% Market share penetration

NDPhA
NORTH DAKOTA
PHARMACISTS
ASSOCIATION

House Industry, Business, and Labor Committee
HB 1440 Committee Work – Chairman Keiser
February 9, 2009 - 9:00 a.m.

Chairman Keiser and members of the committee, my name is Mike Schwab, Executive Vice President of the ND Pharmacists Association. I am here today to provide clarification regarding information being shared about HB 1440.

First, we would like to provide information regarding the $1 million dollars in savings that was estimated by BC/BS of ND on behalf of NDPERS. Attached is an email from NDPERS explaining that the estimate was actually figured if ALL prescriptions were filled at Wal-Mart. This is not a reality. It would be more realistic if a 10-15% was used in their calculations to find any potential savings.

By using more realistic averages, such as what State Medicaid Departments use (no more than 15%), you would see a more realistic savings of roughly $100,000 to $150,000 annually, not $1 million. It appears all parties understood or had knowledge of this but still used the $1 million figure and the assumption that ALL prescriptions would be filled at Wal-Mart. You would only see ALL prescriptions filled at Wal-Mart if NDPERS made it mandatory for all PERS members to shop only at Wal-Mart pharmacies eliminating their choice of where to buy prescriptions in the state.

Second, the State Medicaid Department stated they could possibly save over $240,000 annually. The State Medicaid Department used an average of 15% of prescriptions being filled at Wal-Mart. We feel this is high considering in other states the utilization % is less and we are also wondering if this fiscal note was figured just on Wal-Mart or if other chain pricing programs were used in the calculation. We are curious because certain Medicaid Programs do not allow "annual fee programs" to be paid with Medicaid dollars. We anticipate this average to be considerably less than stated.

Third, a question was asked of Wal-Mart during testimony if they provide delivery or mail outs. The response, if we recall correctly, was yes. Attached is a printout of the "terms and disclosure" for their $ 4 program. It states there are no substitutions or mail orders with the program. Just wanted to clarify they do not do mail orders according to the terms and disclosure statement. You will also notice on the disclosure statement that if individuals already have insurance the program either doesn't apply and/or prices might be higher and in some states they are higher.

Lastly, would like to have BC/BS verify how they arrived at the apparent cost savings if the law was repealed. Are they stating any money saved will be put towards premium reductions? How are they going to save MORE money on brand name medications than generics? Are we not talking about generic prescriptions? Does BC/BS pay the same dispensing fees for everyone or do they fluctuate? Because of network power and negotiation power, do chains typically negotiate a higher reimbursement – need to look at other states for a comparison…?

Thanks for your time and attention once again. I would be happy to try and answer any questions that you may have.

Respectfully Submitted,

Mike

Mike Schwab
EVP - NDPhA

Mike Schwab

From: Reinhardt, Bryan T. [breinhar@nd.gov]
Sent: Friday, January 16, 2009 8:49 AM
To: Collins, J. Sparb; 'mschwab@nodakpharmacy.net'
Subject: RE: NDPhA

Mike,
The $1 million annual figure is likely from a BCBS analysis that showed the NDPERS Health Plan would have saved about $240,000 a quarter if all $4 scripts were filled. As Sparb noted, we did not do any fiscal analysis on this bill. Below is the NDPERS information I provided at their request by email.

If you have any questions, let us know.

Bryan T. Reinhardt
Research Analyst / Benefits Planner
NDPERS
400 E Bdwy, Suite 505
Box 1657
Bismarck, ND 58502
(701) 328-3919

Dan, — Traynor
The annual $1 million figure I used today is extrapolated from a Q2 2007 analysis that the NDPERS Health Plan would have saved about $240,000 if all qualifying $4 generics the plan experienced would have been filled at a Wal-Mart or other $4 generic service. The NDPERS members would have saved a similar amount since their cost sharing under the plan would have been more than the $4 price.

Keep in mind that the NDPERS Health Plan has about 25,000 contracts covering just over 56,000 lives. The actual State of North Dakota is just under 14,000 contracts. Retirees are at about 5,500 contracts and the participating Political Subdivisions (city, county, schools, etc) make up the remaining 5,500.

If you have any questions, please feel free to contact us.

Bryan T. Reinhardt
Research Analyst / Benefits Planner
NDPERS
400 E Bdwy, Suite 505
Box 1657
Bismarck, ND 58502
(701) 328-3919

Hi David,
ny savings in drug costs would likely result in lower future premiums for the contract holders on the NDPERS Health Plan.
ere are the top 10 drugs the NDPERS Health Plan had claims for during the past year (7/07-6/08). I'm checking with BCBS to see if there is a way to tell

if the dispensing pharmacy was in-state or out-of-state. I will email you when I come up with something. If you have any other questions, let us know.

GENNAME	Frequency	Percent	Cumulative Frequency	Cumulative Percent
AZITHROMYCIN	11081	2.33	11081	2.33
LIPITOR	9135	1.92	20216	4.24
LISINOPRIL	8852	1.86	29068	6.10
AMOXICILLIN	8456	1.78	37524	7.88
LEVOTHYROXINE SODIUM	8377	1.76	45901	9.64
HYDROCODONE/ACETAMINOPHEN	8194	1.72	54095	11.36
HYDROCHLOROTHIAZIDE	7275	1.53	61370	12.88
SERTRALINE HCL	6528	1.37	67898	14.25
METFORMIN HCL	6192	1.30	74090	15.55
SIMVASTATIN	6064	1.27	80154	16.83
OTHERS	396221	83.17	476375	100.00

Bryan T. Reinhardt
Research Analyst / Benefits Planner
NDPERS
400 E Bdwy, Suite 505
Box 1657
Bismarck, ND 58502
(701) 328-3919

David,
Here is the NDPERS Health Plan paid to go with the top 10 drugs. This is the amount the plan paid and does not include what the member paid in cost sharing or any discounts, over allowed or COB.

GENNAME	PAID
AZITHROMYCIN	187638.92
LIPITOR	839646.00
LISINOPRIL	90726.65
AMOXICILLIN	32385.82
LEVOTHYROXINE SODIUM	104537.69
HYDROCODONE/ACETAMINOPHEN	40571.52
HYDROCHLOROTHIAZIDE	25973.52
SERTRALINE HCL	95674.18
METFORMIN HCL	92158.92
SIMVASTATIN	140553.57
OTHERS	19132997.32
All	20782864.11

If you have any questions, let me know.
Bryan T. Reinhardt
Research Analyst / Benefits Planner
NDPERS
400 E Bdwy, Suite 505

Box 1657
Bismarck, ND 58502
(701) 328-3919

From: David Flynn [mailto:flynn.economics@gmail.com]
Sent: Monday, August 11, 2008 5:13 PM
To: Reinhardt, Bryan T.
Subject: Re: NDAH-Question

Bryan,

This information is interesting. Is there any information about the expense on these prodcuts? Since you have quantity information a total amount would be sufficient to dervie an average cost.

David

2008/8/11 Reinhardt, Bryan T. <breinhar@nd.gov>

Hi David,

Any savings in drug costs would likely result in lower future premiums for the contract holders on the NDPERS Health Plan.

Here are the top 10 drugs the NDPERS Health Plan had claims for during the past year (7/07-6/08). I'm checking with BCBS to see if there is a way to tell if the dispensing pharmacy was in-state or out-of-state. I will email you when I come up with something. If you have any other questions, let us know.

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Bryan T. Reinhardt

Research Analyst / Benefits Planner

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Bismarck, ND 58502

(701) 328-3919

From: David Flynn [mailto:flynn.economics@gmail.com]
Sent: Thursday, August 07, 2008 3:13 PM
To: Reinhardt, Bryan T.
Subject: NDAH-Question

I am working with Dan Traynor of the analysis of health care cost changes in North Dakota. He forwarded me the email with the approximately $1 million in savings to individuals and NDPERS. How would the NDPERS utilize these savings? It matters as far as calculating the likley economic impacts. Also, are there any figures available for the top prescriptions purchased, and whether they were in state or out of state, for NDPERS holders as well?

David Flynn

David T. Flynn, Ph.D.
Economist

From: Collins, J. Sparb
Sent: Thursday, January 15, 2009 4:10 PM
To: 'mschwab@nodakpharmacy.net'
Cc: Reinhardt, Bryan T.

Subject: RE: NDPhA

[redacted]

Hi Mike

Happy New Year. I will have Bryan send you what we did, but it is basically the information you have previously seen. Also we have not been requested to provide any fiscal notes at this time. Take care

sparb

From: Mike Schwab [mailto:mschwab@nodakpharmacy.net]
Sent: Thursday, January 15, 2009 4:04 PM
To: Collins, J. Sparb
Subject: NDPhA

Hello Sparb,
Hope all is well.

I was wondering if you would please share any fiscal information you have and/or requested for this session as it relates to the ND 51% pharmacy ownership law.

We have been told and hear that NDPERS would save a million dollars (a biennium?) if the ownership law was overturned. I am also wondering if you only factored in the $ 4 prescriptions or if you collectively analyzed the entire list of drugs and their prices that the other entities use?

I assume the fiscal note was only on the $ 4 prescriptions. We are also very curious how that fiscal note was figured. We would appreciate any and all information you can provide or if you have to, just point me in the right direction. Thanks, Sparb.

[redacted]

Mike

Michael D. Schwab
Executive Vice-President
ND Pharmacists Association
ND Pharmacy Service Corporation
1641 Capitol Way
Bismarck, ND 58501-2195
Phone: 701-258-4968
Fax: 701-258-9312
mschwab@nodakpharmacy.net
www.nodakpharmacy.net

[redacted]

WALMART'S PRESCRIPTION PROGRAM DETAILS

1. Walmart's Prescription Program (the "Program") is available at all Walmart, Sam's Club and Neighborhood Market pharmacies in the United States ("Walmart Pharmacy"), except in North Dakota.

2. The Program applies only to certain generic drugs at commonly prescribed dosages. You may obtain a list of generic drugs and dosages covered under the Program (the "Drug List") on Walmart.com or at any Walmart Pharmacy. The Drug List may change and also may vary by state. Not all formulations of a drug (for example, enteric-coated, extended or timed release formulations) are covered under the Program.

3. Under the Program, $4 is the price for up to a 30-day supply of certain covered generic drugs at commonly prescribed dosages (the "$4 Program"). $10 is the price of a 90-day supply of certain covered generic drugs at commonly prescribed dosages (the "$10 Program"). Not all drugs covered by the $4 Program are covered by the $10 Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $4 Program and $10 Program are prorated based on the $4 Program price, but will not exceed $10. Prices for quantities greater than a 90-day supply of drugs covered by the $10 Program are prorated based on the $10 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs (such as tubes, vials or bottles), see Section 5.

4. Under the Program, $9 is the price for up to a 30-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$9 Program"). $24 is the price for a 90-day supply of certain women's health and other covered generic drugs at commonly prescribed dosages (the "$24 Program"). Not all drugs covered by the $9 Program are covered by the $24 Program. Prices for quantities between a 30-day supply and a 90-day supply of drugs covered by both the $9 Program and $24 Program are prorated based on the $9 Program price, but will not exceed $24. Prices for quantities greater than a 90-day supply of drugs covered by the $24 Program are prorated based on the $24 Program price. Prorated pricing is not available under the Program for prepackaged drugs. For pricing policies relating to prepackaged drugs, see Section 5.

5. Prepackaged drugs are covered under the Program only in the unit sizes specified on the Drug List. Prepackaged drugs are dispensed based on the quantities prescribed and unit sizes in stock at the Pharmacy. Unit sizes not specified on the Drug List are not covered under the Program. Multi-unit purchases are charged at a per unit price, based on the price per unit size dispensed, unless otherwise specified. Prepackaged drugs dispensed in unit sizes not specified on the Drug List may be priced higher, even if equivalent quantities of the drug are available in specified unit sizes. Prorated pricing is not available under the Program for prepackaged drugs.

6. Prices of certain drugs covered by the Program may be higher in some states, as noted on the Drug List.

7. Program pricing may be limited to select manufacturers of a covered drug and is available as long as store supplies in stock at the Pharmacy from such manufacturers last.

8. You may pay less or more than the Program price, depending on the terms of your health plan. Prescriber permission may be required to change a 30-day prescription to a 90-day prescription. Certain plans, including government-funded programs, may not cover a 90-day supply.

9. Prescriptions must initially be filled in person. Refills must be picked up in store. There are no substitutions or mail orders.

10. These Program Details are subject to change without advance notice. Changes to these Program Details may be made only in writing.

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ND Department of Human Services
Medical Services
Estimated Medicaid Savings from Redefining Pharmacy Ownership
2009-2011 Biennium

	Total	General	Federal
Estimated Medicaid Savings from Redefining Pharmacy Ownership	82,961	30,679	52,282

Considerations:

Assumes that 5% of Medicaid recipients would fill $4 eligible prescriptions at Walmart. There is no incentive for Medicaid clients to fill at Walmart, as the cost-sharing is the same, regardless of which pharmacy they patronize.

Assumes that local, independent pharmacies would not decrease their pricing.

Assumes no impact in Medicaid enrollees.

The estimate does not include any increases in Medicaid for transportation costs or mail order. (currently North Dakota Medicaid does not pay transportation costs for picking up prescriptions, or having them mailed; however, if small, rural pharmacies close, this may become necessary.)

The estimate assumes Walmart will not change the list of drugs provided at $4. (If they remove drugs from their list, the estimated savings would decline. If they add drugs to their list, the estimated savings could increase.)

Keiser, George J.

From: Cari Wiest [jcbern@bektel.com]
Sent: Saturday, February 07, 2009 11:03 AM
To: Keiser, George J.
Subject: House Bill 1440

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Chairman Keiser,
I am a rural pharmacist and was unable to attend the hearing on House Bill 1440 on February 3. I am hoping you will still consider my testimony before committee work is completed and a vote is taken. If what I am asking is still possible, please forward this testimony to the rest of your committee.
My testimony is pasted below.

Thank-you for your consideration.

Cari Wiest

Testimony of Cari Wiest
Pharmacist in Wishek & Napoleon ND
House Bill 1440
House Human Services Committee
&
House Industry and Labor Committee
Hearing Date: February 3, 2009

Chairman Keiser and members of the House Human Services Committee and Chairman Weisz and members of the House Industry and Labor Committee, I am presenting this testimony in **opposition** to House Bill 1440, which repeals the 51% ownership law for pharmacies in North Dakota.
As a pharmacist working in a rural North Dakota community, I am concerned about repealing the ownership law. I have reviewed the commentary and **dramatic** testimonials presented at the hearing, and as a rural North Dakota pharmacist, I felt compelled to respond. A notable misconception unrealized by a majority of people in North Dakota is the name behind "North Dakotans for Affordable Healthcare". This is a group funded mainly by Wal-Mart and Walgreens. I don't believe for a second that these corporate chain stores have North Dakotan's best interest in mind when they present their argument for placing pharmacies in our state. I don't believe their arguments are about pharmacy at all. The driving force behind these corporations is to increase profits. North Dakota may be the only state in the nation still up-holding the ownership law, but that doesn't mean we are in the wrong. North Dakota's prescription drug prices have been shown to be well **below** the national average--and that is **without** these big-box chain stores in our state.
The arrival of corporate pharmacies in North Dakota does not necessarily mean more competition and is certainly not the answer for people struggling with prescription drug costs. In my eight years as a pharmacist, there have already been changes which have taken away a majority of the opportunity for competition. Pharmacies have very little say in the price of prescription drugs anymore. With the implementation of the Medicare Part D plans and reimbursement rate cuts from insurance companies, operating a pharmacy, or any rural health care facility in North Dakota, has become somewhat of a challenge. Drug costs have risen and reimbursement rates have been cut. If a patient has insurance, Medicaid, or a Medicare Part D plan, it is the insurance companies that determine the patient's co-pay and the amount the pharmacy is reimbursed for each particular medication.

Most of our customers currently have insurance or a Medicare Part D plan. In cases where the patient is eligible for low income subsidy, they will have very low or even no co-pay at all. When we do have uninsured customers, we do whatever we can to provide them with the prescriptions they need. We work closely with the [redacted]tients and their physicians to find cheaper alternatives, or alternatives which are covered by the patients' [redacted]cific plan. I don't feel that bringing Wal-Mart or Walgreens pharmacies to North Dakota will be the answer. [redacted]Will Wal-Mart deliver your prescription on Sunday when you forgot to pick it up the day before? Will Wal-Mart stay open an extra half-hour when you are running late at the doctor's office? Do they provide emergency on-call service in our rural areas? What about those people who don't drive or have a hard time getting around-how will they get their prescriptions? I know there are mail-order pharmacies available to our patients, but what happens when they have problems or questions? Our patients could lose the personal contact currently available to them. In addition, if their prescriptions are being mailed from out of state, how will that benefit North Dakota? I believe that bringing the corporate-run chain stores to North Dakota will eventually be the down-fall of our rural healthcare system. That is a sad scenario. North Dakota is primarily a rural community, and I think by bringing in these large corporations to do our job is sending the wrong message to North Dakotans.

I grew up in a small town and moved back to a small town for a reason. I believe that what I do here is important and I am very proud, and feel very privileged, to have a job here. I would like to remain here and continue to provide pharmacy services to our rural community. I love working in a community where we know everyone by name. I feel we do a wonderful job of providing pharmacy services to our patients. What will happen to our rural communities when they can no longer thrive? Are we trying to urbanize our state? You must ask yourself-what is the real goal here? I'm not seeing the problem these large corporations are professing to solve. The problem, in my opinion, doesn't lie within pharmacy itself. It stems from insurance companies cutting reimbursement rates for rural health care, and drug companies raising drug prices so they can put their advertisements on television. How would opening corporate-run pharmacies in North Dakota change that? It would only make things worse for rural North Dakota.

I think we all agree we want to create more jobs for North Dakota, but at what expense? The few jobs that [redacted]ight be created by bringing in Wal-Mart or Walgreens pharmacies could jeopardize the jobs we already have [redacted]North Dakota's independent pharmacies. Those of us who want to remain in rural North Dakota should not [redacted]ave to worry about the loss of local pharmacy access and the personal services we provide, simply because these large corporations want to improve their bottom line.

Chairman Keiser and members of the House Human Services Committee and House Industry and Labor Committee, I urge a **do not pass** on House Bill 1440.

[redacted]