

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

January 31, 2013

3:05 p.m.

MEMBERS PRESENT

Representative Pete Higgins, Chair
Representative Wes Keller, Vice Chair
Representative Benjamin Nageak
Representative Lance Pruitt
Representative Lora Reinbold
Representative Paul Seaton
Representative Geran Tarr

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

HOUSE BILL NO. 53

"An Act establishing a consultation requirement with respect to the prescription of opiates under certain circumstances."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 53

SHORT TITLE: CONSULTATION FOR OPIATE PRESCRIPTION

SPONSOR(S): REPRESENTATIVE(S) KELLER

| | | |
|----------|-----|---------------------------------|
| 01/16/13 | (H) | PREFILE RELEASED 1/11/13 |
| 01/16/13 | (H) | READ THE FIRST TIME - REFERRALS |
| 01/16/13 | (H) | HSS, L&C |
| 01/31/13 | (H) | HSS AT 3:00 PM CAPITOL 106 |

WITNESS REGISTER

JIM POUND, Staff
Representative Wes Keller
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Presented HB 53 on behalf of the bill sponsor, Representative Keller.

PATRICIA SENNER, Interim Director of Professional Practice
Alaska Nurses Association
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

LEON CHANDLER, MD
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

EMILY NENON, Alaska Government Relations Director
American Cancer Society Cancer Action Network
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

JUDITH DEARBORN, President
Alaska Association of Nurse Anesthetists
Fairbanks, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

ANNA NELSON, Executive Director
Interior AIDS Association (IAA)
Fairbanks, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

LARRY STINSON, M.D.
Advanced Pain Centers of Alaska
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

JAY CALDWELL, Medical Director
Narcotic Drug Treatment Center
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

BOB TWILLMAN, Director of Policy and Advocacy
American Academy of Pain Management
Sonora, California

POSITION STATEMENT: Testified in opposition of proposed HB 53.

RON GREENE, Clinical Director
Narcotic Drug Treatment Center
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

BARRY CHRISTENSEN
Alaska Pharmacist Association
Anchorage, Alaska

POSITION STATEMENT: Testified during discussion of HB 53.

ACTION NARRATIVE

[3:05:54 PM](#)

CHAIR PETE HIGGINS called the House Health and Social Services Standing Committee meeting to order at 3:05 p.m. Representatives Higgins, Reinbold, Pruitt, Nageak, Keller, Tarr, and Seaton were present at the call to order.

HB 53-CONSULTATION FOR OPIATE PRESCRIPTION

[3:06:49 PM](#)

CHAIR HIGGINS announced that the only order of business would be HOUSE BILL NO. 53, "An Act establishing a consultation requirement with respect to the prescription of opiates under certain circumstances."

[3:07:14 PM](#)

REPRESENTATIVE PRUITT moved to adopt committee substitute (CS) for HB 53, labeled 28-LS0177\C, Martin, 1/30/13, as the working document. There being no objection, it was so ordered.

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REPRESENTATIVE KELLER, as the sponsor of proposed HB 53, explained that the proposed bill was about prescription of pain medications. He opined that many people had used some of the opiates, including Darvon and OxyContin. He clarified that the proposed CS, Version C, was an important work in progress, and he asked that the Department of Health and Social Services not yet take a position on the proposed bill, but instead offer insights and suggestions.

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REPRESENTATIVE KELLER explained that testimony to the Alaska Health Care Commission, on which he served, described "the very negative effects on people who take too much of this category of drugs." He reported that data suggested that some patients who had received "too big a dose of these pain meds for six months have like a 1 or 2 percent chance of ever going back to work. It just rearranges their whole lives." He expressed his desire

to ensure that innocent people were not hurt with an inadvertent overdose. He reported that opiates were addictive, naturally-occurring alkaloids found in the opium poppy. He declared that ever increasing dosage was a warning signal. He explained that the proposed bill used 120 mg of morphine equivalent as a baseline level of concern, as any amount above this would require consultations for prescription.

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REPRESENTATIVE SEATON asked if the proposed bill included pain medications other than opiates, and he questioned whether OxyContin was included in the definition of opiates.

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REPRESENTATIVE KELLER replied that the proposed bill included a spectrum of drugs, which included OxyContin and Darvon. He reiterated that an opiate was an alkaloid found in the opium poppy, and he opined that there were also synthetic versions of the alkaloid.

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REPRESENTATIVE PRUITT directed attention to the handout titled, "What are Opiates?" [Included in members' packets]

[3:13:38 PM](#)

JIM POUND, Staff, Representative Wes Keller, Alaska State Legislature, shared that the original proposed bill had been 4 pages, but, as it had generated a lot of interest, the proposed CS was now expanded to 15 pages. He said that testimony and language from many members of the medical profession, primarily the Alaska Board of Nursing, the Alaska State Medical Board, the State of Alaska Board of Dental Examiners, and the Alaska Board of Pharmacy, had been lumped together. He declared that it was difficult to track individuals when prescriptions were obtained from many doctors. He reported that the Alaska Prescription Drug Monitoring Program had been created in 2008, and was administered in the Department of Commerce, Community & Economic Development. He described that this database listed the patients and the "doctors who are licensed to issue opiate-type painkillers." He declared the intent of the proposed bill was for the database to be checked before a prescription was filled, as these drugs were "just as addictive in the long run as their on-the-street brothers, heroin and opium." He reported that

this problem was growing in Alaska and across the rest of the U.S. He said that these prescriptions were initially taken for pain management, but that the dosages were being increased. He pointed out that the definition in Version C, 120 mg of morphine equivalent, would be the standard.

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MR. POUND shared that Version C also included language for maintenance methadone users, those who were addicted to drugs but were enrolled in a "clean-up process" in clinics. He acknowledged that, although these did not fall into the guidelines of pain management, it was necessary to have communication between the methadone clinics and the primary care physicians. He shared that the proposed CS added some exemptions to pain management programs, including an "end-of-life situation." He pointed out that, with Version C, there was now a four week window before pain management consultation was required for opiate pain killer prescriptions.

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REPRESENTATIVE TARR asked if there would be testimony from the boards mentioned earlier.

MR. POUND replied that there would not be testimony from the boards today.

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REPRESENTATIVE SEATON directed attention to Version C, page 3, line 3, and asked for more information.

MR. POUND replied that this new language was added to existing language and would ensure that the medical professionals check with the Alaska Prescription Drug Monitoring Program database to avoid prescription of additional pain medication to individuals already receiving them.

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REPRESENTATIVE SEATON asked to identify the four week exclusion.

MR. POUND replied that this was included in the general language.

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REPRESENTATIVE KELLER offered his belief that there would be testimony about the aforementioned database from the providers, as it was a relatively new system in Alaska. He reported that the database had been paid for with federal funding. He explained that Version C listed the database use requirements for each medical provider, which made parts of the bill appear repetitive.

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MR. POUND, in response an earlier question regarding the four week window from Representative Seaton, directed attention to page 3, line 10 of Version C.

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REPRESENTATIVE SEATON asked to clarify that, although the consultation was after four weeks, failure to complete a required check of the data base for any level of pain medication prior to prescription could result in a revocation, suspension, or reprimand for the provider's medical license.

MR. POUND expressed his agreement.

REPRESENTATIVE SEATON opined that this was not a workable solution, and he offered his belief that funding for the database would expire in August, 2013. He asked if there was a fiscal note to expand or extend the database.

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MR. POUND expressed his anticipation that there would be a fiscal note for the continuation of the database.

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REPRESENTATIVE KELLER explained that there was a presumption that the database would continue to function, which was incumbent on funding by Department of Commerce, Community & Economic Development.

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MR. POUND, in response to a question from Representative Tarr, said that he would try to get representatives from all the aforementioned boards to testify.

REPRESENTATIVE TARR directed attention to the definition of opiate in statute, and suggested that this was an opportunity to align the language in the proposed bill more specifically with the definition.

MR. POUND read: "opiate means (a) a substance having an addiction forming and addiction sustaining capability similar to morphine or being capable of conversion into a drug having addiction forming or addiction sustaining capability."

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REPRESENTATIVE TARR suggested an alignment of the definitions to alleviate any uncertainty in Version C.

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CHAIR HIGGINS, directing attention to page 3, line 3, noted his background in the health profession as a dentist, and suggested that the pharmacists initiate the search on the database.

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REPRESENTATIVE SEATON mentioned that of the 18 pain management specialists in Alaska, only 4 were outside of Anchorage. He questioned whether these specialists would qualify according to the definition in Version C, page 4, line 23. He noted that Version C did not ensure that a currently licensed pain management specialist would qualify under the proposed bill as new regulations would be adopted. He expressed his concern that there would be sufficient certified pain management specialists in Alaska.

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REPRESENTATIVE KELLER expressed his belief that there would be more qualified specialists than currently, as each of the medical boards would list standards for pain management specialists that would include these minimum qualifications listed on page 4, line 23.

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CHAIR HIGGINS opened public testimony.

[3:33:29 PM](#)

The committee took a brief at-ease.

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CHAIR HIGGINS brought the committee back to order.

[3:35:05 PM](#)

PATRICIA SENNER, Interim Director of Professional Practice, Alaska Nurses Association, stated that proposed HB 53 was fashioned after the far more extensive regulations developed by five State of Washington boards and commissions. She noted that the referral requirement was only one provision of the pain management regulations that were addressed by that group and that there were specific guidelines for assessment of patients with chronic pain, which included a pain plan. She said that the State of Washington did not require a referral to the data base, as it was not yet reliable enough. She suggested that, as nurse anesthetists were involved in pain management in Alaska, this group should also be included in the proposed bill. She expressed three concerns with the proposed bill: how can a required referral be made, as it currently takes months for an appointment with a pain management specialist; how could pain management specialists conduct telephone consultations for controlled substances with rural regions; as 11 of the 18 current pain management specialists were anesthesiologists, there would be a need for nurse anesthetists. She expressed that, as the proposed bill included exemptions for palliative, hospice care, and end of life care, it also recognize non-terminal cancer patients, and she asked for cancer patients to be excluded. She opined that, as the prescription drug data base was new, it often lagged real time in its display of data, and it could be difficult to access from rural areas. She offered her belief that the data base was not yet ready to be a requirement, and she suggested that the aforementioned boards propose some pain management guidelines and regulations.

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REPRESENTATIVE SEATON asked if doctors in the State of Washington were no longer accepting pain management patients because of the complex regulations.

MS. SENNER said that she had also heard this, especially for general practitioners.

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LEON CHANDLER, MD, said that the American Association of Pain Management had asked him to testify, although he was not a member of the association. He reported that he had started pain management in 1988 in Alaska, and that the complications were onerous in the best of circumstances. He offered his help with the proposed bill, but he expressed his concern for the unintended consequences throughout Alaska. He acknowledged that at least four pain management doctors would not see any patients who required medical management for pain control. He declared that the problem was with those individuals who were drug seeking. He stated that he had worked with the Drug Enforcement Agency and he pointed to the difficulty for enforcement of these regulations. He directed attention to the three pedestals required to manage these problems: the prescribing physician, the pharmacy, and the regulatory agency. He noted that there was no longer a Drug Enforcement Agency official in Alaska. He declared that, although the goals of the proposed bill were admirable, there was the need for a mechanism to measure the goals for their impact on the intent of the bill. He recommended inserting a sunset clause in the proposed bill, in case the bill proved to be more of a hindrance than a help. He predicted more difficulties when primary care physicians would no longer write prescriptions. He affirmed that a goal of the medical community was to care for the public. He offered his belief that addictive medications could blend into chemical dependency, and not just addictive personalities. He suggested that the proposed bill be closely scrutinized before it was passed as it could influence the medical care system in Alaska.

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EMILY NENON, Alaska Government Relations Director, American Cancer Society Cancer Action Network, commented that there were many pieces of this complex issue which needed to be addressed. She highlighted that cancer related pain for long term cancer survivors could be chronic, and it could be necessary for opiates to maintain a quality of life, even when there was not active treatment for cancer.

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JUDITH DEARBORN, President, Alaska Association of Nurse Anesthetists, offered some background on certified registered nurse anesthetists (CRNA), describing them as a "type of advance practice registered nurse, prepared at the masters or doctoral

level with specialized education in anesthesia and pain management." She reported that, although Alaska statute recognized CRNAs as "nurse anesthetists," the Alaska Board of Nursing recognized this group of 99 currently active members in Alaska as "certified registered nurse anesthetists." She pointed out that, of the nine Alaska boroughs with anesthesia services, four had anesthesia only provided by CRNAs. In rural communities with CRNAs providing the only available pain management, it would be much more costly for patients to travel elsewhere for service from other providers. She directed attention to the November 1, 2012 directive from the Centers for Medicare and Medicaid Services (CMS) which ruled that, as of January 1, 2013, chronic pain management service provided by CRNAs would be eligible for reimbursement for all authorized Medicare services performed under the specific state law and scope of practice. She reported that the Medicare program in Alaska had approved chronic pain management services as within the scope of practice by CRNAs in Alaska. Directing attention to Version C, page 8, line 16, she requested that "nurse anesthetist" be replaced by "certified registered nurse anesthetists."

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ANNA NELSON, Executive Director, Interior AIDS Association (IAA), said that her organization supported the efforts to curb the abuse and over prescription of opiates. She reported that her program was one of two methadone programs in Alaska, and treated people "with long term, chronic addiction to opiates." She stated that the requirement for consultation with primary care providers in proposed HB 53 did "not acknowledge the reality of much of the addict population, most of whom have no health insurance and hence no primary provider." She remarked that some primary care providers had contributed to the initial addiction, whether well-meaning or negligent. She suggested removal of the consultant requirement from the proposed bill, as its passage would create a major barrier to treatment for opiate addiction. She offered her belief that it contradicted some of the efforts to curb prescription drug abuse. She clarified that methadone, when administered in a supervised treatment program, was tightly regulated and initial treatment dosages were limited by federal regulations. As federal regulations required that the initial dosage be no more than 30 mg, this would make it difficult for a primary care physician to establish a base line dosage. She said that patients were seen by the program almost daily, were tested for other drugs, and were required to participate in counseling and education to help change their

lives. She suggested that the primary care providers consult with the addiction trained medical professionals, pointing out that methadone programs were required by federal law to be licensed, accredited, and registered. She noted that the methadone programs were also closely monitored by the State of Alaska's Division of Behavioral Health. She concluded by stating that the proposed bill did not add accountability and it interfered with the treatment for addiction.

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REPRESENTATIVE SEATON asked for clarification of her reference to a 30 mg equivalent, and how that related to the proposed bill.

MS. NELSON, directing attention to Version C, page 14, line 5, said that the consultation by a health care professional with the patient's primary care provider was meaningless, as federal regulations had determined the initial dosage to be 30 mg, which would then be slowly adjusted by the physician from the methadone program to meet the needs of the patient.

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LARRY STINSON, M.D., Advanced Pain Centers of Alaska, offered his support in principle to proposed HB 53. He suggested that treatment programs and cancer programs be exempt from these requirements. He stated that there was a "true problem nationwide and in the state with overprescribing and overdose of narcotics. It's the number one accidental killer of people in the country, ahead of motor vehicle accidents." He pointed out that an equivalent to 120 mg of morphine was a significant amount of medication. He reported that, of his several thousand patients, only a handful received an equivalent amount of medication, and only for very specific circumstances. He expressed concern that any physician would feel "shackled" by this legislation, and he questioned their practice. He reported that certification as a pain specialist required many years of training and practice. He applauded the intentions of proposed HB 53. He referred to an upcoming report from the State of Washington, which stated that 85 percent of the primary care providers were very satisfied with similar State of Washington legislation that limited prescriptions to an equivalent of 120 mg of morphine. He added that the data also reflected a decrease in suicides, emergency room deaths, and domestic violence. He observed that some aspects of the proposed bill did need modification. He declared that there was a serious

problem, and it was not appropriate to ignore this problem. He offered his belief that proposed HB 53 "goes a long way" toward protecting the public.

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REPRESENTATIVE SEATON asked for suggestions to improve the bill as it was written. He directed attention to Version C, page 3, line 3, and asked if this language should be modified.

[4:00:59 PM](#)

DR. STINSON, in response to Representative Seaton, opined that the current language would be cumbersome as written, and would be difficult to perform. He questioned whether the data base was currently reliable enough "to make it worthwhile." He offered his belief that, for patients exceeding the 120 mg equivalent threshold, it would be appropriate to check the data base monthly. He said that the daily use of 180 mg equivalent increased the risk for death, so it would be beneficial to check for any other prescriptions.

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REPRESENTATIVE REINBOLD asked that Dr. Stinson submit written testimony.

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REPRESENTATIVE TARR, referring to testimony that prescription overdose was the number one killer, asked if this was the result of an individual receiving prescriptions from several providers, or overusing a single prescription.

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DR. STINSON replied that patients often become so tolerant of medication that the dosage was continually increased to gain the benefits. He reported that there was not the same tolerance for the side effects to opioids, which could include respiratory depression.

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REPRESENTATIVE REINBOLD asked to clarify that there would be withdrawal treatment available should the proposed bill limit prescriptions to 120 mg equivalents of morphine.

DR. STINSON said that he would often taper medication for patients. He noted that the University of Washington had an access telephone line with pain experts to give guidance for the tapering of pain medication regimens. He expressed his support for the methadone clinics.

[4:07:12 PM](#)

REPRESENTATIVE SEATON asked what the optimum prescription dosage was to require a check of the database.

DR. STINSON replied that, based on the State of Washington epidemiologic data, it would be appropriate for prescriptions of 120 mg equivalents of morphine to be checked monthly on the data base as this was the point "where bad things started happening in increasing frequency." He declared that acute pain and chronic pain were "two different things." He explained that pain medication following major surgery could be waived, but that ongoing use of opioid medications should be monitored.

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REPRESENTATIVE NAGEAK relayed his own experiences with pain and how he managed it. He extolled the need to keep moving. He acknowledged the "high" feeling from medication, and the desire to maintain this feeling.

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JAY CALDWELL, Medical Director, Narcotic Drug Treatment Center, agreed with Ms. Nelson that the general idea of the proposed bill was "headed in the right direction." He opined that there had been a miscalculation in proposed Section 47.37.175 on page 14, line 5 of Version C. He stated that there were only two health care professional categories for treatment. One category was certified for office based opiate treatment for opiate dependent clients, and the other category was at the federally mandated and operated methadone clinics. He stated that no other physicians in Alaska were authorized to treat drug abuse by patients. He stated that pain management physicians and family practice physicians do not treat drug dependence or abuse. He noted that this proposed section only applied to about 30 physicians, in addition to the 2 physicians at the methadone clinics. He pointed out that the patients at the methadone clinic "are an entirely different breed of patients than in any kind of family or private practice." He said that

many of the patients had become opiate dependent as a result of pain. He explained that the difference between dependence and addiction was a behavioral statement. Individuals who were addicted attempted to maintain opiate levels through anti-social methods, whereas dependence was a chemical statement, not everyone who was dependent was an addict, and not all addicts were necessarily dependent. He said that many of the addicts at the methadone treatment centers had been rejected, or felt they had been rejected, by their physicians. He suggested an elimination of the aforementioned proposed section. He acknowledged that opiates were diverted in both private practice, and in pain medicine clinics whereas, methadone clinics only distributed methadone in a liquid, which was "very, very, very carefully monitored." He reported that the clients received methadone daily for the first three months. He explained that the subsequent weekly dosage, which could be taken from the clinic, was only allowable after extensive social, psychological, and nursing evaluations. He pointed out that regular, unannounced urine testing revealed any other medications. He emphasized that the regulations for discussion between the methadone clinic physicians and the primary care physicians was "not even close to being appropriate and I'm sure you will correct that." He expressed support for the remainder of the proposed bill.

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REPRESENTATIVE KELLER asked to clarify that the two methadone clinics should be exempt. He also asked if the methadone clinic contacted a patient's primary care doctor.

DR. CALDWELL replied that the vast majority of the clients did not have a primary care physician. He reported that the clinic would coordinate an appointment with a physician, or the Anchorage Neighborhood Health Center, for any detection of other medical problems. He noted that the clinic insisted that any pregnant women speak with an obstetrician or health care provider. He offered his belief that the methadone clinics had greater regulation, testing, and control than any others.

[4:23:45 PM](#)

BOB TWILLMAN, Director of Policy and Advocacy, American Academy of Pain Management, stated that the American Academy of Pain Management was opposed to proposed HB 53, although it was sympathetic to the intent to provide "good care for people who are on high dose, long term, opioid therapy." He expressed

concern that this method of intervention would not be workable, would have unintended negative consequences, and, based on the Academy's experiences with similar legislation in the State of Washington, would not achieve the goal. He stated that numerous reports suggested that primary care providers would no longer provide pain medication. He offered his belief that this was due to fear by primary care providers for lack of clarity for the rules. He suggested studying the long term results in the State of Washington prior to passing legislation. He pointed out that there were "access problems for people with pain in Washington." He briefed that pain specialists had expressed concern that their appointments were filled with consultations, with the referring primary care physicians assuming that the pain specialist would take care of the patient. The pain specialists declared that the primary care doctors would not take the patients back. He suggested some other interventions, including full funding of the prescription monitoring program, a requirement that all dispensers of pain medication register to access data from the program, and to allow delegates of the dispensers to obtain the reports from the program. He suggested that the monitoring program send unsolicited reports to prescribers if any suspicious behavior was detected, and he endorsed continuing education programs for prescribers about pain management and substance abuse screening, diagnosis, and treatment. He observed that a commission, task force, or interim study committee would be a better alternative to immediate legislation.

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REPRESENTATIVE REINBOLD asked that the proposed solutions be submitted in writing.

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RON GREENE, Clinical Director, Narcotic Drug Treatment Center, shared that there had been not been an overdose in this methadone program, which he attributed to the regular, unscheduled urine tests. He declared that the majority of people take prescriptions as prescribed; however, there was a portion of the population that had problems with addiction to medication.

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REPRESENTATIVE KELLER asked about the largest methadone dosage prescribed in the program.

MR. GREENE replied that the initial dosage was 30 mg, but this dosage could be increased after consultation if there were still signs of withdrawal. He declared that there was not a limit to the amount of methadone. In response to Representative Keller, he pointed out that there was always a risk for death with prescription medication, but since inception of the program in 1974, he had not heard of any overdose deaths in the program. He declared that about 10 percent of the methadone deaths occurred after the initial dose, hence the federal regulations limiting this to 30 mg.

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BARRY CHRISTENSEN, Alaska Pharmacist Association, said that pharmacists filled narcotic prescriptions daily, and as these reports were then submitted each month to a central data base, the posted data would be at least a month old. He expressed concern that proposed HB 53 would require pharmacists to check the data base for every opioid prescription, which included cough syrup and pain pills. He questioned the procedure should the website not be operating or the pharmacy not have internet access. He asked about continued funding for the data base program. He asked that the Alaska Board of Pharmacy be involved with the writing of the regulations regarding pharmacists.

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REPRESENTATIVE REINBOLD asked if the governor had budgeted any funding for this program.

MR. CHRISTENSEN replied that he did not know.

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REPRESENTATIVE SEATON, referring to Version C, page 13, line 25, asked if his association had any comment for making this a mandatory program and its effect.

MR. CHRISTENSEN replied that, as Version C had just been released, there had not been any discussion. He said that although he used the data base whenever he had a concern, the association was also concerned with a requirement to check on every opiate prescription.

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CHAIR HIGGINS left public testimony open.

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REPRESENTATIVE SEATON asked that the sponsor review page 13, line 28, "or providing medical care to a person," for any unintended consequences.

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REPRESENTATIVE KELLER, in response to Representative Tarr, said that, as the sponsor for proposed HB 53, he would accumulate all the suggestions in a proposed blank committee substitute.

[4:38:15 PM](#)

CHAIR HIGGINS expressed his agreement.

[HB 53 was held over.]

[4:38:51 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:38 p.m.