ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
10740 HOUSE HEATH EDUCATION & SOCIAL SERVICES

In Washington, we have also given them a year to comply with the new format. It is not the intent of community pharmacy to over burden the insurance companies by having to "drop everything" and issue new cards. That being said, some companies do not issue new cards unless there is a major change in benefit or claims processor. We would like them to be required to issue the new cards within the 12 month time frame.

I would be happy to provide you with the rules adopted in Oregon as well as the statutes enacting both laws if that would be of assistance in writing the letter of intent as discussed yesterday. As part of the letter, it may also be helpful to outline to whom this law applies. It is important to pharmacists that it apply across the board to any entity issuing cards that can be used for acquiring prescription drug benefits.

Again, thank you so much for your support of community pharmacy. If I can be of assistance to you or Willow, please do not hesitate to call.

Sincerely,

Lis Merten

Lis Houchen Merten
Regional Director, State Government Affairs
924 Capitol Way South, Suite 216
Olympia, WA 98501
(360) 236-1246
lmerten@nacds.org

cc: Nancy Davis, AKPhA
Frank Bickford

Subject: HB 32-Uniform Prescription Card
Date: Wed, 07 May 2003 10:01:19 +0000
From: aimee.mortemore@att.net
To: Representative_Tom_Anderson@legis.state.ak.us, Representative_Bob_Lynn@legis.sate.ak.us, Representative_Nancy_Dahlstrom@legis.state.ak.us, Representative_Carl_Gatto@legis.state.ak.us, Representative_Norm_Rokeberg@legis.state.ak.us, Representative_Harry_Crawford@legis.state.ak.us, Representative_David_Guttenberg@legis.state.ak.us.

Please vote in favor of HB32 when it comes to Committee.

A uniform prescription drug card will greatly benefit the citizens of Alaska. They will be able to obtain their prescription medication with much less hassle.

Thank You,
Aimee Mortemore
330 Old Steese Hwy #344
Fairbanks, AK 99701
aimee.mortemore@att.net
Pharmacist at Fairbanks Memorial Hospital

Subject: HB 32
Date: Wed, 07 May 2003 06:48:41 -0800
From: Roger Penrod <pharmboy@gci.net>
To: Tom Anderson <Representative_Tom_Anderson@legis.state.ak.us>

Representative Anderson,

Please vote in favor of HB 32 when it comes to your committee.

Roger Penrod R.Ph.
Fairbanks, AK

Roger Penrod <pharmboy@gci.net>
Staff Pharmacist
Fairbanks Professional Pharmacy

Subject: HB32-Uniform Prescription Drug Card
Date: Wed, 7 May 2003 02:11:59 -0800
From: "Roger Mortemore" <r.mortemore@worldnet.att.net>
To: <Representative_Tom_Anderson@legis.state.ak.us>,
<Representative_Bob_Lynn@legis.state.ak.us>,
<Representative_Nancy_Dahlstrom@legis.state.ak.us>,
<Representatvie_Carl_Gatto@legis.state.ak.us>,
<Representative_Norm_Rokeberg@legis.state.ak.us>,
<Representatvie_Harry_Crawford@legis.state.ak.us>,
<Representative_David_Guttenberg@legis.state.ak.us>

Please vote in favor of HB 32 when it comes to committee.

This bill will help the citizens of Alaska and the Pharmacists of Alaska to better serve the public. It will save time and money by not wasting time making phone calls to the insurance company which will allow the sick patients to return home and work much quicker.

Thank You,

Roger Mortemore, R.Ph.
Member, Board of Directors,
Alaska Pharmacist Association
1550 Holy Cross
Fairbanks, AK 99709
r.mortemore@att.net
Pharmacy Manager/Pharmacist
Safeway Bentley Mall
30 College Road
Fairbanks, AK 99701

January 28, 2003

Representative John Coghill
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Coghill,

I commend you for your introduction of HB 32 concerning Uniform Prescription Information Cards. This legislation will benefit the general public in many ways. The first thing it will accomplish is saving time for the patient when at a pharmacy to get a prescription drug order filled. Having this information in a clear format will allow the pharmacists and technicians of the given pharmacy to enter the insurance information into the computer in a timely manner and will help to avoid calls to the insurance company "help desk". These calls to insurance companies are quite time consuming and you usually have to navigate through a voice message maze to get the answers you need. Secondly, by clarifying this information, it is a time saving factor that allows the pharmacist to spend more time with their patient (customer) to be sure they understand their medications.

As you may know, nineteen states have already enacted this type of legislation. It truly provides a win-win situation for the consumer and the provider. Thank you for your time.

Sincerely,

Roger Penrod, RPh.
Fairbanks Professional Pharmacy
1001 Nobel Street
Fairbanks, AK 99701
907/452-2556

Subject: HB 32
Date: Wed, 30 Apr 2003 00:52:22 -0800
From: Gerald KW Brown <gkwbrown@alaska.com>
Organization: Brown Family Computer
To: Representative_Tom_Anderson@legis.state.ak.us

Dear Chairperson Anderson,

I am writing you asking you to support HB 32, which is asking for Uniform and standard information to be put on all health care and Prescription Coverage cards issued to to all insured in the State of Alaska. Too many times, we get blank cards (No names or id numbers) cards that lack information as to where to send the information, what company to send it to, what numbers need to be submitted, who the card holder is what control, group or carrier numbers are, who to call if we have questions, this all takes time (some times 15-60 minutes or longer) somes times they are only open 9:00AM - 5:00PM Eastern time so when we get a prescription at 8PM the help desk is closed 4 hours earlier and won't be open til 9AM then next day or Monday, and we have a small child with and ear ache or need pain medication for a burn or broken arm. All we are asking for is to have the needed information issued on the card. simple straight forward. Thank you

Gerald KW Brown, President
Alaska Pharmacists Association
gkwbrown@alaska.com
907-452-1514

Subject: HB 32
Date: Tue, 29 Apr 2003 22:49:45 -0800
From: "Eric and Angie LeBoeuf" <ericleb@alaska.net>
To: <Representative_Tom_Anderson@legis.state.ak.us>

Angie LeBoeuf<?xml:namespace prefix = o ns =
"urn:schemas-microsoft-com:office:office" />

PO Box 110982

Anchorage, AK 99511

April 29, 2003

The Honorable Representative Tom Anderson

State Capitol

Juneau, Alaska

Dear Representative Anderson ,

I would like to ask you to vote in favor of HB 32 when it comes to your committee. This bill will ease the already over tasked pharmacy staff by making the billing process direct and smooth . The end result will be a happier citizen who receives his or her medication in a more timely manner. Currently some insurance cards do not contain all the necessary information needed to process a prescription claim. HB 32 will require that information on the insurance card and prevent unnecessary phone calls to insurance providers. It is a win-win situation for all.

Thank you.

Sincerely,

Angie LeBoeuf

Pharmacist

South Anchorage

Subject: HB 32- Uniform Prescription Drug Card
Date: Tue, 29 Apr 2003 09:32:52 -0800
From: Barry D Christensen <island.pharm@juno.com>
To: Represenative_David_Guttenberg@legis.state.ak.us,
Representative_Harry_Crawford@legis.state.ak.us,
Representative_Norm_Rokeberg@legis.state.ak.us,
Representative_Carl_Gatto@legis.state.ak.us,
Representative_Nancy_Dahlstrom@legis.state.ak.us,
Representative_Bob_Lynn@legis.state.ak.us, Representative_Tom_Anderson@legis.state.ak.us
CC: BPGAlaska@aol.com

Dear Members of the House Labor and Commerce Committee,

As a practicing Community Pharmacist in Ketchikan I urge your support for HB 32 when it appears in your committee. The intent of the bill is to provide for consistent information on prescription drug cards so that pharmacist and patients aren't hindered in picking up a prescription simply because of a lack of information or misinformation on a prescription drug card. The bill is simply a win/win/win for pharmacists/patients/insurance companies in terms of simplifying the filling of a prescription involving a prescription drug card.

The bill does not require the insurance industry to reissue cards immediately so it should not have a fiscal impact upon them. The bill only requires that when they do reissue cards that they follow a format that
will provide pharmacist with the information they need to bill the patients insurance without have to make
multiple phone calls to the insurance company.

Again, I urge your suuport for HB32. If you have any questions regarding this bill please do not hesitate to contact me.

Sincerely,

Barry Christensen, Pharmacist
Island Pharmacy 3526 Tongass Ave.
Ketchikan,AK 99901
Phone: 907-225-6186 Fax: 907-225-6187
e-mail: island.pharm@juno.com

January 28, 2003

Representative John Coghill
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Coghill,

I commend you for your introduction of HB 32 concerning Uniform Prescription Information Cards. This legislation will benefit the general public in many ways. The first thing it will accomplish is saving time for the patient when at a pharmacy to get a prescription drug order filled. Having this information in a clear format will allow the pharmacists and technicians of the given pharmacy to enter the insurance information into the computer in a timely manner and will help to avoid calls to the insurance company "help desk". These calls to insurance companies are quite time consuming and you usually have to navigate through a voice message maze to get the answers you need. Secondly, by clarifying this information, it is a time saving factor that allows the pharmacist to spend more time with their patient (customer) to be sure they understand their medications.

As you may know, nineteen states have already enacted this type of legislation. It truly provides a win-win situation for the consumer and the provider. Thank you for your time.

Sincerely,

Roger Penrod

Roger Penrod, RPh.
Fairbanks Professional Pharmacy
1001 Nobel Street
Fairbanks, AK 99701
907/452-2556

Washington
December 04, 2002
Proposed Rules
Office of Insurance Commissioner - WAC 284-43

WSR 02-23-092
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER
[Filed November 20, 2002, 10:17 a.m.]
Original Notice.
Preproposal statement of inquiry was filed as WSR 02-14-151.
Title of Rule: Pharmacy identification cards.
Purpose: This proposed regulation will implement RCW 48.43.023.
Statute Being Implemented: RCW 48.43.023.
Summary: RCW 48.43.023 requires an entity that provides coverage for prescription drugs provided on an outpatient basis and issues a card or other technology for claims processing to issue to its enrollees a pharmacy identification card or other technology containing all information required for proper prescription drug claims adjudication.

Reasons Supporting Proposal: This proposed regulation will implement RCW 48.43.023.
Name of Agency Personnel Responsible for Drafting and Implementation: Janis LaFlash, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7040; and Enforcement: Carol Sureau, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7050.

RCW 48.43.023 requires that a health plan that provides coverage for prescription drugs and issues a card or other technology for claims processing must include all information required for proper prescription drug claims adjudication. RCW 48.43.023(5) states that in the rule making the insurance commissioner should consider any relevant standards developed by the **National Council** for **Prescription Drug Programs NCPDP** and the requirements of the federal Health Insurance Portability and Accountability Act of 1996.

Date of Intended Adoption: January 22, 2003.
November 20, 2002
Mike Kreidler
Insurance Commissioner
OTS-6058.2
SUBCHAPTER C
PROVIDER ((~~AND FACILITY~~)) CONTRACTS AND PAYMENT
NEW SECTION
WAC 284-43-323 Pharmacy identification cards. (1) This rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

(2) The pharmacy identification card or other technology must include the data element consistent with the "BIN number," "IIN/BIN number" or "RxBIN" which is the ANSI assigned international identification number, identified in the National Council for Prescription Drug Programs (**NCPDP**) Pharmacy ID Card Implementation Guide. Other data elements of the **NCPDP** Guide must be included on the card only if they are required for the processing of claims.

(3) This rule does not compel the issuance of a separate pharmacy identification card provided that the enrollee health plan identification card contains the required data elements.

(4) All plans that use a card or other technology for prescription claims processing that are delivered, issued for delivery or renewed on or after July 1, 2003, must comply with the requirements of this rule.

ALASKA STATE HOUSE OF REPRESENTATIVES

Interim Address:
3044 Badger Road, Suite 290
North Pole, AK 99705
(907)-488-5725
Fax# (907)-488-4721

Session Contact:
(907)-465-3719
FAX# (907)-465-3258
State Capitol
Room 204

REPRESENTATIVE JOHN COGHILL
MAJORITY LEADER

Acronym List

ANSI – American National Standards Institute
BIN – Business Identification Number
GRP – Group Number
HIPPA – Health Insurance Portability and Accountability Act
IC – Insurance Commissioner
IIN – Issuer Identification Number
NCPDP – National Council for Prescription Drug Programs
PCN – Processor's Control Number

Representative_John_Coghill@LEGIS.state.ak.us

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
AL H 275 (AL ST § 27-1-22) **Enacted** – 4/20/00 **Effective** – 8/1/00; 1/1/01 (for new plans)	Yes	No.	Yes – Insurance Commissioner responsible for enforcement(health benefit plan may not conduct business in AL if in violation of law).		Issued upon enrollment; reissued upon any change in enrollees plan that impacts the information on card or if NCPDP revises guidelines.
AR S 800 (AR ST §23-80-401 et. seq) **Enacted** – 4/9/01 **Effective** – 4/9/03 (upon enactment per emergency clause) See Bulletin 8-2001, dated 11/14/2001.	Yes	No.	Yes – Empowers Insurance Commissioner to promulgate administrative rule to establish format (that complies with national standard); IC responsible for enforcement.		Issued upon enrollment; reissued upon any change in enrollees plan that impacts the information on card.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
CA A 207 (Health and Safety Code Section 1363.03; Insurance Code Section 10123.194) **Enacted** – 10/8/01 **Effective** – 7/1/02	No.	(1) The name or logo of the benefit administrator or health care service plan issuing the card, which shall be displayed on the front side of the card. (2) The enrollee's identification number, or the subscriber's identification number when the enrollee is a dependent who accesses services using the subscriber's identification number, which shall be displayed on the front side of the card. (3) A telephone number that pharmacy providers may call for assistance. (4) Information required by the benefit administrator or health care service plan that is necessary to commence processing the pharmacy claim.	No.	Card issuer not required to include the following on the card: (A) Any number that is the same for all of its members, provided that the health care service plan provides this number to the pharmacy on an annual basis. (B) Any information that may result in fraudulent use of the card. (C) Any information that is otherwise prohibited from being included on the card; insurer can issue card or "other technology that performs substantially the same function as a card"; willful violation of act is a crime.	Issued upon enrollment and reissued upon any change in the enrollee's coverage that impacts the data on the card; insurer not required to issue a separate card for rx coverage if the plan issues a card for health insurance in general so long as the card can accommodate all of the required elements; does not apply to nonprofit health plans with 3.5 million + enrollees owning/operating own pharmacies and providing health care services to enrollees in specific geographic area through a mutually exclusive contract with a single medical group.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
CO S 188 (New section to CRS Title 10, Article 16, Part 1) **Enacted** – 6/7/02 **Effective** – 1/1/03	Yes – card to be NCPDP approved format, contain all required and situational fields, and comply with most current implementation guide	No.	No.		Card must be issued upon enrollment and reissued when a person's coverage changes and the change affects data on the card or device.
FL S 1412 (627.4302) **Enacted** -- 5/13/02 **Effective** – 10/1/02	No.	(a) Name of the claims processor; (b) BIN / ANSI number; (c) Group number; (d) Patient identification number; (e) Patient name; (f) Claims submission name and address; (g) Help desk telephone number; and (h) Any other information that the entity finds will assist in the processing of the claim. (a), (b), (g), and (h) must be on the card unless instruction is provided on the card for ready access to such information by electronic means. Card must present info in a manner that is readily identifiable or the info must be embedded in the card through a magnetic strip or smart card.	No.		Card must be issued upon enrollment or renewal of policies after 10/1/02; card must be reissued no later than 60 days after any info on the card changes and becomes effective; may issue a sticker with updated info in lieu of new card until renewal card is sent.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
GA H 670 (33-24-57.1) **Enacted** – 5/1/00 **Effective** – 7/1/00	No.	(1) Subscriber's name and (A) names of all other persons included under the subscriber's coverage; or (B) If a separate card is issued for each person included under subscriber's coverage, the name of covered person for whom such card is issued may be alternatively listed (2) Subscriber's identification number; (3) Group number, if applicable; (4) Effective date of coverage; (5) Name of the subscriber's primary care physician, if applicable; (6) Name of the subscriber's insurer, the name of the health plan, and the plan type or product name, if applicable; (7) Address of office where claims to be filed; (8) Insurer's contact phone numbers and the phone number for coverage confirmation and preauthorization, if applicable; (9) Policy's requirements as to copays, co-insurance payments, or deductibles, as applicable; (10) Either name of the primary hospital and of laboratory and radiology services to be used or toll-free or local number for contacting the health plan and obtaining such information. Such a toll-free or local telephone number shall be available to health care providers and consumers to obtain eligibility and coverage information from at least 7:00 A.M. until 9:00 P.M. daily on Monday through Friday, whether staffed by a live person or via an automated phone-line basis; (11) BIN (12) PCN (13) Pharmacy help desk number & name	No.		Issued upon enrollment; reissued when any information required to be on the card changes; Annual renewal stickers may be issued.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
IA S 452 (514L.1; 514L.2; 514L.3) **Enacted** – 3/26/01 **Effective** – 7/1/03	Yes – Requires Commissioner of Insurance to consider standard when adopting rules.	(1) The international identification number (2) The covered individual's identification number (3) The telephone number of the pharmacy benefits administrator, if different from the provider (4) The processor control number, if required for adjudication (5) The group number, if required for adjudication (6) The person code, if required for adjudication	Yes – Empowers the Commissioner of Insurance to adopt rules to implement.	Note that elements required include "person code" if necessary for adjudication.	Issued upon enrollment; reissued when any information required to be on the card changes.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
IL H 4176 (IL ST CH 215 § 138/15) **Enacted** – 4/15/00 **Effective** – 1/1/01	No.	Front of card: (1) BIN number; (2) Processor control number if required for claims adjudication; (3) Group number; (4) Card issuer identifier; (5) Cardholder ID number; and (6) Cardholder name. Back of card: (1) Claims submission names and addresses; and (2) Help desk telephone numbers and names.	Yes – Empowers Insurance Director to promulgate any regulations necessary to implement the state's responsibilities with respect to the card; to enforce ,the Director , may issue a cease and desist order or require a health benefit plan to submit a plan of correction for violations & may impose upon a health benefit plan an administrative fine not to exceed $250,000 for failure to submit a requested plan of correction, failure to comply with its plan or correction, or repeated violations of this Act		Issued upon enrollment; reissued when any information required to be on the card changes.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
IN H 1958 (IC §§ 27-8-5.8-4; 27-1-9-5) **Enacted** – 5/10/01 **Effective** – 7/1/02 (for compliance)	Yes.	(A) The health benefit plan's name. (B) The insured's name, group number, and identification number. (C) A telephone number to inquire about pharmacy related issues. (D) The issuer's international identification number or ANSI BIN number, labeled as RxBIN. (E) The processor control number, labeled as RxPCN. (F) The insured's pharmacy benefits group number if different than medical group number, labeled as RxGRP.	Yes.	Card must be in format approved by NCPDP or contain certain elements which are required to properly adjudicate a claim (listed to the left); insurer may issue card or other technology;	Cards must be issued upon enrollment; insurers not required to issue more than one card within 12 month period.
MD S 686 (Insurance Section 15-130; Health - General Section 19-706(rr)) **Enacted** – 4/15/01 **Effective** – 10/1/01; 7/1/02 (for compliance)	Yes.	(i) the name or identifying trademark of the entity subject to this section or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator; (ii) the name and identification number of the insured, subscriber, or enrollee; (iii) the telephone number that providers may call for pharmacy benefit assistance; and (iv) all electronic transaction routing information and other numbers required by the entity subject to this section or benefit administrator to process a prescription claim electronically.	No – but empowers the Department of Health to adopt regulations to enable managed care providers to comply with law.	Elements required on card include "electronic transaction routing information and other numbers" required by plan to process claim (does not specify); does not require card to have claims billing address on back; allows insurers to provide enrollees with card or "other technology".	Issued upon enrollment; reissued when any information required to be on the card changes or give enrollee any corrective information required to process claim; HMOs that own and maintains pharmacies that dispense 95% of rx's not required to comply.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
MN H 926 (Minnesota Statues, section 62J.60) **Enacted** – 5/17/01 **Effective** – 1/1/03; 7/1/03 (for compliance)	Yes.	A. Information window containing the following elements (left justified): 1. card issuer name, 2. electronic transaction routing information, 3. card issuer identification number, 4. cardholder (insured) identification number, 5. and cardholder (insured) identification name. B. Card issuer name or logo C. Complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line; D. Card issuer identification number; E. cardholder (insured) identification number; F. cardholder (insured) identification name G. care type H. service type I. provider/clinic name Back: A. Claims submission names and addresses B. Phone numbers and contact names for eligibility, utilization review, precertification, or customer service information.	No. But, group purchaser must certify compliance with standard card law in annual filing made on or after 1/1/03 to Commissioner of Health or Commerce.	Insurer does not have to issue a new card if the MN uniform health care ID card can accommodate all of the elements required to be on the card; Situational or conditional fields must comply with NCPDP standards.	Issued upon enrollment, reissued upon any change in enrollee's health plan that impacts the data on the card; stickers may be used to temporarily update the information on the card.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
MS S 2412 **Enacted** – 4/11/02 **Effective** – 1/1/03	Yes – Insurance Commissioner to take into consideration NCPDP standard when developing regs.	(a) issuer's name or logo (front of card); (b) Patient name and ID number (front of card); (c) ANSI Issuer Identification Number; (d) Processor's control number; (e) Patient's group number; (f) Name and address for claims submission; (g) help desk telephone number. Insurer not require to issue separate card if the required elements are on the health benefit card.	Yes – Empowers Insurance Commissioner to issue any rules to implement the act.		Insurer to provide patient with new card "within reasonable time after any information required to be on card changes; insurer to issue first card for plans that are delivered, issued for delivery or renewed on or after January 1, 2003
NC S 513 (§58-3-177) **Enacted** – 7/22/99 **Effective** – 7/22/99; 7/1/00 (for compliance); 1/1/03 (to comply with electronic processing requirement)	No.	Front: (1) The health benefit plan's name and/or logo. (2) The American National Standards Institute assigned Issuer Identification Number. (3) The processor control number. (4) The insured's group number. (5) The health benefit plan's card issuer identifier. (6) The insured's identification number. (7) The insured's name. Back: (1) The health benefit plan's claims submission name and address. (2) The health benefit plan's help desk telephone number and name.	No.		New card must be reissued annually, if there has been a change in the insured's coverage within the past 12 months.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
ND H 1365 (NDCC 26.1-36 & 54-52.1) **Enacted –** 3/13/01 **Effective –** 8/1/01	Yes.	No.	Yes – Empowers Insurance Commissioner to accept a "national format' as an alternative to the NCPDP standard.	Card must conform with NCPDP standards OR any "national format" accepted by the Insurance Commissioner.	Issued upon enrollment; reissued when any information required to be on the card changes; card issuer may issue stickers (approved by commissioner) to update card.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
NJ S 1330 (NJ Statues Title 17B) **Enacted** – 8/8/01 **Effective** – 9/1/02	Yes – card must comply with NCPDP standards or contain certain required elements.	(1) the name or identification number of the health benefits plan, when required for proper claims adjudication; (2) the American National Standards Institute International Identification Number assigned to the administrator or pharmacy benefits manager of the health benefits plan, labeled as RxBIN, when required for proper claims adjudication; (3) the processor control number, labeled as RxPCN, when required for proper claims adjudication; (4) the insured's group number, labeled as RxGRP, when required for proper claims adjudication; (5) the insured's identification number; (6) the insured's name; except that, if a separate card is issued for another person included under the primary insured's coverage, the name of the covered person to whom the card is issued may be listed instead of the name of the primary insured; (7) the telephone number that providers may call for pharmacy benefits assistance; and (8) any other information necessary for proper claims adjudication, except for information provided on the prescription as required by law or regulation.	Yes – Commissioner of Banking and Insurance to adopt regulations to implement.	Must issue card or other technology; insurer not required to issue a separate card for the pharmacy benefit if another ID card contains all of the required element; insurers may use other data elements as required by HIPAA (1996) in place of the elements required by NCPDP or the elements (listed here to the left).	Issued upon enrollment, reissued within a "reasonable time" (not to exceed 180 days) of change of enrollee's plan that effects data on card; insurer not required to reissue a card more than one time per year.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
NV A 415 (NRS Ch. 679B.133) / regs: NAC 679B (new section) **Enacted** – 5/28/01 **Effective** – 1/1/03	Yes – must comply to NCPDP standard or have certain elements on the card.	(a) The name or logo of the administrator issuing the card or device. (b) The insured's identification number, which must be displayed on the front side of the card or device. (c) The name and address of the administrator to which prescription claims that are not processed electronically or correspondence should be sent. (d) The telephone number that providers may call for assistance concerning pharmacy benefits. (e) Complete information concerning routing of electronic transactions, including, without limitation, the international identification number and, if required by the administrator to process the claim, the processing control number and group number. The information on the card or device must be arranged in a manner that corresponds both in content and form to the content and form required by the plan to process the claim.	Yes – Commissioner to adopt regulations to ensure compliance	Insurer may issue card or other device; this rules only applies to insurers who issue a single ID card for prescription drug benefits; elements of card must also be consistent with HIPAA; insurer not required to issue a separate ID card for prescription benefits if the general health ID card contains all information required for claims adjudication; regs state that an insurer that issues a health plan shall not delay or deny payment of any claim for pharmacy benefits solely on the basis that the prescriber does not have a DEA number; and shall not use a false registration number to process a claim.	Issue upon enrollment, reissue upon renewal;

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
OK H 2719 (OK Statutes Title 36, Section 3634.4) **Enacted** – 6/5/02 **Effective** – 1/1/04	No.	Required on front of card: a. card issuer name or logo d. card holder identification, e. card holder name Required on card - placing unspecified: a. IIN/BIN number labeled as IIN or BIN, b. the Processor Control Number (PCN), labeled as PCN c. the group number, labeled as GRP d. card issuer identification, e. claims processor name and address, and f. a help desk phone number	Insurance Commissioner responsible for enforcement of law and must promulgate rules; IC has authority to impose penalties, etc. to bring noncomplying companies into full compliance.	Insurer may issue card or other technology	Card issued upon enrollment and reissued within a reasonable period upon any change in coverage impacting data on card
OR H 2763 (ORS Ch. 743) **Enacted** – 6/22/01 **Effective** – 7/1/03	No.	No.	Yes – The Director of the Department of Consumer and Business Services shall adopt rules and must consider any national standards developed by a relevant standards development organization approved by ANSI.	Insurer must issue card or other technology that contains all current information required for claims adjudication.	Requires insurer to issue card upon renewal.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
SD S 87 (SD ST § 58-1-19) **Enacted** – 3/3/01 **Effective** – 7/1/02	Yes.	No.	Yes – Empowers Director of Commission of Insurance to consider NCPDP standard when prescribing the elements and format of the card and consider NCPDP implementation guide.	Health benefit plan not required to issue a pharmacy identification card separate from another identification card if the identification card contains the elements of information required by the Division of Insurance.	Issued upon enrollment; reissued when any information required to be on the card changes (but not required to issue more than one card a year).

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
TN S 2769 (TN ST § 56-7-2361) **Enacted** – 6/19/00 **Effective** – 6/19/00; 7/1/01 (for compliance)	No.	(1) The health benefit plan's name and issuer identifier; (2) The American National Standards Institute Issuer Identification Number assigned to the administrator or pharmacy benefit manager of the plan, when required for proper claims adjudication *[Bin Number]*; (3) The processor control number, when required for proper claims adjudication; (4) The insured's group number, when required for proper claims adjudication; (5) The insured's identification number; (6) The insured's name; and (A) The names of all other persons included under the subscriber's coverage and individual identification number information if applicable and required for pharmacy claims processing; or (B) If a separate card is issued for each person included under the subscriber's coverage, the name of the covered person for whom such card is issued may be listed in lieu of the information required by item (A) above.	Yes – Commissioner of Commerce and Insurance responsible for enforcement of law; empowers commissioner to promulgate any rules necessary; health benefit plans found to be in noncompliance subject to the imposition of the penalties and other remedies set forth at Tennessee Code Annotated, Sections 56-1-801(Class C misdemeanor), 56-8-109(civil penalty of $1,000-$50,000), and 56-32-220 (administrative penalty of $1,000-$10,000)	HIPPA adopted identifiers may be used as substitute for any of the listed elements; health benefit plan not required to issue a pharmacy ID card separate from another ID card if the card contains the required elements.	

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
TX S 1237 (Insurance Code Article 21.53L) **Enacted** – 5/30/99 **Effective** – 1/1/00; does not specify date by which IC must adopt rules	No.	1. Enrolled subscriber's or enrolled dependents' names and identification codes 2. Name or logo of the issuer (if applicable); 3. Name or logo of the administrator or pharmacy benefit manager (if different from the health benefit plan); 4. Group / policy number (if applicable); 5. Effective date of coverage; 6. A telephone number for obtaining information relating to covered pharmacy benefits; 7. Copayment information for generic and brand-name prescription drugs; and 8. International Identification Number / Banking Identification Number, assigned by the American National Standards Institute (if applicable)	Yes – Empowers commissioner to adopt rules.	Note – Elements required on card include effective date of coverage and copay amount for brand vs. generic drugs.	Issued upon enrollment; reissued when enrollees coverage is modified; if health benefit plans that administers own pharmacy benefits to issue a card separate from any ID card issued under the plan if the card contains the required elements.
VA H 1176 (38.2-3407.4:2) **Enacted** – 4/5/00 **Effective** – 7/1/02	Yes.	No.	Yes – only states "card shall not be considered part of the evidence of coverage and shall not be required to be filed with or approved by the Commission".		Issued upon enrollment; reissued upon changes to data required to be on card.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

Standard Prescription Benefit Card Legislation

State / Bill Number / Status	Refers to NCPDP Standard?	Lists elements?	Refers to Insurance Commissioner	Misc. Notes	When Issued? When Reissued?
VA H 2654 (38.2-3407.4:2) **Enacted** – 3/19/01 **Effective** – 7/1/02	Yes.	1. The name or identifying trademark of the insurer, corporation, or health maintenance organization or, if another entity administers the prescription benefit, the name or identifying trademark of the benefit administrator; 2. The insured's, subscriber's, or enrollee's name and identification number; 3. The telephone number that providers may call for pharmacy benefit assistance; and 4. The electronic transaction routing information and other numbers required by the insurer, corporation, health maintenance organization or benefit administrator to electronically process a prescription claim.	No.		Issued upon enrollment; reissue card with any changes in the required data elements or give enrollee any corrective information required to process claim.
WA S 5566 (New section to 48.43 RCW) **Enacted** – 4/19/01 **Effective** – 7/1/03	Yes.	No.	Yes – Empowers Insurance Commissioner to promulgate rules to implement act; requires IC to take into consideration NCPDP elements and HIPPA requirements when setting required elements on card.		Issued upon enrollment; reissued upon renewal… but not if card already contains all required elements.

Prepared by the National Association of Chain Drug Stores
Current as of 6/7/02

SITE: **OFFNETS**	*SUBJECT OF MEETING:* HB32
COMMITTEE: House Labor & Commerce	*UPDATE #:* 1
DATE: 5/7/03	

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
✓ Barry Christensen	AK Pharmacists Assoc.		Y HB32

Nnn

HB

51

ALASKA STATE LEGISLATURE

Chair
FISHERIES

Vice-Chair
EDUCATION

Member
HEALTH, EDUCATION AND SOCIAL SERVICES

Member
STATE AFFAIRS

REPRESENTATIVE PAUL SEATON
House District 35

Session:
State Capitol Building
Juneau, Alaska 99801
Phone 907-465-2689
Fax 907-465-3472
1-800-665-2689
Rep.Paul.Seaton@legis.state.ak.us

Interim:
345 W. Sterling Highway
Suite 102B
Homer, Alaska 99603
Phone 907-235-2921
Fax 907-235-4008

MEMORANDUM

TO: Representative Peggy Wilson, Chair
House HESS Committee

FM: Representative Paul Seaton

DATE: January 28, 2003

RE: Committee Hearing for HB 51

At your earliest convenience could you please schedule House Bill 51 for a committee hearing. Attached you will find a copy of the bill and a sponsor statement. If you have any questions please feel free to call me anytime or speak with my lead staff, Chris Knight at ext. 6867

Alaska State Legislature

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Fax: 465-3472
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Homer, AK 99603
Phone: 235-2921
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REPRESENTATIVE Paul Seaton
District 35

Sponsor Statement

HB 51

"An act requiring pharmacists to include generic drug information on containers in which brand-name prescriptions drug orders are dispensed."

As medical technology advances, many senior citizens are taking many different prescription medications to live a longer, healthier life. Seniors receive prescriptions from many different sources, AARP, internet pharmacies, mail order, insurance companies and through local pharmacies as well. Increased availability suggests that drug takers may be taking multiple prescriptions of the same drug, which may be sold under a brand or the generic name. Double dosing may cause severe over-medication leading to serious side effects or even be life-threatening. House Bill 51 was introduced to safeguard Alaskans from overdosing on the same prescription medication.

HB 51 requires pharmacists to include the generic drug name on containers in which a brand-name prescription drug is dispensed. Under this bill, if a person receives a prescription for drug X, then the generic equivalent would also be listed allowing consumers to identify duplicate medications.

One recent story coming out of the Kenai Peninsula involves a woman with Parkinson's disease. The woman placed an order with her insurance company for a particular drug, which they shipped in the generic form arriving about ten days later. In the meantime, the woman went to her local pharmacy and refilled her brand name prescription. Weeks later, her family became increasingly worried when the woman began hallucinating. The family and her doctor were concerned after learning that the woman was double dosing on the same drug.

To safeguard all Alaskans from over-dosing on redundant medications, HB 51 simply requires additional generic labeling on brand name prescriptions.

Representative_Paul_Seaton@legis.state.ak.us

Alaska State Legislature

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REPRESENTATIVE Paul Seaton
District 35

Sectional Analysis

HB 51

"An act requiring pharmacists to include generic drug information on containers in which brand-name prescriptions drug orders are dispensed."

Section 1. Amends **section 08.80.294** of the state statute requiring a pharmacy to list a generic drug equivalent, when the same pharmacy dispenses brand-name prescription drug order.

(b) States that the information required in Section 1 (above) shall be placed directly on the container's label.

Representative_Paul_Seaton@legis.state.ak.us

AARP Alaska

Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska Capitol, Room 104
Juneau, AK 99801-1182

RE: HB 51 (Seaton) – Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the House Health, Education and Social Services Committee to support HB 51, authored by Representative Paul Seaton and co-sponsored by twenty-three House colleagues, including your Committee members Co-Chair Gatto, and Representatives Heinze, Wolf, and Cissna.

AARP believes that anything a state can do to ease the confusion of a consumer taking medication is well worth-while. We understand that Representative Seaton has developed this bill due to a real problem faced by one of his older constituents. We can assure you that many older consumers will benefit from having the generic equivalent name added to a brand name prescription. Helpful and "user-friendly" information will be beneficial for both older patients and younger family members who may be assisting them with their medications.

Representative Seaton's bill will be a welcome addition to quality health care in Alaska.

AARP recommends an "AYE" vote on HB 51.

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
Executive Council Member for Advocacy

Vice-Chair Carl Gatto
Representative Cheryll Heinze
Representative Paul Seaton
Representative Kelly Wolf
Representative Sharon Cissna
Representative Mary Kapsner

Marie Darlin, AARP Capitol City Task Force
Pat Luby, AARP Legislative Representative

02/11/03

To whom it may concern,

Thank you for asking my opinion on this important piece of legislation, House Bill no. 51.

As you know all drugs have generic names and many of them have brand names as well. Many states have, for years, required generic labels on prescriptions since generic labeling is the standard of practice for uniformity and accuracy both medically and scientifically. Unfortunately this not always happening in Alaska for dispensed prescriptions.

I have seen a number of occasions in my own practice where people have mistakenly taken duplicate prescription medications because of these variations in labeling. These have sometimes led to drug intoxication requiring hospitalization. Even then the problem has not been immediately noticed. This unnecessary suffering and cost from drug misadventure can be prevented.

In my opinion I think your wording would be clearer and more concise with changes as written below:

"An Act requiring Pharmacists to label prescription drug containers with generic drug information."

"In addition to other information that may be required under state or federal laws or regulations, the Pharmacist, when dispensing a prescription drug order, shall label using the generic drug name. If the prescriber wishes- such as when brand name is medically indicated, or the patient requests it, the brand name may also be included in parentheses."

I would avoid stipulating exactly where to put labeling since regulations already address this and computer labeling systems have only so many options.

I hope it is obvious that I strongly support generic drug labeling as a matter of education and safety.

The State Board of Pharmacy may also have an opinion on this matter.

Respectfully submitted,

R P Albertson

R. P. Albertson RPh, CS, CGP, FASCP

February 3, 2003

Honorable Representative Paul Seaton
State Capital, Room 428
Juneau, Alaska 99801-1182

Dear Representative Seaton:

Please accept this letter in support of HB 51 relating to including generic drug information on containers in which brand name prescription drug orders are dispensed. Homer Senior Citizens, Inc. supports this legislation because it would help to eliminate the possibility of an individual taking a double dose of medication. This legislation is particularly important for seniors and caregivers that take care of seniors.

At the present time, because prescriptions are sometimes written using the generic name and sometimes using the brand name, it is possible for an individual to have two bottles of medication with different names on them, which are in fact the same. Because both labels will indicate a dosage such as one pill three times a day, it is very possible for the individual to take a double dose. This is particularly true if the individual is a senior who has some dementia or the individual is being helped by a caregiver that is not totally familiar with the medications and is only reading the dosage levels.

One might ask how an individual could have two prescriptions for the same medication with different names at the same time. What may happen is that a doctor prescribes a medication for an individual to be purchased from a mail in pharmacy. These usually are generic drugs because the mail in pharmacy is usually associated with a medical insurance plan. At some point, a prescription may not arrive and the individual asks the doctor to write a prescription to a local pharmacy to get them by until the other prescription arrives. This prescription may be written for a brand name. Thus the individual now has two bottles of the same drug with different names. This same scenario could also occur between to local pharmacies if the doctor used the generic name for the first pharmacy and for the next used the brand name.

In any case, this legislation would help to eliminate the possible confusion that an individual or caregiver may have and thus a possible overdose. If we can provide additional information, please contact us.

Sincerely,

Fred Lau
Administrator
Homer Senior Citizens, Inc.

Aetna™

Representative Paul Seaton
Alaska State Legislature
Pouch V
Juneau, Alaska 99801

Dear Representative Seaton:

This is a letter in support of House Bill 51 "An Act requiring pharmacists to include generic drug information on containers in which brand-name prescription drug orders are dispensed".

The bill should achieve two important benefits.

The first is to avoid confusion by patients inadvertently taking dual dosages of medication because they do not equate a brand name drug with a generic equivalent.

The second may be increased recognition by consumers that there are generic drug equivalents available for many brand name drugs that are equally effective but less expensive than the brand name drugs. The increasing cost of drugs is one of the leading drivers of health insurance costs. Many health benefit plans have provisions which encourage use of generic drugs in order to reduce the cost of health insurance.

Thank you.

Sincerely,

Jeff Beck by (RL)

Jeff Beck
Aetna

Subject: HB 51 Follow-up
Date: Fri, 24 Jan 2003 17:27:36 -0500
From: "Laubacher, Cynthia" <Cynthia_Laubacher@medcohealth.com>
To: "'rep.paul.seaton@legis.state.ak.us'" <rep.paul.seaton@legis.state.ak.us>

Represenative Seaton: Thank you for your call. I apologize for the e-mail, but the (800) number won't work for out of state callers, and I can't seem to access the state website for your office number.

I spoke with my folks in headquarters and explained your goal. They re-thought their initial comments and have no concerns with the proposal as it is written.

On a side note, I looked up your bio and learned that we have something in common - we were both raised in Oxnard! I graduated from Santa Clara High - a long-time football rival of Hueneme. I am always pleased and surprised to meet someone from my hometown. I hope we have the chance to meet if I get a chance to make it up to Alaska!

In the meantime, please feel free to contact me if I can ever be of assistance. Best of luck with HB 51. Have a wonderful weekend!

Cindy

Cynthia M. Laubacher
Director, State Government Affairs
Medco Health Solutions, Inc.
916-726-1081
916-726-9756 - fax

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
Division of Legal and Research Services

State Capitol
Juneau, AK 99801
Phone: 907-465-3991
Fax: 907-465-3908

January 17, 2003

Memorandum

TO: Representative-elect Paul Seaton

FROM: Patricia Young
Manager

RE: Reducing Prescription Drug Errors

You asked for background information that we could quickly gather on problems encountered by the elderly in using prescription drugs. You were particularly interested in information on efforts to deal with such problems.

As you'll see from the attached materials, the Institute for Safe Medicine Practices (ISMP) is a good source of information on all aspects of your question.[1] The organization publishes "Safe Medicine," a newsletter that among other things, always prints generic names of medications in ***red.*** In contrast, they capitalize specific brand names and print them in ***green.*** They follow specific brand names with the generic name in parentheses. We've provided several documents from the institute website, including testimony before the U.S. Ways and Means Committee that includes some specific recommendations in regard to reducing prescription errors, misuse, and adverse events.

We've also included information from the National Institute on Aging (NIA) and the Food and Drug Administration (FDA). The National Association of Boards of Pharmacy (*www.nabp.net*) and the Administration on Aging (*www.aoa.gov/elderpage.html*) are good resources as well.

During our quick search we encountered a number of references to "Brown Bag" medicine check programs through which pharmacists, nurses, or doctors assess seniors' collections of medications for compatibility, expiration dates, etc. We include a description of one such program. We also include information on a National Association of Boards of Pharmacy study commissioned by the FDA to assess the extent and usefulness of the private sector prescription information that patients receive along with their medications.[2]

Lastly, we include a printout of "Recommended Best Practices—Medication Errors," published by the Tennessee Department of Health, and adopted by Tennessee Improving Patient Safety (TIPS). Under "15 Ways to Lower your Dose of Medication Errors," we found the following statement and guidelines:

> A study from the University of Chicago Medical Center places the incidence of medication errors between 1.7 and 59.1 percent. According to the Joint Commission on Accreditation of Healthcare Organizations, 15 percent of reported medication errors are due to confusion

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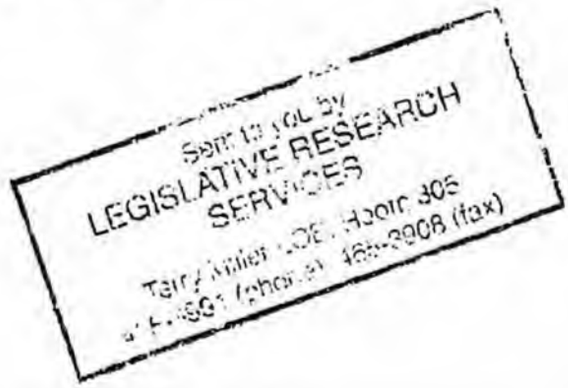
[1] The Institute for Safe Medication Practices website address is *www.ismp.org.*

[2] The results of that study, published in 2001, can be found at *http://www.fda.gov/cder/reports/prescriptionInfo/default.htm.*

U.S. Food and Drug Administration

Department of Health and Human Services
Food and Drug Administration
5600 Fishers Lane (HFI-40)
Rockville, MD 20857
February 2000
(FDA) 00-3237



Medicines and Older Adults

The Food and Drug Administration, or FDA, is a United States government agency that makes sure medicines are safe and accurately labeled.

Be More Careful With Medicines

While everyone needs to be careful about taking medicines, older adults need to be even more careful. This is because:

- Older people often take more medicines than younger people
- Older people may react differently to medicine. T

This brochure will tell you what older adults need to know about the medicines they take.

Problems

Two of the biggest problems older people have with medicines are:

- Reactions from mixing two or more drugs in the body, called "drug interactions." A drug interaction can cause bad effects (usually called side effects), such as a rash, stomach upset or sleepiness.
- Getting too much of one medicine, called "drug overdose." This, too, can cause side effects.

Older people are more likely to have side effects from drug interactions or drug overdosages because:

- They are more likely to take a number of different drugs.
- Their bodies use food and drugs slowly. This means that it may take longer for a drug to start working. Drugs also may stay in their bodies longer. This can cause too much of the medicine to be in the body.

Common side effects of drugs are:

- upset stomach, such as diarrhea or constipation
- blurred vision
- dizziness
- mood changes
- skin rash

"Start low and go slow" is good advice for older people when taking medicines. This means

- What does the drug do?
- When should I take the drug? How often?
- Does it matter if I take it with food?
- Are there any foods I should stop eating while I'm on this drug?
- Is it safe to drink alcohol, such as beer or wine, while I'm on this drug?
- How long will I need to take this drug?
- What should I do if I forget to take the medicine?
- What are common side effects?
- How will I know if this drug is working?
- Where should I keep this drug?

How to Save Money on Medicines

- When trying a drug for the first time, ask your doctor for free samples. Or ask the pharmacist for just a few pills before getting the whole prescription filled. That way, you can see if you have problems with the medicine before paying for a whole bottle.
- For drugs you take all the time, buy larger amounts at a time so that the price for each pill is cheaper. But before you do this make sure you will be able to use all the medicine within at least a year. Holding on to medicines for a long time may cause the drug to lose its ability to work.
- Call around to see which store has the lowest price.
- If you are an older person ask about a senior citizen's discount.
- Ask your doctor if it's OK to take a generic drug instead of the brand-name drug. If it is OK, tell the pharmacist you want the generic version of the medicine.
- For drugs bought over the counter, buy the store-brand or discount brand. The pharmacist can help you choose.
- Call or write to the local chapter of the American Association for Retired Persons (AARP) or a local chapter of a health organization, such as the American Diabetes Association or the American Heart Association. You may be able to buy drugs through them at lower prices.

Do You Have Other Questions About Medicines?

FDA may have an office near you. Look for the number in the blue pages of the phone book.

Or, call FDA's toll-free number, 1-888-INFO-FDA (1-888-463-6332). Or, on the World Wide Web at *www.fda.gov*.

Suicides, drug overdoses overtake crashes in deaths ; Lee Filas Daily Herald Staff Writer; ; Chicago Daily Herald (Paddock) ; 11-06-2002 ;

Suicides, drug overdoses overtake crashes in deaths
Byline: Lee Filas Daily Herald Staff Writer
Edition: Lake
Section: NEWS

For the first time since 1997, auto accidents were not the leading cause of unnatural deaths in Lake County, according to a report by the coroner's office.

That dubious distinction in 2001 went to suicides and drug overdoses. Suicides took over the top slot with 44 cases, while drug overdoses - prescription and illegal - ranked second with 41 deaths, the annual report stated.
Deaths investigated in 2001 showed 39 people died as a result of auto accidents, down 26 percent from the 53 recorded in 2000.

Jim Wipper, deputy Lake County coroner, said the decrease in vehicular deaths is something the coroner's office would like to see more of in the future.

"It's definitely the trend we are happiest seeing," Wipper said. "We look at that as one of the most positive trends we've uncovered, and it's something that we have worked hard to decrease."

That improvement was offset by a rise in drug overdoses - up 8 percent from 2000 - and a dramatic increase in homicides over previous years, Wipper said.

The 19 homicides in 2001 more than doubled the 8 recorded in 2000. The number is still less than the 25 murders recorded in 1997, but more than the 15 recorded in 1998.

"That's definitely a concern for us," Wipper said. "It's always a concern when we see a jump in any category, but to see that large of an increase is definitely something we need to look at."

Lake County Board Chairman Suzi Schmidt said the rise in homicides is alarming, but not a complete surprise given the county's growing population.

"Simply stated, the more people we have, the more crime we are going to get," Schmidt said. "Any kind of rise in crime is definitely a concern, be it white collar, homicide or robbery."

Wipper said deaths are labeled as either natural or unnatural by the coroner's office. There were a total of 2,941 deaths recorded in the county in 2001, of which 2,756 involved natural causes.

The remaining 185 are listed in the report as violent - overdoses, homicides, suicides and vehicular deaths - or accidental - drowning, fire and other accidents.

This is the fifth consecutive annual increase in drug overdose deaths in the county.

Wipper said a more readily available supply of cocaine and heroin has contributed to the increase.

"But the No. 1 cause of overdose deaths remains prescription overdoses, like painkillers and such," he said.

Testimony of Michael R. Cohen, MS, RPh

President, Institute for Safe Medication Practices

Testimony Before the Committee on Ways and Means

Subcommittee on Health, Congress of the United States

House of Representatives

Hearing on

Medicare Reform: Laying the Groundwork for a Prescription Drug Benefit

March 27, 2001

Good afternoon. Madame Chairman and Members of the Committee, thank you for the opportunity to speak with you this afternoon about important health care quality issues related to the design of a prescription drug benefit program for Medicare beneficiaries. I am Michael R. Cohen, a pharmacist and president of the Institute for Safe Medication Practices (ISMP). ISMP is an independent, nonprofit organization that works closely with practitioners, regulatory agencies, health care institutions, professional organizations and the pharmaceutical industry to provide education about adverse drug events and their prevention. A board of trustees representing the health care community at large governs this interdisciplinary effort by nurses, pharmacists, physicians and health care consumers. Our primary focus has been on proper and safe use of medications. We have a long history of learning about medication errors from health care practitioners and consumers who voluntarily report medication errors and hazardous conditions through a national reporting program operated by the United States Pharmacopeia. All reports are shared directly with the US Food and Drug Administration, Office of Post-marketing Drug Risk Assessment. Dialog with FDA is ongoing when reports relate to drug nomenclature issues (proprietary and nonproprietary names), or pharmaceutical labeling, packaging and medical device design.

Information about medication errors, other adverse drug events, and recommendations for prevention are shared with the medical community through our web site (www.ismp.org); ongoing columns in 16 professional journals that reach nurses, nurse practitioners, pharmacists, physicians, and physician assistants; and a biweekly publication, *ISMP Medication Safety Alert!* that reaches all US hospitals, and. Currently, we are preparing to launch a similar newsletter for chain and independent community pharmacies. In addition, we reach regulatory authorities and pharmaceutical manufacturers internationally through regular publications in international journals and newsletters. Information from ISMP has been used to effect thousands of improvements in professional practice and commercial drug labeling, packaging and nomenclature. The organization has gained the trust and respect of practitioners and senior officials in health care throughout the nation.

Recommendations to Reduce Error and Improve the Quality of Medication Use
Medications are a blessing, but humans must safely prescribe, prepare, dispense, and administer these drugs. Yet humans are fallible, and as clearly articulated in the recent reports by the Institute of Medicine (IOM), errors and other adverse events occur and cause unbearable

human and financial cost. Medication use has been further complicated by the large number of new drugs and technologies introduced every year, an increasing elderly population with chronic and acute conditions requiring complex treatment strategies, and the proliferation of over-the-counter products. In light of this fact, much can and should be done to enhance medication safety.

The current prescription drug benefit legislation is a strong and appropriate vehicle to drive medication safety. Payers bear responsibility for medication errors when they occur because of insufficient support of basic services and lack of quality/safety requirements. As purchasers of pharmacy services through mail and community pharmacies, payers - including Medicare - should require providers to comply with standards most likely to enhance medication safety. They should offer their beneficiaries some assurance of safe pharmaceutical care, which includes important monitoring of the appropriateness of drug therapy and its effects, not just accurate dispensing.
ISMP has identified several focal points that would be most appropriate for legislation related to prescription drug benefits:

- Continuous quality improvement activities to enhance safety in our nation. s pharmacies;
- Better clinical utilization of community pharmacists and pharmacy beneficiaries; and
- Expanded use of effective technology.

Achieving and maintaining standards related to these focal points will likely require resources that are not currently available. Thus, legislation must also include changes in the current reimbursement systems to properly support any required safety enhancements.

Continuous Quality Improvement

Data from the USP-ISMP Medication Error Reporting Program reveals that medication-related problems are repetitive in nature. An incident of misuse in one setting is likely to repeat itself in another. Most importantly, the system changes necessary to prevent errors are similar and a growing body of literature is available to guide these efforts. Tragically, too many organizations and individual providers do not believe similar incidents could happen to them. They fail to use information about errors occurring elsewhere as a roadmap for improvement in their own organization or practice. It is not until a serious error hits home that aggressive prevention efforts are implemented. With so much evidence-based information about error prevention at hand, there is little excuse for reacting to errors after they happen instead of preventing them. We need Congress to help shorten the interval between the lessons taught by errors and the widespread corrective action to prevent future errors.

The development and implementation of continuous quality improvement (CQI) efforts should be the highest priority in all pharmacies. Such efforts must be aimed specifically at preventing well-known and repetitive categories of prescribing and dispensing errors, which erode patient confidence in our health care system. For example, in order to participate in the prescription drug benefit program, pharmacies should be required to seek out medication safety information and use it proactively to prevent medication errors. At the same time, safety issues recognized internally and reported by patients must be documented and analyzed, and a process must be established to determine the best strategies to prevent future problems and ensure its implementation. An annual survey to assess consumer perceptions of the quality of pharmaceutical products and professional services might also be required to supply additional

information upon which to base improvement strategies.

Informational tools like our *ISMP Medication Safety Alert!* publication, or ISMP. s *Quarterly Action Agenda*, which is a readily available list of medication problems compiled from our nation. s reporting programs, can be a backbone of any CQI effort. The very purpose of the USP-ISMP Medication Error Reporting Program - indeed the purpose of any type of safety reporting program and the expert recommendations that stem from it - is to guide the implementation of quality improvement initiatives by practitioners and organizations. If this is not accomplished, the value of any medical safety-reporting program is diminished. Thus, appropriate funding is needed to ensure that information flowing from error reporting programs are efficiently transformed into learning programs to prevent future errors. Research-based information, anecdotal reports of adverse events, reports from the Joint Commission on Accreditation of Healthcare Organization. s Sentinel Event Newsletter, and information from other sources are also instrumental in this effort. ISMP is prepared to assist the Secretary of Health and Human Services, as well as the nation. s professional licensing boards, health departments, accreditation agencies, regulatory authorities, and individual organizations in using such informational tools to develop effective CQI strategies that can successfully stop repetitive medical errors.

Practice sites should also be required to conduct self-assessments to help prioritize improvement projects at least annually. In a cooperative project with the American Hospital Association (AHA), ISMP recently developed and distributed the ISMP Medication Safety Self-Assessment to virtually all US hospitals. This weighted self-assessment instrument provides a list of nearly 200 effective medication error reduction strategies in the general hospital setting. Nearly 1,500 hospitals participated fully in the project, which resulted in a large national database of hospital efforts to improve patient safety with medications. This database will allow health care providers to identify areas of weakness and focus improvement activities upon system elements and characteristics that are known to be effective for preventing patient harm. We will also be able to track improvement efforts in the nation. s hospitals over time by repeating the process at a later date.

While 1,500 hospitals completed the assessment and sent data to ISMP, there are approximately 6,000 acute care hospitals in the US. Through 1,000 follow-up telephone calls to a randomized list of hospitals, we learned that many more hospitals would have participated had it not been for advice given them by a national risk management organization to seek legal counsel before returning data to us. This letter instilled a renewed fear of discoverability in a future lawsuit, which had a chilling effect on the ability of hospitals to participate in this extremely valuable project. Unless the basic problem - discoverability of information used in quality improvement projects like this one . is addressed by Congress, we will continue to lose valuable opportunities to address costly (both human and financial) patient safety issues. Records of quality improvement activities must be afforded protection under available state peer review or other protective statutes and thus protected from discovery during civil litigation. It should be noted that Governor Gray Davis of California signed legislation last August to require quality improvement activities following written policies and procedures in the state. s pharmacies. A process must be in place to detect and analyze medication errors. Importantly, information that is part of the proceedings and records of review are protected from discovery. Texas and Florida also have quality improvement requirements that include the above protective provisions and several other states are now considering them. This should be a nationwide standard.

Recently, the American Pharmaceutical Association Foundation and the National Association of Chain Drug Stores agreed to fund ISMP to independently develop and implement a similar

self-assessment tool for the nation's community pharmacies (chain, independent as well as hospital and clinic ambulatory care pharmacies).

Quality improvement requirements should involve all participants in pharmaceutical care, including claims processors and pharmacy benefit managers. Unfortunately, payment policies actually contribute to error. Underpayment of pharmacists, lack of standards for claims processing, numerous interruptions, and phone calls for prescription reimbursement adjudication and pre-approval have resulted in less time available for drug monitoring and patient education activities. An example is requiring pharmacists to dispense drugs at a dose higher than prescribed and making patients split the tablets . an error-prone process- to decrease the cost of a prescription medication. For example, the manufacturer may similarly price an 80 mg, 40 mg, 20 mg, and 10 mg tablet. Although the physician may prescribe 20 mg tablets to be taken four times a day, the pharmacist is required to dispense the 80 mg tablet and tell the patient to take ¼ tablet four times a day. Some patients may become confused and take the full tablet or inaccurately split the tablet. In many cases, to assure that the patient takes the medication properly, a pharmacist will actually break the tablets into one-quarter size. However, the split tablets may begin to crumble in the prescription vial, leading to inaccurate doses.

I would also underscore the need for Congress to oversee providers and payer activities and that participants agree, as a condition of participation, to periodic visits from appropriate authorities to review documentation of quality improvement activities. Currently, little or no oversight exists from standards organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Medicare Peer Review Organizations, state professional boards, departments of health, etc. Without oversight, the private sector has not solved problems associated with safe medication use.

Surely, continuous quality improvement activities are better for the health care provider and public since it offers the potential for reducing the number of prescription errors. A new study released in the American Pharmaceutical Association. s (APhA) March/April Journal of the American Pharmaceutical Association (JAPhA) has updated an analysis of prescription drug use problems in the United States. It estimates that drug misuse costs the economy more than $177 billion each year. The estimated number of patient deaths has increased from 198,000 in 1995 to 218,000 in 2000. Clearly, we must have required quality improvement activities to reduce this unnecessary burden. In the legislation, the Secretary of Human Health and Services should be directed to form a task force to examine these and other suggestions to formulate quality improvement requirements that would accompany the prescription drug benefit program. Funding for these activities must be assured.

Improved utilization of pharmacists and pharmacy beneficiaries

The value of medications used appropriately is immense. But, if pharmaceutical care involves reimbursement for only dispensing activities, the drug safety problem will only worsen. Worse, we are overlooking one of the nation. s most valuable allies in assuring proper drug use. A trip to the local pharmacy often provides clear evidence that many pharmacy graduates, now educated at the doctoral level with advanced clinical training, are sorely underutilized in the fight against costly adverse drug events. Instead of performing clinical functions for which they are well trained - overseeing a competent technical dispensing staff, screening new prescriptions for safety concerns, educating patients on proper drug use, monitoring patients for side effects - many are tied instead to dispensing activities, managing pharmacy benefit plans and drug inventories, and performing clerical tasks. Further, with improving technologies (robotics, bar coding of pharmaceuticals and computerized prescriptions) and increasing numbers of certified

pharmacy technicians (over 80,000 currently), more of the pharmacist. s time will be available for clinical functions.

The Institute of Medicine (IOM) Committee on the Quality of Health Care in America, in their most recent report, *Crossing the Quality Chasm: A New Health System for the 21st Century* IOM urges a strong national commitment to improve health care across six broad dimensions of quality: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity. The authors suggest that the current health care system is failing to provide safe, high-quality care consistently to all Americans because it is poorly designed and relies on outdated systems. The report envisions a revamped system which is centered on patient needs and preferences, encourages teamwork among health care providers, and makes greater use of evidence-based approaches to care and information technology. The IOM Committee members recognized that, if organizations are expected to change the processes of care, broader environmental changes are also needed. Importantly, examination of current payment methods (e.g., fee for service, capitation, etc.) to remove barriers to innovation and quality, and testing of options to better align payment methods with quality goals. Realigning the payment to recognize pharmacist clinical services fits right into that idea.

To prevent adverse drug reactions, we need better ways to detect problems early. Pharmacists can serve well in this role, also. They could manage the risk of existing technologies by aggressively monitoring the effects of new drugs on the market and identifying the need for special monitoring to prevent serious adverse events. Thus, pharmacists could safely monitor new and useful drugs that might otherwise be removed from the market because they are being prescribed inappropriately. With the new prescription drug benefit program, strong consideration should be given to reimbursing pharmacists for time spent monitoring patients closely to detect and report anticipated or previously unrecognized problems to the FDA. This would result in earlier detection of medication-related problems and their timely resolution.

Further, we should learn from the valuable experience of the HCFA-required drug regimen review process in long term care, which has saved billions of dollars in prescription drug benefits while also protecting residents from preventable adverse drug events. A comprehensive, on site, drug regimen review is conducted initially upon a patient. s admission to a facility and reassessed monthly. As part of drug regimen review, the pharmacist evaluates appropriateness and safety of medication orders and verifies documentation. The pharmacist investigates possible adverse drug reactions in residents who exhibit various identified disorders. A current written diagnosis or identified need and relevant diagnostic data must support medication orders. As needed (PRN) medication orders must include specific written indications for use. Medications selected must be consistent with patients. care plans and shall have a favorable benefit-to-cost ratio reflecting consideration of medical history, the significance of any past drug reactions, and cost. When problems arise, the pharmacist makes recommendations (including identification of the concern, specific means to correct the situation and a determination of how and when improvement will be measured) to appropriate personnel. . Consultant pharmacist-conducted drug regimen review improves optimal therapeutic outcomes by 43% and saves $3.6 billion annually in costs from avoided medication-related problems. (Bootman JL, Harrison DL, Cox E: The health care costs of drug-related morbidity and mortality in nursing facilities. Arch Int Med 1997; 157:1531-36. The recommendations must be addressed as a condition of participation.

In the ambulatory care setting, beneficiaries themselves should be required to undergo at least a quarterly review of their prescription and over-the-counter medication regimen by a pharmacist. Similar to the above functions, the requirement would establish that presently prescribed drugs

are necessary, that possible adverse effects are identified and reported to the patient. s primary care provider, that the beneficiary is aware of proper storage requirements, dosing schedules, side effects, and so on. Pharmacists would be paid to monitor patients closely to detect problems with new drugs or for suspected problems. Not only would this improve care and vastly reduce the nearly $200 billion dollar cost of adverse drug events, it would also eliminate the cost of unneeded medications that patients may still be receiving! The savings to Americans would be enormous. We believe that the legislation should not move forward without a provision for this drug monitoring review with logistics determined by the Secretary.

Another important component is improving patient understanding of their important role in safe medication use and error prevention. About 25% of medication errors reported to our program and FDA. s MedWatch program stem from confusion between proprietary and nonproprietary names. An educated patient or caregiver can be a crucial last check on the safety of any medication. For example, if patients are aware of the name and purpose of their medication, they are better able to recognize if a pharmacist misread the prescription and dispenses a different medication for an unexpected purpose. Legislation should require that the medication. s purpose and full instructions be written on each new prescription so that pharmacists can educate patients properly and prevent errors if the purpose and prescribed drug do not match. Listed indications for the drug will also help patients and pharmacists ensure that their interpretation of the prescription is consistent with the prescriber. s intent.

Regrettably, the requirement for patient counseling in OBRA 90 legislation is vastly underutilized. Few patients take advantage of the pharmacist. s offer to counsel. Instead, they rush the pharmacist to fill a prescription and may not read accompanying drug information material that could prevent adverse events. The new legislation must address the issue by insisting that patients and caregivers have full explanations of new medications while in the doctor. s office or pharmacy.

Further, legislation should facilitate health care practitioners. access to crucial information about the patient. Harvard researchers (Leape LL et al. Systems analysis of adverse drug events. JAMA 1995; 274:35-43) showed that over 40% of adverse drug events can be tied to insufficient information about the patient or drug at the time of prescribing, dispensing and administration of medications. The most recent IOM report notes that clinicians operate in silos without the benefit of complete information about the patient. s conditions, medical history, treatment received in other settings, or medications prescribed by other clinicians. The report encourages cooperation among clinicians to exchange appropriate information and coordinate care.

Indeed, the same researchers (Leape LL et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA 1999;282:267-270) showed that pharmacists could prevent 66% of adverse drug events if given access to clinical information to screen and adjust doses and suggest other interventions when clinical indicated.

For example, if a physician fails to adjust the dose of a potentially toxic medication that is excreted through the kidneys in a patient with poor renal function, costly hospitalization, dialysis, transplant, or death may result. While renal function and other important clinical information may be residing in hospital or physician office records, it is often inaccessible to community pharmacists. But with better access to clinical information such as laboratory data, chronic diseases, organ function, allergies, and weight, the pharmacist can screen drug orders appropriately and prevent untold numbers of errors, injuries, and associated costs. The use of web sites or "smart cards" where patients could voluntarily maintain confidential clinical information accessible to their health care practitioners could significantly improve access to

information.

Improved use of technology

Health care remains relatively untouched by information technology that has transformed so many other aspects of society. Patient information, including medication prescriptions, is still dispersed on paper, poorly organized, often illegible, and difficult to retrieve. Yet, research shows (Bates DW et al. Effect of computerized physician order entry and a team intervention on prevention of serious medication errors. *JAMA* 1998;280:1311-16) that over half of all medication errors can be prevented through computerization physician order entry (CPOE). An ISMP survey (*ISMP Medication Safety Alert!* February 10, 1999 - www.ismp.org) of our nation. s computer systems shows that fewer than 13% of US hospitals even have the capability for CPOE. Even fewer ambulatory care physicians are using electronic prescribing technology (estimated to be under 5%). Nevertheless, our survey shows that most in-use prescribing software today does not alert users to errors in an accurate and efficient manner. System vendors and organizations must jointly accept responsibility for designing and implementing systems that offer clinical support to providers and warn about potentially unsafe prescriptions.

Most of the technology software problems stem from the lack of interface and compatibility standards to allow stand alone systems to be fully integrated with each other to ensure that appropriate patient and drug information is available to providers. For example, standards are needed to ensure that any physician can send a prescription to any pharmacy electronically. This eliminates the risk of misinterpreting a handwritten prescription while increasing the detection of potential adverse drug events. We also need to address regulatory and legal barriers that prevent use of electronic prescribing. For example, in many states, verified electronic signatures are not acceptable, thus prescribers must physically sign each prescription. Further, incentives should be provided to reward health care practitioners and organizations that adopt technology known to reduce medication errors, such as electronic prescribing and bar code technology.

Bar coding technology can greatly enhance the accuracy of drug dispensing and administration. Although the use of such technology is expanding in ambulatory care pharmacies, mainly through robotics, the pharmaceutical industry must join in this effort by assuring that all drug packages have a standardized, readable bar code or other machine-readable code.

Be an informed consumer

Unfortunately, medication errors happen. They happen in hospitals, in pharmacies, or even at home. And sometimes people get hurt because of these errors.

The more information you have, the better able you are to to prevent errors and to take care of yourself. You have to ask your pharmacists, doctors and nurses about your medications, and you have to expect answers.

Also, if you have any chronic illnesses, pick up one of the consumer guides about medications at a bookstore or from the library. Find out all that you can about your illnesses and the medications you are taking. What you learn will help protect you later.

Your doctors, nurses and pharmacists work hard to keep you healthy, but you are also responsible. Learn what questions to ask. Expect answers--it's your life and your health!

Key Questions

Your pharmacist can be your partner to prevent medication errors. Find one who offers services like monitoring your therapy and keeping a complete list in the pharmacy computer of all your medications and chronic medical conditions. Include over-the-counter medications, vitamins, nutritional supplements and herbal products even if you bought them somewhere else. It's worth the cost. With this information in one place, your pharmacist can help to protect you against harmful drug interactions, duplicate medications and other potential problems.

Before you leave the pharmacy, your pharmacist should give you printed information about the medication and make sure that you understand the answers to these questions:

1. What are the brand and generic names of the medications?
2. What does it look like?
3. Why am I taking it?
4. How much should I take, and how often?
5. When is the best time to take it?
6. How long will I need to take it?
7. What side effects should I expect, and what should I do if they happen?
8. What should I do if I miss a dose?
9. Does this interact with my other medications or any foods?
10. Does this replace anything else I was taking?
11. Where and how do I store it?

When you buy over-the-counter

States setting up nonprofit prescription operation

DRUGS: Plan intended for millions of state employees, Medicaid recipients.

By MILT FREUDENHEIM
The New York Times

In the strongest challenge yet in the battle between states and manufacturers and distributors of prescription drugs, nine states and the District of Columbia are organizing a joint, nonprofit operation to manage their prescription plans, officials in charge of the effort said.

The states intend to hold down spending on medicines for millions of state employees and Medicaid beneficiaries by creating an organization designed to be immune to drug makers' promotions of many of their more expensive products.

The new organization is being formed at a time when two-thirds of the states are reducing Medicaid coverage, restricting eligibility or ending benefits altogether for at least 1 million people. A study by the Kaiser Family Foundation said that state Medicaid directors expect further cuts in benefits and eligibility.

Dozens of states are facing their largest deficits in years. Their combined shortfall for the current fiscal year is estimated at $45 billion, with some state deficits reaching 20 percent.

Health care spending is a major part of the financial problems the states face, and drugs are the fastest growing component.

New York, for example, spent $2.4 billion on prescription drugs for more than 3 million Medicaid recipients in 2001, 7.5 percent of all its Medicaid spending and an increase of 75 percent from 1998.

"New York has the most to gain," from the new organization, said Peter E. Shumlin, chairman of the National Legislative Association on Prescription Drug Prices, the group that is organizing the new benefit plan. Shumlin said New York "is doing the least of all the states" in his group to hold down drug spending.

The new drug benefit manager will try to help New York, Maine, Massachusetts, Connecticut, Rhode Island, Vermont, New Hampshire, Pennsylvania and Hawaii maximize the drug benefits they can provide given their current budget constraints.

Drug benefits for the state employees and Medicaid recipients in most of those states are currently managed by private companies called pharmacy benefit managers. These drug plan managers collect sizable rebates from drug makers in return for promoting certain drugs. They then create lists of drugs for different ailments and often set prices that encourage drug plan members to opt for the drugs that have been promoted.

ISMP **MEDICATION SAFETY** ALERT!

Request a Brown-Bag Check-up

If you have a chronic condition, you may routinely take many different kinds of medications. Often, the dose or times of the medication may need to be adjusted as your health changes. Sometimes, you may also have medications ordered by different doctors, particularly if you visit a number of specialists. These situations can lead to a great deal of confusion when taking medications. As a safety measure, ask to schedule a "brown-bag check-up" with your primary doctor or local pharmacist. A brown-bag check-up is when you gather all of your current medications and over-the-counter products into a "brown-bag" and show them to your doctor or pharmacist so he/she can look for any potential problems.

Schedule your brown-bag appointment in advance so the doctor or pharmacist has allotted enough time for the visit. Remember to take any prescription medications, over-the-counter medications, herbal products or "natural products" you are using.

During the "check-up", the doctor or pharmacist will review all of the medications and products you are currently taking, to see if they are the same as those listed on your medical record or pharmacy profile. They can double check these medications for the correct dosage strength, frequency, or identify if you are using outdated or discontinued medications. These practitioners can also screen the medications and products for potential duplication of therapy or side effects. This is why it is important to include non-prescription products in the bag.

A brown-bag check-up is not only helpful to patients, but is useful for physicians and pharmacists too. This review will help healthcare practitioners know whether you understand how to take the medication, or if you are aware of any special precautions that you may need to know about. This is also a good time for the doctor to discuss with you any special laboratory testing that may be needed with certain drugs. You should be prepared to ask any questions you may have about your medications. Don't be afraid to write them down, so that you do not forget to ask.

Having a single doctor "in charge" or aware of all of the medications and products that you take, is a safe rule. If this is impossible, keep your list

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***** P A T I E N T I N F O R M A T I O N L E A F L E T *****

DATE: February 12, 2003
PATIENT: JOHN DOE

RX # 229072
DR. DR DR. PHONE# 907-000-0000

DRUG NAME: CELEBREX 200MG CAPSULE 200MG C SEARLE LAB AWP 02/02/2003
GENERIC NAME: CELECOXIB (ce-le-KOX-ib)

COMMON USES: This medicine is a nonsteroidal anti-inflammatory drug (NSAID) known as a COX-2 inhibitor used to relieve the symptoms of osteoarthritis and rheumatoid arthritis in adults. It is also used to treat acute pain or menstrual pain and discomfort. It may also be used to treat other conditions as determined by your doctor. This drug works by blocking the enzyme in your body that makes prostaglandins. Decreasing prostaglandins helps to reduce pain and swelling.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine may come with a patient information leaflet. Ask your doctor, nurse, or pharmacist any questions you may have about this medicine. Take this medicine with food. STORE THIS MEDICINE at room temperature between 59 and 86 degrees F (15 and 30 degrees C) in a tightly-closed container, away from heat and light. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do NOT take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to aspirin or any medicine containing aspirin or to a nonsteroidal anti-inflammatory drug (such as Feldene, Motrin, Naprosyn, Clinoril). DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a sulfonamide antibiotic (Septra DS, Bactrim DS, Gantrisin). A severe reaction includes a severe rash, hives, breathing difficulties, or dizziness. If you have a question about whether you are allergic to this medicine, contact your doctor or pharmacist. IF YOU EXPERIENCE difficulty breathing; tightness of chest; swelling of eyelids, face, or lips; or if you develop a rash or hives, tell your doctor immediately. Do not take any more doses of this medicine unless your doctor tells you to do so. DO NOT EXCEED THE RECOMMENDED DOSE or take this medicine for longer than prescribed without checking with your doctor. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. THIS MEDICINE MAY CAUSE stomach bleeding. If you drink alcohol on a daily basis, do not take this medicine without first discussing it with your doctor. Alcohol use combined with this medicine may increase your risk for stomach bleeding. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes any medicines that contain aspirin, ibuprofen, naproxen, or ketoprofen. Aspirin as prescribed by your doctor for reasons such as heart attack or stroke prevention (i.e., non-arthritis doses) should be continued. CAUTION IS ADVISED when this medicine is used in the elderly, as they may be more sensitive to the side effects of this medicine. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine

ACCOMPANY EACH PRESCRIPTION

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907-694-7007

***** PATIENT INFORMATION LEAFLET *****

DATE: February 12, 2003
PATIENT: DOE JOHN

RX # 229068
DR. DR DR. PHONE# 907-000-0000

DRUG NAME: PREVACID 30MG DR CAP 30MG DR C TAP AWP 01/17/2002
GENERIC NAME: LANSOPRAZOLE (lan-SOE-pra-zole)

COMMON USES: This medicine is a proton pump inhibitor used to treat ulcers, gastroesophageal reflux (GERD), erosive esophagitis, or Zollinger-Ellison syndrome. It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE in the morning unless your doctor directs otherwise. TAKE THIS MEDICINE before eating. SWALLOW WHOLE. Do not break, crush, or chew before swallowing. IF YOU HAVE TROUBLE SWALLOWING THE CAPSULE, check with your pharmacist to see if capsule may be opened. STORE THIS MEDICINE at room temperature between 59 and 86 degrees F (15 to 30 degrees C) away from light and moisture. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS DRUG IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment include headache, diarrhea, gas, or constipation. If they continue or are bothersome, check with your doctor. CONTACT YOUR DOCTOR IMMEDIATELY if you experience stomach/abdominal pain, rash, back pain, unusual tiredness, dizziness, vomiting, chest pain, dark urine, yellowing eyes or skin, persistent fever or sore throat, easy bruising or bleeding. IF YOU EXPERIENCE difficulty breathing; tightness of chest; swelling of eyelids, face, or lips; or if you develop a rash or hives, tell your doctor immediately. Do not take any more doses of this medicine unless your doctor tells you to do so. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

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***** P A T I E N T I N F O R M A T I O N L E A F L E T *****

DATE: February 12, 2003
PATIENT: DOE JOHN

RX # 229067
DR. DR DR. PHONE# 907-000-0000

DRUG NAME: FLUOXETINE 20MG CAP 20MG C PAR AWP 03/22/2002
GENERIC NAME: FLUOXETINE (floo-OX-uh-teen)

COMMON USES: This medicine is a selective serotonin reuptake inhibitor (SSRI) used to treat depression, obsessive-compulsive disorder (OCD), or bulimia. This medicine may also be used to treat PMS (premenstrual syndrome). It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE WITH FOOD if it upsets your stomach. STORE THIS MEDICINE at room temperature, away from heat and light. CONTINUE TO TAKE THIS MEDICINE even if you feel better. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: UP TO 4 WEEKS MAY PASS before this medicine reaches its full effect. Do not stop taking this medicine without checking with your doctor. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. Using this medicine alone, with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. THIS MEDICINE WILL ADD TO THE EFFECTS of alcohol and other depressants. Ask your pharmacist if you have questions about which medicines are depressants. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes any medicines that contain dextromethorphan. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. THIS MEDICINE IS EXCRETED IN BREAST MILK. The manufacturer of this medicine states that taking this medicine while breast-feeding is not recommended. CONSULT WITH YOUR DOCTOR ABOUT BREAST-FEEDING.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nervousness, trouble sleeping, headache, drowsiness, fatigue, nausea, vomiting, diarrhea, loss of appetite, dry mouth, sweating, dizziness, lightheadedness, muscle spasms, or changes in sexual function. If they continue or are bothersome, check with your doctor. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

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***** P A T I E N T I N F O R M A T I O N L E A F L E T *****

DATE: February 12, 2003
PATIENT: JOHN DOE

RX # 229071
DR: DR DR. PHONE# 907-000-0000

DRUG NAME: ALBUTEROL INH MG I ANDRX PHAR AWP 09/23/2002
GENERIC NAME: ALBUTEROL (al-BYOO-ter-ole)

COMMON USES: This medicine is a bronchodilator used to treat or prevent the symptoms of asthma, emphysema, and other breathing conditions. This medicine is also used to prevent the symptoms of exercise-induced asthma. It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. THIS MEDICINE MAY COME with an instruction leaflet. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. BEFORE USING THIS MEDICINE, be sure that the canister is properly inserted into the inhaler unit and SHAKE WELL. Exhale slowly and deeply. UNLESS YOUR DOCTOR HAS TOLD YOU OTHERWISE, position the mouthpiece between your lips and try to rest your tongue flat. Your doctor may have told you to hold the inhaler 1 or 2 inches (2 or 3 centimeters) away from your open mouth or may have instructed you to use a special spacing device. AS YOU START TO TAKE A SLOW, DEEP BREATH, PRESS THE CANISTER AND MOUTHPIECE TOGETHER at exactly the same time to administer a dose of this medicine. Continue inhaling slowly and deeply and hold your breath for as long as comfortable, then exhale slowly through pursed lips or through your nose. If more than 1 inhalation is to be used, wait a few minutes and repeat the above process. KEEP THE SPRAY AWAY from your eyes. KEEP TRACK OF THE NUMBER of sprays you use and subtract this number from the number of doses in the container. This will help you know when the container is becoming empty. STORE THIS MEDICINE at room temperature, away from extreme temperatures and direct sunlight. Do not puncture, break, or burn container, even if it appears empty. IF YOU MISS A DOSE OF THIS MEDICINE and you are using it regularly, use it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule.

CAUTIONS: KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. BEFORE YOU HAVE ANY MEDICAL OR DENTAL TREATMENTS, EMERGENCY CARE, OR SURGERY, tell the doctor or dentist that you are using this medicine. AVOID LARGE AMOUNTS OF caffeine-containing foods and beverages, such as coffee, tea, cocoa, cola drinks, and chocolate. Before switching brands of this medicine, consult your doctor or pharmacist. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include fast heartbeat, nervousness, tremors, headache, difficulty sleeping, or nausea. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience rash, hives, itching, wheezing, or increased difficulty breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

Brand only

Both Brand & Generic

Family PHARMACY
907-694-7007
11432 Business Blvd.
Eagle River, AK 99577
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

RX#229068 DR.DR
JOHN, DOE 2/12/03
TAKE ONE CAPSULE ONCE DAILY

PREVACID 30MG DR CAP 30
NO REFILLS **PC** RX EXP: 2/12/04

Family PHARMACY
907-694-7007
11432 Business Blvd.
Eagle River, AK 99577
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

RX#229072 DR.DR
DOE, JOHN 2/12/03
TAKE ONE CAPSULE ONCE DAILY

CELEBREX 200MG CAPSULE 60
NO REFILLS **PC** RX EXP: 2/12/04

Family PHARMACY
907-694-7007
11432 Business Blvd.
Eagle River, AK 99577
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

RX#229067 DR.DR
JOHN, DOE 2/12/03
TAKE ONE CAPSULE ONCE DAILY

FLUOXETINE 20MG CAP 100
W/F:PROZAC 20MG CAP
NO REFILLS **PC** RX EXP: 2/12/04

Family PHARMACY
907-694-7007
11432 Business Blvd.
Eagle River, AK 99577
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

RX#229071 DR.DR
DOE, JOHN 2/12/03
INHALE AS DIRECTED

ALBUTEROL INH 17
W/F:PROVENTIL 90MCG AER
NO REFILLS **PC** RX EXP: 2/12/04

COMMITTEE: House Health, Education and Social Services Standing Committee

SUBJECT: HB 51 LABELING OF PRESCRIBED DRUGS

DATE: February 13, 2003

PLEASE SIGN IN

PLEASE PRINT: NAME & TITLE	ADDRESS	PHONE	REPRESENTING (No acronyms unless for a state agency, please)	DO YOU WANT TO TESTIFY ?
April L. Sapp Asst Nurse Mngr	8172 Thunder St	7633471	Public Health Policy Course (UAA)	NO
E-mail address:	bradleysgirl772@hotmail.com			
Rebecca Tully RN	2870 LINDA AVE	789-5737	Public Health Policy Course (UAA)	NO
E-mail address:	rtully2@excite.com			
Marie Marlow			AARP	Yes
E-mail address:				
Rosalee Walker		586-2873	OPAG	NO
E-mail address:				
E-mail address:				

HB

72

Session:
State Capitol, Room 13
Juneau, AK 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

Alaska State Legislature
Representative David Guttenberg

Interim:
119 N. Cushman
Suite 211
Fairbanks, AK 99701
(907) 456-8172
(907)451-9293 Fax

District 8

MEMORANDUM

TO: Representative Peggy Wilson, Chairman
House Health, Education & Social Services Committee

FROM: Representative David Guttenberg

DATE: March 28, 2003

RE: HB 72: Board of Regents Composition & Qualifications

Dear Representative Wilson,

May I officially request that you please schedule HB 72 for hearing before your committee at your earliest convenience.

Enclosed are:

1) HB 72 (Committee Substitute Pending)
2) Sponsor Statement
3) Sectional Analysis prepared by Legislative Legal Services
4) Zero Fiscal Note
5) Current Statute: AS 14.40.120 – AS 14.40.150
6) *Requirements for the Position and Rules Governing the Election of Nominees for Student Regent & Student Commissioner* – Packet for Campus Elections from Office of Board of Regents
7) *Master List Student Regents* – Board of Regents Website
8) *A Student Regent on the Board of Regents*: Original proposal by Chip Wagoner – ASUA Student Body President 2/22/72
9) *Regent nominees clear hurdles*: Comments of Current Student Regent, Derek Miller – Fairbanks Daily News-Miner 2/13/03

Further information will be provided as it arrives or upon request.

Thank you for your consideration.

Anderson • Cantwell • Chena • Denali Park • Ester • Geist • Goldstream • Healy • Pike
University Campus • University Hills • University West
<Representative_David_Guttenberg@legis.state.ak.us>

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 3, 2003

SUBJECT: University of Alaska Board of Regents - HB 72

TO: Representative David Guttenberg
Attn: Jomo

FROM: Michael F. Ford
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Intent.

Section 2. Adds a non-voting student member to the University of Alaska Board of Regents.

Section 3. Requires at least one regent to have graduated from the University of Alaska.

Section 4. Technical amendment.

Section 5. Technical amendment.

Section 6. Requires that the Governor appoint two University of Alaska students to the Board of Regents. Specifies that the student with the longest service on the board is a voting member and the second student member is non-voting, except for board subcommittees. Provides that voting status is determined by relative periods of service, not by the status of the original appointee.

Section 7. Transition section regarding application of the Act to existing board members.

Section 8. Effective date.

MFF:med
03-231.med

TITLE 14: CHAPTER 40 - Article 2
Board of Regent and President of the University of Alaska

Sec. 14.40.120. University governed by Board of Regents.

The University of Alaska shall be governed by a Board of Regents consisting of 11 regents.

Sec. 14.40.130. Qualifications of regents; special provisions relating to student regent.

(a) Each regent shall be a citizen of the United States and a resident of the state.

(b) In addition to satisfying the requirements of (a) of this section, the regent appointed under AS 14.40.150 (b) must
- (1) be enrolled as a full-time student at the University of Alaska at the time of appointment;
- (2) remain a full-time student while serving.

(c) Failure of the regent appointed under AS 14.40.150 (b) to remain enrolled as a full-time student at the University of Alaska during the term for which the regent was appointed results in forfeiture of that office.

(d) The governor shall appoint a successor from those students appearing upon the list of nominees submitted under AS 14.40.150 (b) within 60 days of a forfeiture or vacancy in the office.

(e) For purposes of this section, the term "full-time student" is defined as provided in the University of Alaska Academic Regulations.

Sec. 14.40.140. Term of office.

Except for a student regent as specified in AS 14.40.150 (b), the term of office of a regent is eight years. The term of office begins on the first Monday in February of the year in which the appointment is made. Each regent serves until a successor is appointed and qualifies.

Sec. 14.40.150. Appointment of regents.

(a) The governor shall appoint the regents subject to confirmation by a majority of all the members of the legislature in joint session. The names of those appointed shall be sent to the legislature within five days after the opening of the session, for confirmation or rejection. If a person appointed is not confirmed by a majority vote of all the members of the legislature, the appointment ceases and the name of another person shall be submitted

within three days after the rejection. If the legislature adjourns without confirming the nominee, or if an interim vacancy occurs, the governor may appoint a qualified person to fill the vacancy. However, the person who has failed to be confirmed may not be appointed. The term of office of the appointee expires on the fifth day of the session of the legislature following the appointment.

(b) At least one member of the Board of Regents must be a student. The student shall be appointed from a list of nominees submitted to the governor. The governor shall make the appointment from the list within 60 days after it is submitted. The list shall consist of the names of two students from each campus of the University of Alaska after an election is held at each campus. Elections shall be conducted under rules established by the Office of the Governor. The term of office of the regent appointed from the general student body, University of Alaska, is for two years. The term of office begins June 1 of the year in which the appointment is made. An appointment made under AS 14.40.130(d) shall be for the unexpired term of the original appointee. The term "campus" used in this subsection means a portion of the University of Alaska designated as a "campus" by the Board of Regents.

University of Alaska Board of Regents
Alaska Commission on Postsecondary Education

Requirements for the Positions and Rules Governing the Election of Nominees for Student Regent & Student Commissioner

Alaska law stipulates that each campus will select two nominees for student regent and student commissioner through an election held under rules established by the Governor. The following are the requirements for the positions and rules to carry out the election of nominees. The appointment term is June 1, 2003 through May 31, 2005.

POSITION REQUIREMENTS

A student must:

1. be enrolled and remain enrolled as a full-time student (12 credits undergraduate, 9 credits graduate) [Alaska Statutes 14.40.130 and 14.42.015.e].

2. carry a cumulative 2.5 G.P.A. (or if freshman status, must have proof on high school transcript of 2.5 cumulative G.P.A.) [Office of the Governor]

3. be a student at the particular campus [Alaska Statutes 14.40.150 and 14.42.015.e].

4. be a United States citizen [Alaska Statute 14.40.130].

5. be a resident of Alaska [Alaska Statute 14.40.130].

6. if 18 years of age or older prior to the last general election, must be a registered voter in the State of Alaska [Alaska Statute 39.05.100].

REQUIRED APPLICATION MATERIALS

Failure to submit the below listed documentation will result in deletion from the list of nominees submitted to the Governor!

1. election certification;
2. names of all candidates in the local election and the number of votes they each received;
3. letters of recommendation;
4. proof of cumulative 2.5 G.P.A.;
5. resume or brief personal biography.

ELECTION RULES/PROCEDURES

- The Board of Regents' Office will disseminate instructions regarding the nomination, election and reporting of the student regent and student commissioner elections. The campus director or chancellor will appoint an ad-hoc student appeal board in cases of alleged voting irregularities.

- Only students may appear on the ballot and be nominated for the position of student regent.

- An election will be held on each campus. A campus is defined by the Board of Regents as a university institution in any of the following locations: Anchorage, Bethel, Dillingham, Fairbanks, Homer, Juneau, Ketchikan, Kodiak, Kotzebue, Nome, Palmer, Sitka, Soldotna, and Valdez. For the student representative position on the Alaska Commission on Postsecondary Education, Alaska Pacific University and Sheldon Jackson College are included as campuses.

- Elections will be conducted by local student associations on each campus. In the case where no established student association exists, an ad-hoc student group will be appointed by the local administration (campus director or chancellor).

- Each local student association or group will provide nominating petitions, advertising, and adequate polling time(s) and place(s) for the election.

- The nominating petitions will contain the requirements for the position, a minimum of three signatures of students who endorse the nomination of the candidate, the deadline for submitting the petition, and the date of the election.

- The local student association or group will establish an election committee to oversee the election, polls, and counting of ballots if such is not provided for in the organization of the group. Voting discrepancies will be resolved by the election committee or appealed to the ad-hoc student appeal board for final settlement within 24 hours after the election. If not appealed, the election results will be attested to by the election committee and become final 24 hours after the election.

- The local student group is responsible for meeting the following timetable in relation to the election:

  -> Nominating Petition Deadline - minimum of one week prior to election.

  -> Elections should be advertised at least one week prior to election. Nomination petition availability should be advertised at least one week prior to petition deadline.

  -> Elections must be conducted by **February 21, 2003.**

  -> Results must be received by the Board of Regents' Office at the close of business on **March 5, 2003.**

Student Regent/Student Commissioner
Election Rules

- Each student may vote as determined by the requirements of local student associations or groups. No student may vote more than once. Each student will cast a vote for only one candidate for each position. **Students may vote only for candidates from their respective campus.**

- All elections will be by secret ballot.

- Each voter must satisfy election or polling officials of their status as qualified students to vote in the election.

- A campus will be allowed to submit, through the Board of Regents' Office to the Office of the Governor, the names of two nominees for each position who receive the greatest number of student votes in a campus election.

- In a situation where there is a tie vote between a second and third place candidate, the local student association will elect, or if there is no organized group, the ad-hoc student group will elect, by secret ballot, the second candidate for its campus from among the tied candidates.

- Local student associations are responsible for forwarding results to the Board of Regents' Office. The requested information should be forwarded to the Board of Regents' Office, University of Alaska, Suite 202A Butrovich Building, Fairbanks, AK 99775-5300 or faxed to (907) 474-6342. The office telephone number is (907) 474-7908.

- The Board of Regents' Office will be responsible for delivering the names of the candidates to the Office of the Governor by **March 12, 2003.**

Excerpts of pertinent Alaska State Statutes are attached.

Questions regarding the process should be directed to Ms. Jeannie D. Phillips, Board of Regents' Office, University of Alaska Statewide System, (907) 474-7908, or by electronic mail to SYBOR@ ALASKA.EDU.

Board of Regents

MASTER LIST OF STUDENT REGENTS

STUDENT REGENT	TERM	CAMPUS	COMMENTS
Wendte, Ronald W.	1974-76	Juneau	First Student Regent
Lemke, Bruce	1976	--	Appointment not confirmed by legislature - resigned.
LaParle, Gerard R.	1976-77	Fairbanks	--
Davidge, Ric	1977	Juneau	--
Sharilyn Mumaw	1977-80	Anchorage	First female student regent; first student regent from UA Anchorage; completed an extended term due to resignation of Regent Davidge on December 31, 1977.
Burgess, Timothy	1980-82	Fairbanks	--
Hannan, Sara T.	1982-84	Fairbanks	--
Shaver, Lynn B.	1984-86	Anchorage	--
Bousley, Lance P.	1986-87	Juneau	Resigned at Spring 1987 graduation.
Judith J. Graham	1987-89	Anchorage	--
Van Hatten, Jack III (Buddy)	1989-90	Fairbanks	Resigned for personal reasons.
Reeve, Mary	1990-91	Anchorage	Served for remainder of Van Hatten's term.
Lamkin, Timothy S.	1991-93	Fairbanks	First student regent to hold a board officer position (Vice President).
Otterbacher, Scott A.	1993-95	Fairbanks	Also attended UA Anchorage and UA Southeast
Hayes, Joe L., Jr.	1995-97	Fairbanks	First African-American to serve on Board of Regents.
Nelson-Wright, Annette M.	1997-99	Juneau	--
Horst, Joshua B.	1999-01	Juneau	--
Hardenbrook, Joe	2001-02	Fairbanks	Legislature failed to vote on confirmation.
Miller, Derek	2002-03	Fairbanks	Appointed after special election authorized by Governor Knowles to serve remainder of J. Hardenbrook term.

Last updated October 30, 2002

A STUDENT ON THE BOARD OF REGENTS

PROPOSED BY CHIP WAGONER

ASUA PRESIDENT

2/22/72

The concept of a student on the Board of Regents is one that would have been dismissed without thought ten years ago. Today, however, the students have shown an increased concern and awareness in their educational development. With this in mind, the combined student governments at Anchorage and at Fairbanks have proposed the placement of one student on the University of Alaska Board of Regents.

This booklet has been prepared by the Associated Students with the hope that it will aid you in evaluating this innovative concept in higher education.

RESOLUTION

The following resolution was unanimously passed by the Associated Students of the University of Alaska, Fairbanks and the combined Associated Students of the University of Alaska, Anchorage and A.C.C.

WHEREAS, the State of Alaska has recognized the maturity of young people by giving them voting privileges at age 18, and

WHEREAS, the University of Alaska students have shown their maturity and their concern by registering to vote, and

WHEREAS, the Past United States Commissioner of Education, Earl J. McGrath, supports this concept citing students as "initiators of policy rather than protesters against policy," and

WHEREAS, this concept has proved successful at the University of Massachusetts, Otterbein College, Antioch College and the University of Connecticut, and

WHEREAS, the united Anchorage-Fairbanks campuses have expressed support of the concept both as students and voters,

THEREFORE, be it resolved that the students of the University of Alaska at Anchorage and at Fairbanks wholeheartedly support the concept of placing a student on the University of Alaska Board of Regents.

At the present time, the student body president of the Fairbanks campus is allowed to sit in on the Board of Regents' meetings. He is allowed to take part in the discussions of the Board with the exception of the executive sessions. He is not allowed to vote. This is obviously an unintentional exclusion of the Southcentral and Southeastern students. However, the students have decided that they would prefer to have one student on the Board with voting privileges rather than three students with non-voting privileges. Dr. Earl J. McGrath, the United States Commissioner of Education under the Truman and Eisenhower administrations, has supported this viewpoint stating, ". . . Even where students regularly attend meetings of the Board and its committees, the force of their influence remains obscure because generally they have only the privilege of discussion."[1] Thus, in a sense, what the students are now seeking is a vote on the Board of Regents, a vote to determine their educational objectives and a vote to determine their future.

One might ask how effective a student could be on the Board. What could he contribute? The student by being a "consumer" would be in a position to predict, in most cases, the effect of a Board decision. He would also be able to make more reliable judgments in certain areas due to his experiences as a student. For example, a Regent decision to increase the length of a University semester would be disastrous to Alaskan students seeking jobs. Other students in the "Lower 49" that had their term end earlier would have an advantage of getting Alaskan jobs. For many U. of A. students, the income from a summer job means an additional year of education. Would a Regent with a full time job understand this? Possibly. Would a student? Definitely.

The students' positions as consumers should give them the right to voice their concerns within the institution which so directly affects them. We have all learned the value of citizenship and democracy from our parents, our schools and our heritage. The United States government and the state of Alaska have both acknowledged the value of participation in a democratic society by recognizing the voting rights of its citizens, (Women suffrage, 18 year old vote, protection of minority groups' voting rights). However, the University administration has emphatically stated that higher education is a privilege and not a right. This we agree with, but is it not possible for a democratic privilege? There are no voting students on the Administrative Council, Academic Council or the Board of Regents. Although the University Assembly is an exception, it is dominated by faculty with veto

[1] Earl J. McGrath, Should Students Share the Power, (Philadelphia: Temple University Press, 1970), p. 42.

power by the administration. In short, the students are not allowed to participate effectively regarding their education. The students know the principles but they do not know the demanding responsibilities of citizenship and they will not learn these in a classroom situation. They will learn them through meaningful, effective participation in the University structure. One of the objectives of the institution according to the University catalog is: "To strive above all to develop in its students at all levels those qualities of mind and body that are necessary for life as a worthy human being in a democratic society."[2] Once again stressing the importance of a vote is the following excerpt from a bulletin published by the National Association of Student Personnel Administrators, (NASPA), "If the students are to be allowed to sit on a committee they should be accorded the same rights and responsibilities as other members of the committee."[3]

The students are aware of the importance of education in determining their future social status, economic well being and ability to effectively participate in society. It follows that students are justified in requesting a vote on the Board in which to influence the quality and purpose of their education. Dr. McGrath, in his book, *Should Students Share the Power*, says: "The weight of opinion and practice indicates wide acceptance of the idea that students should have some voice in the bodies which determine the purposes and the programs of institutions of higher education. Since virtually every committee, to one degree or another, deals with matters which affect the character and quality of the students' education and since students' experiences may often shed peculiar light on these matters, it is reasonable that students should hold membership in all such deliberative bodies."[4] The Board of Regents is such a deliberative body.

Another point to consider is the improved communication that would result between the University policy-makers and the students. At the present time, few of the students know who the Regents are or how to contact them. The Board decisions which affect students are as visible as the Regents are invisible. This is not the fault of the present Regents as their time is spent with University business, occupations, civic-minded endeavors and of course family and friends. Since the Regents are busy people they rely on the

[2]University of Alaska, University of Alaska Catalog 1971-1972. (College: University Relations, 1971), p. 8.

[3]Richard Antes, "Involving Students in University Governance," in NASPA Journal, ed. by NASPA Editorial Board. (Bloomington: NASPA, July, 1971), p. 51.

[4]McGrath, Should Students Share the Power, p. 67.

University administration to provide them with most of the information they need. As such, the student viewpoint is often absent. Dr. J. L. Zwingle, President of the Association of Governing Boards of Universities and Colleges states, "Campus tensions, it now seems obvious, arose from one shortcoming among governing boards (with more than equal share among administrators): Failure to understand what was developing on the campus (California and Columbia). These were not failures of intelligence but failures of attention."[5] Looking at the other side of the coin, we see students that are frustrated from not knowing or understanding why a decision was made. This leads to a disillusionment with the system, a lack of trust with the administration and a further break-down of communication. A student Regent's major responsibility to the Board then, could quite conceivably be to keep the Regents informed of student opinion and to keep the students informed of the reasons behind the Board's decisions. However, at the present time this is not possible. Therefore, we seek a full member of the Board with voting privileges to insure that the student Board member will be informed of all meetings, receive all background information used by the Regents in making a decision, be able to take part in all discussions freely, be considered as a legitimate member of the Board by the other Regents and by the administration. Also, a voting student Regent would be credible in the eyes of the students and not considered a "token" Regent.

One might suggest that no student is mature enough to be a Regent and thus could not possibly be considered credible. Admittedly, there are those students that do show their immaturity at times but all large groups have these types of individuals. The state of Alaska should be proud that her students have shown the maturity and the responsibility needed to not follow the disruptive trends of students at other universities in the country. Instead, they have worked within the system to improve their education.

Others view the brief involvement of students as being a deteriment to placing a student on the Board. This should not necessarily be considered a drawback because a student's short term* on the Board will insure a fresh point of view. The student Regent will probably make mistakes but his presence has a definite advantage to it. The older Regents, (average age near 60), will guide him in their areas of knowledge just as he will contribute his thoughts and experiences to them.

[5]J. L. Zwingle, "The Lay Governing Board," in Perspectives on Campus Tensions, ed. by David C. Nichols. (Washington D.C.: American Council on Education, 1970), p. 195.

*Our proposed bill will discuss the length of the term.

Another possible drawback on placing a student on the Board is the element of time. One Regent has estimated that his Board position involves about two months of his time per year. It is obvious that the position demands hard work, responsibility and a devotion to the University of Alaska. Could and should a student be a Regent and a student at the same time? The answer is unequivocally yes. First, the position will be a tremendous learning experience for the student. He will learn practical politics, budgets, organization, investments management, etc. It would well be the most satisfying, rewarding and educational experience of his life. Capable students have proven that studies are not necessarily hurt be devoting their time to other areas. Noting for example the three most demanding positions in student government in Alaska, we find that an average of 47 hours were spent working in student government, while 17 credits were earned, with a grade point average of 3.4 out of a possible 4.0 scale. The great number of hours which these three people spend in their jobs is justification enough of the devotion to the University. ". . . When students enjoy the rights and responsibilities of citizenship in a Free social order, they almost uniformly discharge their obligations thoughtfully, diligently and with an arresting dedication to public rather than personal ends."[6]

One aspect of this consideration which we have not discussed has been that of Public Relations. Will this concept improve or harm the University's image? First, it must be stated that the idea of placing a student on the Board of Regents is not a particularly new or liberal idea. Other schools which have students on their Board as voting members are: University of Maine, University of New Hampshire, University of Massachusetts, University of Connecticut, Cornell University and Antioch College.

The concept of a student Regent is not one that has swept across the country like a prairie fire. However, it is viewed as highly innovative in many circles of higher education. Otterbein College, which placed three students on their Board in 1970, knows this well as they built a public relations "success story" around the idea. In a letter from Tom Clark, Director of Public Relations at Otterbein, we learned, "The governance and board reorganization was much in the news in 1970 and 1971. We appeared in many national publications and on television a great deal. I hope you were able to catch some of it. At this

[6]McGrath, Should Students Share the Power, p. 83.

point, the College, through its experience with the governance, has become quite well known and respected in academic circles."[7] The knowledge that the University of Alaska and thus the state of Alaska, loses many residents to Universities in other states makes this concept even more appealing to the U. of A. from a public relations standpoint.

We students believe that our proposed bill will be considered one of the best in regards to placing a student on the Board. Following is a discussion of the bill.

PROPOSED BILL TO PLACE A STUDENT ON THE UNIVERSITY OF ALASKA BOARD OF REGENTS

We first had to decide how many students to place on the Board. There were two avenues of thought. One suggestion was to have one student from Anchorage and one student from Fairbanks on the Board. This idea was not decided upon because the Southeastern students would be neglected and because we felt that two students representing 20% of the Board would be politically and otherwise, unfeasible. The decision therefore, was to choose the other obvious answer and have only one Student Regent.

The most challenging task we faced in the proposal was how to select a student for a Regent position. The decision as to which student should be a member is one which must be made in a fair manner, with emphasis on ability and character and not on popularity. Other Universities such as the University of Massachusetts, have made their student body president an automatic member of their Board. However, this would not be a wise decision for our University as the student body president (no matter who he was) could not do justice to both positions. Time alone would not allow for it. Also, a student body president is to represent the best interests of the student body on his campus, whereas a student member of the Board would represent the best interests of the state in helping to determine the role of the University. This is a most important point! The student member of the Board would not be a member to represent the students' interests, but would be a member who would have the experience of a student at the time a decision was made. This would help encourage the University to look at all sides of an issue. There are many ways of looking at a four-sided square. This concept also negates the argument that the Regent position would become a "political football."

[7] Letter, T. Clark to D. Scott, Feb. 11, 1972. (University of Alaska, ASUA Files).