2009 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1523

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1523

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 3, 2009

Recorder Job Number: 8548

Committee Clerk Signature Ellen LeTang

Chairman Keiser: Opened the hearing on HB 1523 relating to Pharmacy ownership by hospitals.

Ken Svedjan~Representative from District 17, Grand Forks. Introduces HB 1523 and it gives an exception to the existing law as it relates to operating a pharmacy in a hospital. This bill has no relevance to HB 1440 except if the HB 1440 passes we don't need this bill. If HB 1440 doesn't pass, I would like this bill to be put in place. Hospitals have changed over years where small town clinic are part of a larger health care hospital system. The pharmacy is located within the confines of building own and operated by altered health systems, but under the current law, they cannot sell that pharmacy to an altered health system. They could sell the pharmacy to a competing interest that would operate to within the altered health systems facilities but they cannot sell to Altru. That's the bottom line what this bill is about.

Vice Chairman Kasper: On page three, line one, is collocated with the hospital or any other medical clinics owned? I interoperated that as the expansion of the situation you just described where the hospital has a pharmacy because it is also expanding to clinics owned by hospitals. Would it be in Grand Forks or any clinic?

Svedjan: First of all, this bill is not specific to Altru, I used that example, but yes. The collocation requirement would pertain to any other facilities that are part of that system that may be located outside.

Vice Chairman Kasper: So you are saying that clinic A in group A, outside the hospital does not have a pharmacy in clinic A right now. The only way that they could buy that is if somebody put a pharmacy in there or the hospital start a hospital in that clinic that does not have pharmacy right now.

Svedjan: It's almost the reverse of what said. The pharmacy has (inaudible) now within their facilities. If that pharmacy becomes available for sale, the passage of this bill will allow for the health system that owns those facilities to purchase that pharmacy and carry on.

Representative N Johnson: Would this apply if health care system to entice the pharmacist to establish a pharmacy in there, then ups the rent where to the point they finally disband and then the hospital or whatever medical system purchase that pharmacy and operate it?

Svedjan: I'm not looking at this bill in that way. Could something like happen, I don't know. This is not the intent of this bill.

Arnold Thomas~President of North Dakota of Health Care Association. See testimony attachment 1. We ask for the adoption and passage of HB 1523.

Bev Adams~Executive Administrator of the Health Policy Consortium. See testimony attachment 2.

Representative Nottestad: How many hospitals are currently operating pharmacies? How many in the other hospitals under the current law?

Adams: I can only speak for the four large hospitals, that question would be best directed elsewhere for other North Dakota hospitals. For the four hospitals I represent, we all have

grandfathered claused clinics and we also have hospital pharmacy that allows us to operate just hospital pharmacies

Representative Nottestad: Name the other two. You said Altru and Med Center, what others?

Adams: Trinity and Med Center Americare has two.

Keiser: The 51% pharmacy law, but Med Center, I think, their pharmacy come in under the 51%. If this law were the only law we had, couldn't any clinic or health care find a pharmacist to own 51% to open a pharmacy and rent the space to them?

Adams: That is correct.

Chairman Keiser: So that would generate revenue of the 49% to offset the financial concerns of this facility?

Adams: That is correct if the pharmacist is will to allow the hospital to have ownership interest.

Chairman Keiser: There is rent at least.

Adams: You are correct.

Chairman Keiser: What is the worst case scenario, how many pharmacies could Med Center open?

Adams: All the integrated health systems have clinics all over the state in North Dakota. We provide 80% of the health care in North Dakota even though we are thought of as rural.

Chairman Keiser: It not really one but potentially could be more.

Adams: You are correct. You would have to look at the feasibility of opening these pharmacies.

Vice Chairman Kasper: You said that these hospitals have locations that cover 80% of the health care here in North Dakota.

Adams: My testimony said that we provide 80% of the health care. I don't know if our locations cover 80% of the state.

Vice Chairman Kasper: If you provide 80% of the health care, you theoretically, you could own 80% of pharmacy benefits as well?

Adams: It depends on where the client want to purchase their prescriptions.

Vice Chairman Kasper: I understand that, but theoretically, you could have 80% of the market simply by opening pharmacies in your facilities.

Adams: Theoretically, yes.

Tom Simmer~Hospital Pharmacist at Med Center One in Bismarck. See testimony attachment 3.

Jeff Zak~Director of Pharmacy of Altru Health Systems of North Dakota. We have a unique situation in Grand Forks that we need to remedy, the sooner the better which is one issue. The other issue is the access to the limitations to our patients that come to our clinics.

Representative Nottestad: Do you have at the south end of your campus a Thrifty White.

Zak: Yes.

Representative Nottestad: Is there any reason why if the group youare involved in, choose to sell, that Thrifty White Corporation couldn't purchase into that area and solve the problem without this legislation?

Zak: Thrifty White and ourselves are partners right now.

Joan Johnson~Hospital Pharmacist in Bismarck. In no other state do pharmacists get up and testify against laws that allow other health care providers & pharmacists to provide care. The University operates three outpatient pharmacies and from the proceeds, they run anti coagulation clinic run by pharmacists. Hospitals have been components of the cognitive services that owners are trying to promote for years and years. Hospitals have hired pharmacists for their cognitive services. We in the hospitals, have pharmacist everywhere and hospitals have been more promotive pharmacy that is not tied into product than any other

group. Yet, when it comes down to something like this, I don't think it's a worst case scenario, this would be a best case scenario because it would provide more service and option in North Dakota.

Anyone here to testify in opposition of HB 1523.

Howard Anderson~Executive Director of the North Dakota State Board of Pharmacy. See testimony attachment 4.

Jerry Wahl~Hospital Pharmacist in Dickinson and Chairman of the Board for the North Dakota Pharmacist Association. We talk about continuity of care relating to patients discharged from the hospital and going home. When we have a patient discharged from our hospital, our pharmacist helps that patient which is continuity. Also, as far as hospital pharmacists are concern, there is disagreement within the North Dakota Pharmacist Association about the ownership law and there is also disagreement in the North Dakota Society of Pharmacists that support the ownership law. Not all hospital pharmacists have a problem with North Dakota Pharmacists Association. There is a rift with a few but not all. They can have access to 51% but some want it all. Another question I have is what hours are they going to keep? Are they clinic hours or are going to be open all hours?

Dave Olig~Self. My wife and I own two pharmacies. (Hard to hear the testimony). My concern is there is a clinic there and they open a pharmacy. The clinic from a big health care closes and then pharmacy goes away; this puts them at risk for losing a pharmacy in their home town.

Kapser: If every hospital & clinic in the state of North Dakota, had a pharmacy, what happens to the pharmacies that are free standing?

Olig: We can speculate, the last person to turn off the lights for health care is the pharmacists. It does put those communities who have pharmacies at risk.

Representative Nottestad: With the telepharmacies capabilities, would it be necessary for a pharmacist where they could put a tech in?

Olig: Yes, but its second best.

Representative Nottestad: The cost would be less than a pharmacy or hospital, yet they would achieve the same thing.

Olig: Those things are being done with in patient market because it's become very difficult to provide service in in-patient hospital services. It cost too much to put those types of services in place, so we are looking at doing telepharmacy services to small hospitals from larger hospitals.

Chairman Keiser: Why 51% for a hospital. Why shouldn't they have a lower standard?

Olig: I ask, why should they? Pharmacies are in charge of pharmacies and not by an administrator.

Chairman Keiser: Isn't it a possibility that a hospital could lose money on the pharmacy but provide the additional services. It doesn't need to be from their perspective. Isn't it possible in a fully integrated system, there might be some benefits for them owning for the level of service that could be provided?

Olig: I don't so. Explains why.

Gary Baylor~Thrifty White Drug. I wanted to follow up on some of the comments regarding feasibility of pharmacies in rural hospitals. If you put pharmacies in small hospital it keeps the community alive and hospital viable.

Chairman Keiser: On an economic standpoint, communities can't support a hospital and a separate pharmacy, but combining both would be effective?

Baylor: No, because it was tried & it didn't work, not enough numbers.

Chairman Keiser: Closes the hearing on HB 1523

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1523

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 4, 2009

Recorder Job Number: 8648

Committee Clerk Signature Ellen LeTang

Chairman Keiser: Opened the committee work session on HB 1523.

Chairman Keiser: Yesterday we hear two pharmacy bills. One the general bill that would remove the 51% ownership and the second bill carved out an exemption for all hospitals with six hospitals with grandfathered pharmacies in their premises. This would remove the pharmacy in a clinic, nursing home and anything that they owned and co occupy. Do you know what taxes accompany that pharmacy which is part of the Med Center Cooperation?

Marcy Dickerson~North Dakota Office of Tax Commission. Section 57-02-08, subsection eight, does provide for exemption of charitable properties including hospitals that are used entirely or in part for a charitable purposes excluding any property there that is leased or otherwise used with a (?). So, I guess it would matter on how is the pharmacy.

Chairman Keiser: Are they currently being taxed?

Dickerson: I believe they are, but I don't know. I could find out.

Chairman Keiser: Could you because that is a concern.

Vice Chairman Kasper: Could not the hospital structure that new pharmacy, maybe under the ownership of the new umbrella nonprofit or set up an entire new ownership and call it nonprofit incorporated and claim that that pharmacy is nonprofit.

Dickerson: I think what it still boils down to that the property overall would be owned by the hospital, not by this new organization. As such, I think it would still come under this as part of the hospitals otherwise exempt property that may or may not be considered useful property. There are many opinions that are written on this subsection.

Vice Chairman Kasper: If they structured it nonprofit and wanted it to be nonprofit and said it's nonprofit and flowed the dollars into their nonprofit and gave to charity and didn't use these other dollars for profit in any other way, would they not be able to claim that they are nonprofit?

Dickerson: It isn't what they do or when the proceeds of the sale, it's they providing a charitable service when they are making the sale.

Chairman Keiser: There is a different section just for hospitals that says that the integral part of the operation is deemed to be part of that charity.

Dickerson: You know, I'm not familiar with that section. There has been a lot of discussion about whether hospitals are really charitable or not.

Representative Amerman: If the bill passes, then they would hire pharmacy students to come in as an apprentice, would it be the same thing as charitable?

Dickerson: That would be debatable and would be up to the local governing body to make a determination and it would wind up in court.

Chairman Keiser: The reality is that the hospitals want it to help offset what the books say are a loss.

Dickerson: Is there a concern in the small towns. I guess you could craft language that would say if they are subject to property tax like any profit making organization.

Representative Nottestad: The point is that every hospital is unique.

Chairman Keiser: Closes the hearing on 1523.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1523

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 9, 2009

Recorder Job Number: 9001

Committee Clerk Signature Ellen LeTang

Chairman Keiser: Opened the committee work session on HB 1523.

Chairman Keiser: What are the wishes of the committee?

Vice Chairman Kasper: Motions a Do Not Pass.

Representative Amerman: Second.

Voting rolling was taken on HB 1523 for a Do Not Pass with 10 yea's, 3 nay's, 0 absent and Representative Gruchalla is the carrier.

Date: Feb 9 - 2009
Roll Call Vote # 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1523

House House, Business & Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

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

Motion Made By Seconded By

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

Total (Yes) 10 No 3

Absent 0

Floor Assignment Gruchalla

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

REPORT OF STANDING COMMITTEE

HB 1523: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO NOT PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1523 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

HB 1523

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on House Bill 1523
House Industry, Business and Labor Committee
February 3, 2009

Chairman Keiser, Members of the House Industry, Business and Labor Committee, I am Arnold Thomas, President of the North Dakota Healthcare Association, here this afternoon in support of HB 1523.

Representatives from Altru Health System described the situation this bill addresses. As written, it would provide a specific exemption from the present pharmacy ownership law and permit hospitals to operate a retail pharmacy in a clinic.

Clinic-outpatient service

As written it is not clear if the provisions in HB 1523 extend to all clinics owned or leased by a hospital. Our amendment would eliminate any ambiguity with respect to the exemption for hospitals and hospital clinics. Our amendment permits operation of a retail pharmacy within a hospital or any facility owned or leased by a hospital, provided the pharmacy is managed exclusively by a licensed pharmacist who exercises independent professional judgment in the practice of pharmacy at all times.

I have attached testimony from Erik Christenson, Pharm. D. His testimony underscores the access and choice restrictions created by the current law and supporting reasons for exempting hospitals from the current pharmacy ownership law.

We ask for adoption of our amendment and a committee "Do Pass" recommendation.

Mr. Chairman, I will entertain any questions you or the committee may have.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

PROPOSED AMENDMENTS TO HOUSE BILL 1523
OFFERED BY THE NORTH DAKOTA HEALTHCARE ASSOCIATION
FEBRUARY 3, 2009

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

Section 43-15-35 of the North Dakota Century Code is amended and reenacted as follows:

43-15-35. Requirements for permit to operate pharmacy.

1. The board shall issue a permit to operate a pharmacy, or a renewal permit, upon satisfactory proof of all of the following:
   a. The pharmacy will be conducted in full compliance with existing laws and with the rules and regulations established by the board.
   b. The equipment and facilities of the pharmacy are such that prescriptions can be filled accurately and properly, and United States pharmacopeia and national formulary preparations properly compounded and so that it may be operated and maintained in a manner that will not endanger public health and safety. The pharmacy is equipped with proper pharmaceutical and sanitary appliances and kept in a clean, sanitary, and orderly manner.

c. The pharmacy is equipped with proper pharmaceutical and sanitary appliances and kept in a clean, sanitary, and orderly manner.

d. The management of the pharmacy is under the personal charge of a pharmacist duly licensed under the laws of this state.

e. The applicant for such permit is qualified to conduct the pharmacy, and is a licensed pharmacist in good standing or is a partnership, each active member of which is a licensed pharmacist in good standing; a corporation or an association, the majority stock in which is owned by licensed pharmacists in good standing; or a limited liability company, the majority membership interests in which is owned by licensed pharmacists in good standing, actively and regularly employed in and responsible for the management, supervision, and operation of such pharmacy.

f. Suitable reference sources either in book or electronic data form, are available in the pharmacy or on-line, which might include the United States pharmacopeia and national formulary, the United States pharmacopeia dispensing information, facts and comparisons, micro medex, the American society of health-system pharmacists formulary, or other suitable references pertinent to the practice carried on in the licensed pharmacy.

2. The provisions of subdivision e of subsection 1 do not apply to:

a. The holder of a permit on July 1, 1963, if otherwise qualified to conduct the pharmacy, provided that any such permitholder that discontinues

operations under such permit or fails to renew such permit upon expiration is not exempt from the provisions of subdivision e of subsection 1 as to the discontinued or lapsed permit.

b. A ~~hospital~~ pharmacy ~~furnishing service only to patients in that hospital~~ located within a hospital or any facility owned or leased by a hospital, provided the pharmacy is managed exclusively by a pharmacist licensed in accordance with the provisions of this chapter who exercises independent professional judgment in the practice of pharmacy at all times.

~~c. The applicant for a permit to operate a pharmacy which is a hospital, if the pharmacy for which the hospital seeks a permit to operate is a retail pharmacy that is the sole provider of pharmacy services in the community and is a retail pharmacy that was in existence before the hospital took over operations. A hospital operating a pharmacy under this subdivision may operate the pharmacy at any location in the community.~~

c. The applicant for a permit to operate a pharmacy which is the owner of a postgraduate medical residency training program if the pharmacy is collocated with and is run in direct conjunction with the postgraduate medical residency training program. For purposes of this subdivision, the postgraduate medical residency training program must be accredited by the accreditation council on graduate medical education or other national accrediting organization.

Testimony on House Bill 1440

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

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

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

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

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

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

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

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

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

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

HPC
healthpolicyconsortium

Altru Health System | Medcenter One medcenterone.com | MeritCare | Trinity Health

North Dakota 2009 Legislative Session
House – Industry Business and Labor Committee
Testimony on House Bill 1523
February 3, 2009

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

My name is Beverley Adams and I am the Executive Administrator of the Health Policy Consortium (HPC) which is comprised of the four largest integrated health systems in the State of North Dakota. They are Altru (Grand Forks), MedCenter One (Bismarck), MeritCare (Fargo) and Trinity (Minot). We are in support of HB 1523, which creates a health system exception to the requirement of the North Dakota Century Code Sec. 43-15-35 Subd. 1(e), which requires a retail pharmacy to be owned by at least 51% by pharmacists. We are also not opposed to the amendments proposed by NDHA Executive Director, Chip Thomas.

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

centers, orthopedics, cardiology, children's hospital specialties, neonatology organ transplants, nephrology, cancer treatments, dermatology and reproductive specialists. These are services that small rural hospitals cannot provide.

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

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

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

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

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

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

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

Also, with the rapid care and walk in clinics, that do not currently have any pharmacy services, this would provide young mothers with children the

ability to fill prescriptions immediately without having to travel with small sick children to yet another location to fill a prescription.

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

No other State has this 51% ownership requirement. In addition, there currently exist numerous exceptions to the 51% requirement. There is a common sense patient driven reason to allow hospitals and healthcare systems to own and operate a retail pharmacy.

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

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

As you know HB 1440 heard testimony this morning and this bill is somewhat contradictory to the objectives of HB 1440. Although the HPC clearly supports HB 1523, the primary objectives for the HPC are

comprehensive patient care. The support of this Bill is a step in the right direction for patient care; however, HB 1440 is what ultimately is best for patients, not just hospitals. HB 1523 provides greater access for patients and allows hospitals to provide comprehensive patient care, but HB 1523 will not create a free market economy so that patients can fill prescriptions that they otherwise could not afford or split their pills because they cannot afford to take the dose as prescribed by their physician. The HPC members believe that HB 1523 would be better than our current ownership requirements as it relates to patients; however we strongly support HB 1440 even though this would create additional competition for hospital pharmacies as this is what is ultimately best for our patients.

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

Please consider these comments as you deliberate on HB 1523. Chairman Weisz and members of the committee thank you for the time to speak to you today. I am available to answer any questions that you may have at this time.

testimony 3

Testimony in favor of
HB 1523
By Tom Simmer

My name is Tom Simmer and I am a hospital pharmacist at Medcenter One. I am here to provide testimony in support of HB 1523. There are three quick points that I would like to make in my testimony.

1. Hospitals are open 24 hours a day and 7 days a week. Our goal is to provide around the clock comprehensive services which include pharmacy. One of the core services provided by hospital pharmacists is that they round with physicians to assure appropriate use of pharmaceuticals in the treatment plan. The use of medications is an integral part of care and patients should be able to continue to use hospital based pharmacy services as they transition to their home or to long term care facilities.

2. We have expanded our clinic services to address patient's need for convenient care. The Medcenter One North Walk-In Clinic provides 1,500-2,000 visits each month. At the present time, the worried mother must tote her sick child back and forth to the car and into another location to fill any medication needs. The N.D. Board of Pharmacy denied two applications submitted by Medcenter One within the last year to provide pharmacy and then telepharmacy services at that location. It is unfortunate that as an integrated system, we are not able to provide prescription services directly linked to the patient's medical record.

3. During the expansion of our hospital pharmacy to allow for robot automation in 2005, Medcenter One needed to maintain the hospital pharmacy in conjunction with our out-patient grandfathered pharmacy at the main campus. Since the operations could not be separated without fear of losing the out-patient permit, the Board Room and CEO's office were downsized significantly.

These points all reflect why hospitals should be able to operate retail pharmacies in conjunction with other medical services; HB 1523 would give hospitals that privilege. Hospital pharmacists want to continue to work closely with physicians to provide continuity of care and high quality medical services in wherever our hospital provides care.

Thank you for your time and I would be happy to answer any questions you may have.

BOARD OF PHARMACY
State of North Dakota

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HOUSE BILL #1523 – Relating to Hospital Retail Pharmacies
Industry, Business and Labor Committee
2:00 PM - Tuesday – February 3rd, 2009
Peace Garden Room

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

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

The issues relative to whether hospitals should be in the pharmacy business are different and yet the same as the issues in House Bill #1440. I am including that same testimony below for the record. I just want to make a couple of salient points.

In all instances, pharmacies ***can*** locate in clinics, hospitals, grocery stores or any other suitable location just by executing a lease with a pharmacist, pharmacists or a company controlled by pharmacists. Business associate agreements can be executed to provide coordinated care of the patient, by provision of the pharmacist services required. Pharmacies in clinics, under a contract, can be sure that samples are dispensed appropriately, labeled according to the prescribers wishes and information provided to the patient by the pharmacist. All these services can be provided with a lease department or a contractual arrangement with a pharmacist or pharmacy.

The most disturbing statement I hear over and over again from pharmacists who work for non-pharmacist owners is "*that is not the decision that I would have made, but they did not ask me*". In North Dakota, because of the environment you have created and maintained, the pharmacist must be consulted as they are the owner and in control of the business.

I would like to address specifically the situation of the Grand Forks Clinic Pharmacy, which is a grandfathered pharmacy as a partnership of physicians. You, that is the North Dakota Legislature, in 2005 passed NDCC 45-21-05 Merger of partnerships. This specifically allows partnerships, such as Grand Forks Clinic Pharmacy's partnership, to be merged into another business entity, such as Altru Health Systems. The benefits, including the grandfathered status, would accrue to the surviving entity under current North Dakota Law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We hope you agree and will keep it that way.

Thank you.

45-21-05. (905) Merger of partnerships.

1. Pursuant to a plan of merger approved as provided in subsection 3, a partnership may be merged with one or more other organizations.

2. The plan of merger must set forth:

   a. The name of:

      (1) The partnership;

      (2) Each other constituent organization proposing to merge; and

      (3) The surviving organization into which the other organizations will merge;

   b. The status of each partner;

   c. The terms and conditions of the merger;

   d. The manner and basis of converting the ownership interests of each constituent organization into ownership interests or obligations of the surviving organization, or into money or other property in whole or part; and

   e. The street address of the principal executive office of the surviving organization.

3. The plan of merger must be approved:

   a. In the case of a partnership that is a party to the merger, by all of the partners, or a number or percentage specified for merger in the partnership agreement; and

   b. In the case of a constituent organization other than a partnership that is a party to the merger, by the vote required for approval of a merger by the governing statute of the constituent organization in the jurisdiction in which the constituent organization is organized.

4. After a plan of merger is approved and before the merger takes effect, the plan may be amended or abandoned as provided in the plan.

5. The merger takes effect on the later of:

   a. The approval of the plan of merger by all constituent organizations, as provided in subsection 3;

   b. The filing of all records required by law to be filed as a condition to the effectiveness of the merger; or

   c. Any effective date specified in the plan of merger.