MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

1435

DESCRIPTION

2007 HOUSE HUMAN SERVICES

HB 1435

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 29, 2007

Recorder Job Number: 2214

Committee Clerk Signature Judy Schaefer

Minutes:

Vice Chair Pietsch: opens the hearing on HB 1435.

Avery Smith CPA CM Deputy State Health Officer: Representative Price asked me to come in and provide you with some back ground information on situations where you end up with immunizations in the state of ND, and what we are talking about when we talk about the providing choice option, and why we landed there. See attached. It is a complicated and expensive issue.

Lisa Clute, Executive Office of First District Health Unit: See attached testimony. Amendments on this bill will be offered.

Kirby Kruger, epidemiologist for the ND Department if Health: See attached testimony with proposed amendments and spread sheets attached. The sole purpose of this spread sheet is to give us an estimate for the 3 months target cost for the local public Health Unit vaccination inventory. The doses represented here are only doses that are given at the local public health unit to children that have insurance, which is the population that is of concern for reimbursement.

Representative Weisz: In the start up why isn't HPV costs mandated?

Mr. Kruger: At this time HPV is ACIP recommended vaccination. So we are going to be recommending that children receive it regardless of whether it is requirement for school entry or not.

Keith Johnson, administrator of Custer Health in Mandan: Ito stand to support this bill . This has been a very intense cooperation between legislators, the health department, local public health units, and Blue Cross Blue Shield. All the providers have a common goal of not wanting immunization rates in this state to fall. The 15 month extension is very essential as far as the providers are concerned.

Representative Pietsch: Any others in favor of the bill? Any opposition of HB 1435? If not we will close HB 1435.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2280

Committee Clerk Signature Judy Kelsch

Minutes.

Chairman Price: Take out HB 1435. We have amendments in front of us from the health department.

Representative Porter moves the amendments. **Representative Hatlestad** seconds the motion a verbal vote taken with all 12 yeas.

Chairman Price: We had a discussion on the amount that is in your amendments of 4 million plus, as to why. Why the start up and catch up funds for HPV when it is not one mandated?

Kirby **Kruger:** I look at immunizing as many kids as we can to prevent many of these diseases as possible. HPV and influenza are not mandatory.

Representative Conrad moves a do pass as amended RR/Appropriations. **Representative Kaldor** seconds the motion. The vote was 12 yeas 0 nays, and 0 absent. **Representative Pietsch** will carry the bill to the floor.

Date: 1/30
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1435 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move Amendments

Motion Made By Rep Potter Seconded By Rep Hatlestad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) "Click here to type Yes Vote" 17 No "Click here to type No Vote" 0

Absent 0

Floor Assignment _____

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

Date: 1/30
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1435 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass Amended RR/app

Motion Made By Rep Conrad Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Rep. Pietsch

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

REPORT OF STANDING COMMITTEE

HB 1435: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1435 was placed on the Sixth order on the calendar.

Page 1, line 11, after "received" insert "age appropriate"

Page 1, line 13, remove "1 and 2" and remove "conjugate vaccine (MCV4) for"

Page 1, line 14, remove "meningitis"

Page 1, line 18, replace "October" with "July"

Page 1, line 19, after "distribute" insert "vaccines purchased under section 3 of this Act" and after "units" insert "and other immunization providers"

Page 1, line 24, replace "$3,495,634" with "$4,268,077"

Page 2, line 2, replace "immunization program grants" with "vaccines" and after "units" insert "and other immunization providers"

Page 2, line 3, remove "Of the amount appropriated, $983,273 is for MCV4 and"

Page 2, remove line 4

Renumber accordingly

2007 HOUSE APPROPRIATIONS

HB 1435

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **1435**

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: **9 February 2007**

Recorder Job Number: **3309**

Committee Clerk Signature Jan Prindle

Minutes:

Representative C. Price, District 40, introduced the bill. HB 1435 came in because I wanted to make sure that we had the proper discussion on the fact that there are some issues coming up on child immunizations. There is going to be impact on the consumers of child immunizations and local public health units as ND transitions from the universal select state to a provider's choice state. What this bill does is extends our present system of delivering vaccines for a period of time. Its purpose is to make the transition as seamless as possible for both consumers and providers in hopes to maintaining our high vaccination rate. The appropriation is a one-time cost to the state. The need to transition came because of the reduction of federal 317 funds. We'll continue to get our vaccine for children funds, but not the 317 funds in the amount we had before so we can't do business as usual where your constituents would go to the local public health and get the immunizations for school and pay $10 for administration. If we don't do something to address the transition there is going to be a financial risk potential to our local public health units. Some of the issues for consumers is if a client who does not have insurance coverage or they do not have vaccine for children coverage, which would be Medicaid or Native American, they would basically have to "up front" the entire cost when they walk in the door to have their children immunized for school. We'll no longer be able to do max vaccination clinics. The State Health Department originally

planned to implement provider's choice on September 1, 2207, but there are a number of things that needed to be addressed and because of some of the concerns coming forward from the local public health units, we're having this discussion. We need to implement a billing system so public health units can bill private insurance, they'll need to recruit additional providers to administer immunizations and do some of the paperwork, and we need to educate the public that things aren't business as usual as far as getting their kids vaccinated before and school. **I did pass out some amendments**. The bill appropriates a potential of $1.5 million to the Department of Health to purchase the vaccines and distribute them to the local public health units. If we can get the transition done quickly and efficiently we may not need all of it. If we run into snags, in the last 18 months there is another $1.0 million of contingency funds only to be used if the system is not up and running as we wish. We also put in there that the department should report to LC as requested during the biennium on how the implementation is going.

Chairman Svedjan: You indicated to me that of all the bills you sent down to us this is your higher priority.

Representative Price: Personally I put this number 1, because right now we have done an excellent job of having our children vaccinated through the system that has been set up. Our constituents are not used to going to the clinic and having to "up-front" this money.

Representative Pollert: I move the amendment.

Representative Kempenich: I second.

A voice vote was taken: The amendment .0202 was accepted.

Representative Pollert: I move Do Pass as Amended.

Representative Gulleson: I second.

A roll call vote was taken: Yes: 23, No: 0, Absent: 1 (Aarsvold)

Representative Pollert will carry the bill.

Attach 1

70748.0202
Title.

Prepared by the Legislative Council staff for
Representative Pollert
February 9, 2007

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1435

Page 1, line 17, after the second boldfaced period insert:

"1."

Page 1, line 18, replace "September 30, 2008" with "December 31, 2007"

Page 1, line 19, remove "funds"

Page 1, after line 23, insert:

"2. During the period beginning January 1, 2008, through June 30, 2009, the state department of health may distribute vaccines purchased under section 3 of this Act to local public health units and other immunization providers for the purpose of continuing the transition to a provider choice immunization program."

Page 2, line 1, after "**APPROPRIATION**" insert "**- CONTINGENT APPROPRIATION - LEGISLATIVE COUNCIL REPORT**"

Page 2, line 2, replace "$4,268,077" with "$2,500,000"

Page 2, line 5, after the period insert "Of the total amount appropriated, $1,000,000 is only available if the department of health determines that vaccines need to be purchased after December 31, 2007, pursuant to section 2 of this Act. The department shall report to the legislative council as requested, during the 2007-08 interim, on the status of the immunization program."

Renumber accordingly

Date: 2/9/07
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1435

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70748.0202

Action Taken Adopt Amendment 0202

Motion Made By Pollert Seconded By Kempenich

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Representative Wald			Representative Aarsvold		
Representative Monson			Representative Gulleson		
Representative Hawken					
Representative Klein					
Representative Martinson					
Representative Carlson			Representative Glassheim		
Representative Carlisle			Representative Kroeber		
Representative Skarphol			Representative Williams		
Representative Thoreson					
Representative Pollert			Representative Ekstrom		
Representative Bellew			Representative Kerzman		
Representative Kreidt			Representative Metcalf		
Representative Nelson					
Representative Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote - carries

Date: 2/9/07
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1435

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70748.0202

Action Taken Do Pass as amended

Motion Made By Pollert Seconded By Gulleson

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Representative Wald	✓		Representative Aarsvold	—	
Representative Monson	✓		Representative Gulleson	✓	
Representative Hawken	✓				
Representative Klein	✓				
Representative Martinson	✓				
Representative Carlson	✓		Representative Glassheim	✓	
Representative Carlisle	✓		Representative Kroeber	✓	
Representative Skarphol	✓		Representative Williams	✓	
Representative Thoreson	✓				
Representative Pollert	✓		Representative Ekstrom	✓	
Representative Bellew	✓		Representative Kerzman	✓	
Representative Kreidt	✓		Representative Metcalf	✓	
Representative Nelson	✓				
Representative Wieland	✓				

Total (Yes) 23 No 0

Absent 1

Floor Assignment Pollert

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

REPORT OF STANDING COMMITTEE

HB 1435, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (23 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1435 was placed on the Sixth order on the calendar.

Page 1, line 17, after the second boldfaced period insert:

"1."

Page 1, line 18, replace "September 30, 2008" with "December 31, 2007"

Page 1, line 19, remove "funds"

Page 1, after line 23, insert:

"2. During the period beginning January 1, 2008, through June 30, 2009, the state department of health may distribute vaccines purchased under section 3 of this Act to local public health units and other immunization providers for the purpose of continuing the transition to a provider choice immunization program."

Page 2, line 1, after "**APPROPRIATION**" insert "**- CONTINGENT APPROPRIATION - LEGISLATIVE COUNCIL REPORT**"

Page 2, line 2, replace "$4,268,077" with "$2,500,000"

Page 2, line 5, after the period insert "Of the total amount appropriated, $1,000,000 is only available if the department of health determines that vaccines need to be purchased after December 31, 2007, pursuant to section 2 of this Act. The department shall report to the legislative council as requested, during the 2007-08 interim, on the status of the immunization program."

Renumber accordingly

2007 SENATE HUMAN SERVICES

HB 1435

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3-12-07

Recorder Job Number: 4872, 4932

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Senator J. Lee opened the hearing on HB 1435 relating to child immunizations; and to provide an appropriation.

Senator J. Lee (District #13) introduced HB 1435 to bring to the attention of the committee the need of funding for immunizations.

Arvy Smith (Deputy State Health Officer, ND Dept. of Health) testified in support of HB 1435. See attachment #1 and #1a. First she addressed her power point presentation (#1a).

Senator Warner asked how many approved clinics there are.

Ms. Smith said there are only about 30. She offered to provide a listing. (Attachment #1b) There are none in Bismarck. They either need to cover them with a different source or send them to Beulah to be covered with the federal available VFC funding.

They are working on mechanisms to expand that. It is a federal rule and they can't change it. They are exploring deputizing the local public health units and clinics as a federally qualified health center so they would have more of them available and have vaccines more accessible. (Meter 26:00) Ms. Smith continued with her written testimony (#1) which included a proposed amendment.

Senator J. Lee asked for clarification on the amendment and Ms. Smith explained that both sections 1 and 2 would be deleted and some change of language in 3. The $2.5 million would be just for the 6 month transition period, although $1million of that can be used later if there was a major delay that caused it to go after December 31. They have $19.2million authority in HB 1004, budget bill, which allows them to funnel the money through their department and handle the provider choice scenario. (Meter 32:45) She explained how that works.

Lisa Clute (Executive Officer, First District Health Unit) testified on HB 1435. (Attachment #2) They support the amendments proposed by the health department.

Senator J. Lee asked if she was comfortable with the bill with the proposed amendments from the health department and if they were making any recommendations for changes.

Ms. Clute said they met with the health department to discuss the proposed amendment. As long as dialogue is open they have no problem with them. Provider choice is a work in progress.

Senator J. Lee asked if there was any potential for school clinics to ever come back.

Ms. Clute said she didn't know the answer but they will work hard to do that because they view it as such a vital mechanism.

Attachment #3 is testimony from Stephen McDonough, pediatrician, in support of HB 1136 and HB 1435.

There was no opposing or neutral testimony.

The hearing on HB 1435 was closed.

Senator J. Lee asked Rod St. Aubyn (BC/BS) what they were doing about vaccinations.

Rod St. Aubyn (BC/BS) responded that they follow the ACIP recommendation. Whatever they come out with is what BC/BS did with their standard method plan. As far as self funded, the

recommendation is the same thing and for the most part they do as well. The only exception to that would be PERS which has not included the new HPV vaccination in the new contract.

Senator J. Lee asked if there is a deductible for the insured on the vaccinations.

Mr. St. Aubyn said he wasn't sure. There are different options and different plans.

Senator J. Lee recognized Arvy Smith (Health Department) who clarified that PERS is covering HPV for children through 18. Some discussion pertaining to that followed.

Senator J. Lee recessed the committee.

JOB #4932

(Meter 17:20) Senator J. Lee opened HB 1435 for discussion.

Senator Erbele moved to amend HB 1435 by deleting sections 1 and 2 and adding language on page 2 line 8.

The motion was seconded by Senator Dever.

Roll call vote 6-0-0. Amendment accepted.

There was discussion on wanting to get school clinics back in and wondering how to do it.

Senator J. Lee recognized Lisa Clute.

Lisa Clute (First District Health Unit) said that is a logistical issue for a local public health unit. Provider choice eliminates the ability to go into schools and immunize. The options are universal coverage or provider choice.

Senator Pomeroy moved a Do Pass as amended and rerefer to appropriations.

The motion was seconded by Senator Erbele.

This is just an appropriation bill now. The policy is in HB 1136.

Senator J. Lee recognized Lisa Clute.

Lisa Clute (First District Health Unit) reminded the committee that 1435 is only a transition bill from universal to provider choice. It's a one time appropriation. What it is doing is assuring

that population is not lost while putting in provider choice. It's a safety net for that population that won't be covered when the move is made to provider choice.

Senator Warner asked if there is any place they are being asked to make a policy decision on the change from universal to provider choice.

Ms. Clute said, as far as she knows, that decision was made by the state health department and the governor's office. This bill was introduced as a result of that decision to move to provider choice.

Senator Dever asked if the governor's budget in any way factors this transition in.

Ms. Clute said there was no money allocated for this.

Kirby Kruger (Department of Health) offered information that HB 1004, the department budget, has two FTE's and about $220,000 for the implementation and support of provider choice. That was all that was included over and above what they usually get.

Roll call vote 5-1-0. Motion carried. Carrier is Senator Erbele.

Date: 3-12-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1435

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken amendment

Motion Made By Sen. Erbele Seconded By Senator Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair 1	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever 2	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

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

Date: 3-12-07

Roll Call Vote #: 2

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1435

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70748.0301

Action Taken Do Pass / Amend / refer

Motion Made By Sen. Pomeroy Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner		✓

Total (Yes) 5 No 1

Absent 0

Floor Assignment Senator Erbele

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

REPORT OF STANDING COMMITTEE

HB 1435, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Reengrossed HB 1435 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "amend and reenact subsection 1 of section 23-07-17.1 of the North Dakota"

Page 1, line 2, remove "Century Code, relating to child immunizations; and to" and after "appropriation" insert "; and to provide for a report to the legislative council"

Page 1, remove lines 4 through 23

Page 2, remove lines 1 through 4

Page 2, line 8, replace "providing vaccines to" with "implementing the provider choice program including the purchase of vaccines for"

Page 2, line 11, remove the second comma

Page 2, line 12, remove "pursuant to section 2 of this Act"

Renumber accordingly

2007 SENATE APPROPRIATIONS

HB 1435

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1435

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-19-07

Recorder Job Number: 5299

Committee Clerk Signature Alice Delzer

Minutes:

Chairman Holmberg opened the hearing on HB 1435 at 4:12 pm on March 19, 2007 regarding the appropriation to the State Health Department for the purpose of implementing the Provider Choice Program including the purchase of vaccines for public health units and other immunization providers.

Representative Carla Sue Price, District 40, Minot gave oral testimony in support of HB 1435. She made comments regarding the funding changes and the fact that the federal funding will be cut dramatically and the coverage would go from universal coverage, which we have been under, to Provider Choice. Provider Choice is a totally different program and we have real concerns concerning this program. The bill before you is an attempt to make that transition smooth She expressed concerns regarding the local public health units and vaccination for children, the costs of these vaccinations and who will pay for them. Also talked about the State Health Department and it's involvement in the vaccination of children. Her biggest concern is if the parent has to pay for all the school vaccinations and the price is going up all the time. We have a high percentage rate of school immunizations and we don't want to lose it because these are all contagious diseases.

Senator Judy Lee, District 13, West Fargo gave oral testimony regarding HB 1435 and explained the amendments. She expressed concerns regarding the transition of the program

from local health units to the State Health Department, the fact that various sources of payment are now required, federal funding is decreased and immunizations are not going to be done through the school anymore because of the various sources of payment that will now be required. When vaccinations were provided under universal coverage we could do the school clinics but now they will be privately insured but I am hoping that at some point in the future they can have the schools do that again. She stated that is one of the reasons why we have had high immunization rates. She stated our priority has to be the children and their need to have the vaccinations regarding these contagious diseases.

Arvy Smith, Deputy State Health Officer presented written testimony (1) and oral testimony in support of HB 1435. She shared the changes that are taking effect, stating the costs of vaccinations have increased and our funding from the federal government has decreased. Vaccination is a federal mandate. She also shared the different funding sources for vaccines.

Senator Krauter asked if they have received official notice regarding funding from the federal government. He was informed that .previously North Dakota got a disproportionate share per child. They said they will reformulate that based on population of children we are projected to drop in funding. We don't know when this will happen, it could happen within 5 years. We are fighting to save it.

Senator Bowman had questions regarding vaccines and their usage and whether that eventually would drive down the cost of health care. He was informed that it would depend on which vaccine you look at.

Senator Wardner asked what period of time do children get these shots. He was informed birth through age 18.

Senator Lindaas had questions regarding if there is any agency, federal or otherwise that looks at accountability of the vaccine producers in terms of justification of increase of costs. He

was told the FDA provides some oversight. They have to approve all these vaccines. The next step is the Advisory Committee on Immunization Practices, recommending the vaccine to be provided and they will look at numerous things, including cost effectiveness and the pricing.

Senator Krauter had questions regarding the federal money available and how long it will be available. He also had questions concerning line 11 in testimony.

Senator Mathern also had questions regarding the federal funding and expressed concern that amendments would be prepared to address these issues.

Lisa Clute, Executive Officer of First District Health Unit presented written testimony (2) and oral testimony in support of HB 1435 and requested a Do Pass on this bill.

Chairman Holmberg closed the hearing on HB 1435.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1434, 1435, 1004

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-22-07

Recorder Job Number: 5482

Committee Clerk Signature

Minutes:

Senator Kilzer opened the subcommittee committee discussion on HB 1334, 1335, 1004, and Senator Kilzer indicated what had transpired to day on HB 1434, after questions were responded to the committee decided to accept HB 1434. He then discussed what had transpired to date on HB 1435 as well as the appropriations that are currently in it.

He distributed an amendment concerning the morgue in Grand Forks.

Senator Mathern expressed concerns on the language in the appropriations. The differences between the 0207 and 0208 amendments were then discussed together with the appropriations.

Senator Mathern indicated he talked with Dr. Wilson, Dept. of Health, and asked Don Morrisette to prepare amendments. The amendment has the same language as that from the oil tax fund. The only difference is one has $25,000 and the other has the new figure of $75,000.

Arvy Smith worked with UND on that to see how to deal with it and they indicated it would take about one year to construct the building and one year to begin autopsy operations.

Senator Kilzer discussed the $75,000 and referenced $125,000. He then questioned where the other location is.

Don Morrisette indicated it is strictly in section 4.

Senator Kilzer questioned about Section 6. The response was that emails were sent. The only other item recalled was to remove section 8 out of bill.

Don Morrisette stated that page 4 removes legislative intent and is part of the corrected amendment.

Senator Mathern stated he would like to see section 6 amended. After yesterday's meeting did spend some time on this and would like the opportunity to go thru 1-16 and see if we can include some of them in the recommendations we make.

He stated this set of amendments is the same as yours with the removal of section 8 and then lists other items. They are in a different rank order. He asked the department of health to put them in their order.

Arvy Smith presented comments on section 18.

Senator Mathern stated one item on school health we could be open to other methods of funding and consideration of the fact that we passed a bill that supports school nursing. He has amendments that are an option to fund that. We take the language of what was passed in a senate bill and school nursing bill and pass it in this format by taking the money from DPI and moving it to the health department.

Senator Kilzer indicated schools already receive tobacco funds from three sources. This would increase that by $1million to permit the schools to expand school nursing program.

Senator Kilzer asked if SB 2385 is still around. The response was that the house defeated it.

Senator Mathern indicated this takes a different approach as to how to fund it and it requires a local match I haven't spoken with Dr Sanstead but they have seen the language and agree.

Senator Mathern looked for state equity in salary adjustments. The Health Department did not get the same funding as other agencies did.

Arvy Smith indicated the adjustments are now all 17 percent below others state agencies.

Senator Mathern stated in some agencies there was direct funding but not in the health dept

Senator Kilzer stated as he remembers to bring people to 90 percent of marketable salary would take $50 million.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1435

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-22-07

Recorder Job Number: 5461

Committee Clerk Signature Janet Pinks

Minutes:

Chairman Holmberg opened the hearing on HB 1435.

Senator Kilzer indicated this is bill to supplement decreases in the federal situation. They are going to have vaccine at the reduced rate next year. What the amendment does is take the $2.5 million in the next two years and reduces it by ¼ because the new crisis and availability of stockpiles of vaccines will not change until after Jan. 1. Which is why it was taken from $2.5 to $1.8 million and this will also give us a seat at the conference committee.

Senator Kilzer moved do pass on the amendment 0303, Senator Grindberg seconded.

Discussion followed.

Senator Mathern indicated what he was hearing from the department is they would like to have options to do immunizations clinics in schools. This new process of provider choice essentially creates a situation where we are not going into 7th grade anymore and providing immunizations. We have concerns that will lead to a reduction of immunizations. As an alternative to the amendments I would distribute this other amendment

Chairman Holmberg indicated we will act on the first amendment.

Senator Mathern indicated it makes it impossible or difficult to use any additional money available for school clinics. Senator Kilzer is cored in the amounts possibly being lower but we

should preserve the $2.5 million to give options to the Health dept to continue doing immunizations to the degree they can save money under the cost of the program.

An oral vote was taken on Senator Kilzer's amendment. It was a do pass

Senator Mathern moved to further amend 0302 indicating the amendments, pg 2 line 12, indicates any funds not used for implementation provider choice may be used for payment of other immunization projects. Essentially, we are moving into a brand new method of payment for immunizations and delivery of immunizations. This method has been worked out with local public health, providers, Blue Cross, Blue Shield, and Department of Health and there is concern about how well this would work. This amendment says lets be creative.

Chairman Holmberg indicated if we adopt this amendment, the other amendment would be gone.

Mathern moved approval of .0302 and would give flexibility, _____ seconded. No discussion. A show of hands brought a 7/7 vote and did not pass.

Senator Bowman moved a do pass as amended, Senator Kilzer seconded. A roll call vote was taken resulting in 14 yes. The motion passed. Senator Kilzer will carry the bill.

Chairman Holmberg closed the hearing on HB 1435.

70748.0302
Title.

Prepared by the Legislative Council staff for
Senator Mathern
March 20, 2007

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1435

In lieu of the amendments adopted by the Senate as printed on pages 808 and 809 of the Senate Journal, Reengrossed House Bill No. 1435 is amended as follows:

Page 1, line 1, remove "amend and reenact subsection 1 of section 23-07-17.1 of the North Dakota"

Page 1, line 2, remove "Century Code, relating to child immunizations; and to" and after "appropriation" insert "; and to provide for a report to the legislative council"

Page 1, remove lines 4 through 23

Page 2, remove lines 1 through 4

Page 2, line 8, replace "providing vaccines to" with "implementing the provider choice program, including the purchase of vaccines for"

Page 2, line 11, replace the second comma with a period

Page 2, line 12, replace "pursuant to section 2 of this Act" with "Any portion of the $2,500,000 appropriation that is not necessary for implementation of provider choice may be used for other immunization projects, including vaccination clinics in schools or other locations"

Renumber accordingly

70748.0303
Title.0500

Prepared by the Legislative Council staff for
Senator Kilzer
March 21, 2007

3-22-07

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1435

In addition to the amendments adopted by the Senate as printed on pages 808 and 809 of the Senate Journal, Reengrossed House Bill No. 1435 is further amended as follows:

Page 2, line 7, replace "$2,500,000" with "$1,850,000"

Renumber accordingly

Date:
Roll Call Vote #:

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1435

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP w Amend 307

Motion Made By Bo. Seconded By

Senators	Yes	No	Senators	Yes	No
Senator Ray Holmberg, Chrm	✓		Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm	✓		Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm	✓		Senator Tim Mathern	✓	
Senator Randel Christmann	✓		Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour	✓	
Senator Ralph L. Kilzer	✓		Senator Harvey Tallackson	✓	
Senator Karen K. Krebsbach	✓				
Senator Rich Wardner	✓				

Total (Yes) 14 No

Absent

Floor Assignment Kilzer

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

REPORT OF STANDING COMMITTEE

HB 1435: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1435 was placed on the Sixth order on the calendar.

In addition to the amendments adopted by the Senate as printed on pages 808 and 809 of the Senate Journal, Reengrossed House Bill No. 1435 is further amended as follows:

Page 2, line 7, replace "$2,500,000" with "$1,850,000"

Renumber accordingly

2007 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1435

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

House Human Services Committee

☒ Check here for Conference Committee

Hearing Date: April13, 2007

Recorder Job Number: 5998

Committee Clerk Signature Judy Lehock

Minutes:

Chairman Pollert: I would like to ask the senate side on the changes and why on HB 1435.

Senator Kilzer: This did come through appropriations as a bill separate from the health department, which did also contain some appropriation for handling vaccines. In appropriations department when we look at a bill like that and it is not in the executive budget, it is at risk because it is not fully clothed when it comes to us. We looked at this and didn't understand the 317 funding, and we heard later that carry over will not be allowed as it has in the past. For those two reasons we reduced it by 25%, which would be the first 6 months in the next biennium. That is why we reduced the appropriation.

Senator Lee: We have gotten some additional information about the need for that first 6 months to be funded in order to establish the provider choice program. That is where we were coming from. I would hope that from here on we might be able to figure out what we need to do in order to make sure we have a stream line and painless implementation of provider choice. We know that is coming. This is the next chapter.

Chairman Pollert: I appreciate Senator's comments about the budget process and this bill being over and above. He knows we are struggling with that issue in the human services

budget too with what was and wasn't in there. This is an education process for me as well on the 317 funding and what it can and can not be used for.

Representative Price: We could have the department explain what they liked about the bill as it or if they need to see change. There is a lot of unknown for us.

Senator Lee: Also we did get a hand out that is very helpful. It talks about the varies portions of funding, 317 being one, and why we would be looking at several billing entities. That is part of the issues for the public health unit as to who pays for what. WE will make sure that is available to them.

Chairman Pollert: If I am correct when it left the house side there was 1 ½ million of basically 6 months and the other million dollars was a contingency in case they couldn't make it in that time frame.

Arvey Smith, Deputy State Health Officer: See attached document. I will take you into page 2 where there are 2, major federal funding, and the VFC underinsured. Those are not a concern. The underinsured if they don't go to that clinic and they are served like at public health than they can not use that funding source. One thing that is in the works is to get the local public health unit authorized to provide those on behalf of a federally qualified health center.

Representative Price: Will that be through o entity?

Ms. Smith: Yes we have Coal Country who has agreed to be that entity. They are a federally qualified health center. They will designate according to providers to do this. They are in Beulah. They will do it for the state. The one in Grand Forks, Northwood is considering doing Grand Forks, if they don't Coal Country will do the entire state.

Senator Warner: How many entities are on the list here?

Ms Amith: It would be all the providers, all public health units and than all private providers. Of the private providers, 69 of them are rural health clinics. So the rural health clinics can already do the under insured.

Senator Lee: Are there any issues with the deputizing, or any objections that have been raised by the feds or anyone being able to implement.

Ms. Smith: What we are hearing from the feds this is one of those goofy federal regulations that we wish would go away. What better purpose is there of rural health centers and federally qualified entities than to make sure that kids in rural areas get vaccinated. That is Coal Countries philosophy, and they are willing to do this.

Chairman Pollert: And we are trying to do this in a 6 month frame?

Ms Smith: We have the documents just about ready to go out the door to get signed. We should do this regardless of where the funding goes. We are almost good to go on this one piece. All of these changes that are going on in immunization, and all these changes are being bundled into this provider choice thing. Some will happen regardless of that, and you need to deal with them.

Representative Price: What is Coal Country getting for this?

Ms Smith: Nothing, the liability stays with who is providing the vaccine. For this piece they will not take anything. Billing issues will be another story.

Representative Price: How will the vaccines be distributed?

Ms Smith: There are new federal rules that will change how vaccines are distributed. Right now our providers can place orders every month. There will be a central distribution center that will distribute the vaccines and will limit how many times people can order.

Representative Lee: What do we do about out dated vaccine?

Ms. Smith: That is some of the challenges that are coming up. With all the new vaccines how does a small unit or provider predict what they need? They have to guess over a 6 month period. The vaccines are good for a couple of years. We talked about trading back and forth. We will need to monitor that closely. All of that will happen regardless of this bill. That is federal rules.

Representative Price: You can't order and distribute to others?

Ms. Smith: We have to order for everyone, even for the Federal. With provider choice even for the non federal we will order so we get the lower rate. If they all order separately they pay more.

Representative Price: How will they know if they only order every 6 months?

Ms. Smith: When we order out of end cap that is also bound to the 6 what ever the federal rules are. If we didn't order the non federal vaccines for the providers they would have to order them individually.

Molly Sender, immunization director: Answers from the audience and hard to understand. Every state has a different mechanism for distributing vaccines.

Senator Lee: Can you shuffle around if you are doing the ordering and there is a difference in demand from one region to another is it legal?

Ms Smith: We are exploring if there are ways that we will be able to juggle stuff. They can't sell it to one another. I don't know if they can borrow back and forth. I don't know who should control that. That will be a challenge and we will look for ways to fix it. Another thing they do need to know which is federal and which is state. The federal can only be used for the ones that are eligible. When this was all federal money it was all the VFP, or the 317 federal money. The 317 money is the other pocket of federal funding and that is more collectable as to what they can do with it. They are telling us now it is not intended for insured kids. We

were able to cover all our kids with the 317 and the VFC money. Now the 317 is going to be declining, plus the increased costs. Even if the 317 didn't reduce the cost of the new vaccines are so high.

Senator Lee: The 317 is on page 3.

Ms. Smith: The difficulty is the self funded that have their own rules that people can't mandate what they do with that.

Senator Warner: How do we deal with issue of high deductibles?

Ms. Smith: That is a complicated issue. If a family has a high deductible, but some say we cover vaccines. Those are considered to be insured, even though they haven't met their deductible they will pay all 350 bucks for an HPV. We would have to collect from the private individual on that.

Representative Price: How will the public health unit know that?

Ms. Smith: They will have to try to collect that information. The other piece of that is if their policy indicates that it does not cover certain vaccines those are the ones that fall into that under insured category. How we get that out of people is a challenge. Than there are custodial parents who may not know how the children are covered. The federal accepts the word of the client. A form is sent home with them, and asks whether they are insured or not. The information they give and an attempt has been made we will proceed accordingly.

Senator Lee: But they could eat the cost. When I think my insurance covers it and I fill out the form only I don't know they don't cover the vaccine, now I have a high amount to pay. Than there is a collection issue.

Chairman Pollert: We are running out of time. What more information does the committee want?

Senator Kilzer: When Lisa had her presentation I asked about the involvement of the state health council. I would like to ask that question again, and hear if they have any input.

Chairman Pollert: Do you want the state council to come forward?

Senator Kilzer: I will see Dennis Wolf this week end.

Chairman Pollert: Should we go to an hour next time?

Representative Kaldor: The policy portion of the original bill 1435 is that incorporated somewhere else? Is it in 1136?

Chairman Pollert: Yes, and with that committee we are adjourned.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

House Human Services Committee

☒ Check here for Conference Committee

Hearing Date: April 16, 2007

Recorder Job Number: 6056

Committee Clerk Signature Judy Schock

Minutes:

Chairman Pollert: We will call the conference meeting together for HB 1435. All members were present. We had some questions for the health department.

Senator Lee: I believe I forwarded this message from Dr.Rice to every one last week, and I have made copies. See attached.

Arvey Smith, Deputy State Health Officer: Back to the document we were talking about the various funding. See attached. We heard an almost immediate drop from like 1.7 million a year to 300,000 a year. Now we are haring a gradual decline. On page 3 about funding and insurances and costs.

Senator Warner: Is the HPV the only (could not understand).

Ms. Smith: At this time yes.

Representative Price: So we can just decrease 386 off that?

Ms. Smith: This is based on the federal purchase rate which is the lowest. At the time we did these estimates we were looking at 300.

Representative Price. This has 288. We did not put HPV in as one of our required vaccines.

Ms Smith: We all know it is available, but not the demand for it. On the next page it has the more expensive vaccines, and the costs. One age group to do the HPV is 1.2 million dollars, and we still have the 12-18 year olds. Calculating 25% still leaves 8.8 million.

Representative Price: HPV isn't a part of this discussion. It is not mandated for school age. We were not looking at those to be part of the funding.

Ms. Smith: So are you saying we turn the others away?

Representative Price: It has to be ordered and you have to make appointments. Because we are struggling with the funding it is not my priority.

Ms Smith: the insurance is covering it for the most part. If we do this all children will fall into one category or another. Right now 36% of our children fall into the VFC category, and they are entitled to the vaccine. BC covers 47% and there are another 17% that are insured, but do not know what their insurance plans do. On page 6 we get to the cost of this. The catch up on page 7 we are almost up to 20 million. If the state purchases the vaccine using state funding we can get the federal rate. We considered coming to the legislation for 16-18 million dollars to vaccinate using state money. That would have been the easiest route for the department to do. We came up with the providers to give the state the money and we purchase the vaccine at the middle rate. That is all we are trying to do here. We have been in the position of needing to know whether ea child is eligible under the federal program or under the state program. We would need to know and wouldn't want to mess with this underinsured business so than the state just pay for those, that would bump the 16 million higher. What happened than 1435 in the Governor's budget he gave us two FTE's to help us get this done and to be managing and monitoring the purchasing of all the vaccines and the inventory issues of working with all the providers, and on handling the cash flow. The 2 FTE's would cost around 222 thousand a biennium. The plan was this would be in place July, 1 at the start of the biennium. Public

health has been concerned that that would be difficult to achieve. We ran calculations for what that would cost to delay 6 months than the state would be purchasing the vaccines during that time period, and we would use 317 money we have as well. That calculation was that 1.5 million for those 6 months and than another million was given for beyond that 6 months for other issues may arise. When 1435 went into the senate it backed off to 1million 850. The mandate to delay 6 months was removed. The way the bill is now the biggest concern is where it talks about of the total amount appropriated out of that 1.8 million a million dollars is only available after December 31. That leaves only 850 for those 6 months when we had calculated it would cost a million and a half. We have two willing interested entities in facilitating the billing process for local public health. We now have BC covering local public health vaccines, but we need to do electronic billing, again the billing system will help with that. We will implement as soon as possible so children will fall into one of two categories either VFC or insured.

Representative Pollert: The way it looks the 1.85 is bundled together, so it was 1 and a half for 6 months so basically if it stayed bundled together, granted the million was in there, but if you kept the 1,85 in there that actually would give you almost 8 and a half months to implement a program. The 2 and a half has to come off the budget, right? There is a million and a half in the first half of the session and a million contingency yet all 2 ½ million has to be tken off as far as the budget. So lets say we kept the 1.85 in there and nothing contingent you could write the language contingent that what is left doesn't be used you are actually extending the date 2.4 months. You'd have 350 thousand there and granted what we are talking about so you would actually be giving the local public health unit extra over 2 months. You would be giving 8 months to implement a program, if the 1.8 stayed in there.

Ms. Smith: I have not done the math. I think the way it is written now we have flexibility to use it for any unforeseen problems, and possibly do special programs.

Senator Lee: How do you anticipate a school vaccination program being done now compared to before? You got to know where the money is coming from.

Ms Smith: What we are being told the schools are already collecting a certain amount of information. Molly might be able to tell you.

Molly Sender, immunization director: (she was in the audience answering and I could not understand all) We screen VFC, Medicaid, and native Americans, they are all done differently. Also some health units send out papers for them to fill out ahead of time. They should know how many for VFC kids.

Senator Lee: Is anyone paying over $8.00 now? If one was in line as a VFC kid and I could bring mine along and be self insured program that doesn't cover that vaccine you could tell me It will cost you plus $8,00 administration fee. I am likely to say I don't have that kind of money, an than my kid doesn't get vaccinated than. That is my concern here. I think vaccinations are such a huge wellness public health priority. I don't see us ever do a health clinic as we have in the past, which I think is a terrible shame. I also understand moving to other providers.

Ms. Smith: The ones with the high deductible plans. One thing to remember even if we would have come and asked for 16 million to cover the none VFC and athe legislation passed that we would still want to know gong into the school are you Medicaid or are you federal or not, because we don't want to spend general funds. We would still have that decision point regardless. One way we are looking doing it is some people with high deductibles have made that decision for what ever reason and maybe can afford to pay for that and others can not. I think public health will have to look at a sliding fee scale. What can not be collected someone will have to pay for that. That is where some of the access will help. What we were

envisioning was for instance Coal Country federal qualified health center is payment system. Local public health would give a million dollars worth of shots during the 3 month period. The billing payer would read that off at the NDIS, they gave a million bucks worth they would give local health a million bucks period, and they handle the collection. We may increase the administration fee to cover that uncollectible gap.

Senator Lee: Mr. Chairman is there any additional money in health department budget to provide to the public health unit for reimbursement for having to be in the collection business.

Chairman Pollert: I think it was all put into local health the 900,000 general fund increase and a 1.1 and a 900,000 put into 1 thousand 4, I think. It was just a flat 900,000 not to deal with the billing issue. Originally I think at the beginning of the session you were looking for 1.9. There was a conversation that 800 or 900 thousand would be acceptable.

Ms Smith: The thing I just described the billing won't be their headache it will be the central payment process. They will be held harmless.

Senator Lee: I heard you say that I just can't imagine that they really are not going to have anything do?

Ms Smith: At this point that is what we hope.

Representative Price: Will all the vaccines be purchased at the federal rates? Now we get to the end of the quarter and Custer Health has administered 200,000 dollars worth of vaccines and have billed for them and they come up 10,000 dollars short.

Ms Smith: There are three rates and it would go into the middle. The one I described the payment process is going to give local public health their 200,000, and the payment processor we need to cover the 10,000. I am thinking it comes out of here until we get a handle on how much it is, and than we will try to add it into the admin fee.

Representative Price: Your thing is, okay I bring in a child for vaccine, I fill out the forms, I sign it, I give them $8.00 for the shot, they bill and public health is out of it they get a check once a month and they are not on the hook for anything, and they are guaranteed for the next 2 years? Public health who has no idea where this is going for is not on the book for this because the tax payers and we are fighting about property taxes in this session. It is something at this point I think the state needs to make sure at least for the next 2 years that there is enough money there. I want people to pay the administration fee but I don't want the public health units going into this blind and than being on the hook for thousands of dollars that they have no control over.

Ms Smith: That is what we are shooting for. We would probably need to increase that admin fee to cover it after this is gone. We just don't know how many people that is.

Representative Price: Do you feel an advantage to take the admin fee to even to 10 bucks now because they are going to have a little bit more to do , and they will have to collect information that they have not had to collect to that extent?

Ms. Smith: We can do that and that can start covering this right away.

Representative Price: That is not to cover this that is to cover what they have to collect on their end that they have not had to do before.

Ms. Smith: I think that is possible. We don't need legislation to do it.

Representative Price: You can have this ready by the time this goes into effect? We don't want it taking a year and half to do.

Ms. Smith: I don't know. If we don't do any of this every thing is in the private sector. Not only is it the private rate, but we can see people being charged above. They can get charged 400 or up to 24 for an admin fee. We are going to keep the admin fee below that.

Senator Lee: What is the difference in the percentage and or dollars between the federal rate and the middle rate? What percentage of our kids covered between PERS and (couldn't understand)? Is there no way we can access that federal rate? Seems to me there is a significant difference in dollars in percent. I like dollars best, between the federal rate and the next rate is.

Ms. Smith: Page 5 at the top. It has to be state or federal money. The private rate recognizes that is the private purchase rate. If they charge 400 this has only 360 for HPV. That number than climbs more. A couple of the drug companies have said we don't care where you got the money from we are going to cover it at the federal contract rate.

Chairman Pollert: So we can't reroute it like we reroute a lot of other things?

Senator Lee: We have 233 bucks difference between the two, per kid. That is a lot of money.

Ms. Smith: HPV goes from 360 down to 288. The other thing we look at in the group HPV is the big money hog.

Chairman Pollert: How many vaccinations are we adding in after this session three or four? What happens if you delayed information of the new vaccinations?

Ms. Smith: Four, and say not covered. If we end up doing something unique with HPV. The others I think we will be fine.

Chairman Pollert: The reason I am asking is because of a shift in how we are doing the programs if you are better off do the old system and bring the new ones on line delayed from down the road, what ever it is.

Senator Lee: I think taking HPV out and into another category. Maybe three is something we can do.

Representative Price: We talked about the administration fee for the people who are used to paying $8.00 to get the shot. I don't think that should be any different if it is a BC person. As

long as the vaccine, which is the expensive part, is picked up. Is that how you are seeing this moving forward that the vaccine is covered and administration and the provider still after that check?

Dan Ulmer, Vice President of Government affairs with BC/BS: One point in the conversation we struggled with paying public health to administer immunizations. These folks are on a young salary etc. and already paid to do this kind of work. However when you read Dr. Rice's email, you will discover we are talking about paying administration fees and other things. See attached.

Representative Price: I don't have a problem how the vaccine is paid for if parents still pay that 10.00.

Mr Ulmer: I think they should have a tough struggle here trying to figure out how to find 16 million bucks. We see the importance here it is critically important. Even the self funded plans pay for immunizations etc. The percentage is pretty high, what normally happens is the self funded plan will (could not understand) I would say 90% will take care of them.

Representative Price: What happens when they are self funded or full insured plan if it is 500 dollar deductible 80-20 for the vaccine?

Mr.Ulmer: Some plans don't but the vast majorities are. The wellness benefit includes immunizations.

Senator Lee: I am happy to hear it is that high percentage. If we can figure out a way to get everyone in the state that would be good. WE ultimately have the same goals here just how we get there. Can we work with that idea that we don't have a lot of them that are not covered? If we got 90 % that are covered don't we mostly have to deal with the pen?

Mr. Ulmer: You start looking at 300 and some odd thousand lives in ND that we would cover as well as self insured what ever is left over. Despite what the insurance commissioner says

there is a significant chunk of other insurance companies that have different plans. That would be the issue. What would you do when Mom discovers that gee my health insurance doesn't cover it, and now I have 1,000 bucks worth of immunizations for my kid? Some kids will fall through the cracks.

Senator Lee: Did you tell me that there were some self insured very significant size including Minot that may not be covered.

Lisa Clute, Executive Officer: Minot is a self insured plan and at this point I don't believe they are. That is the problem with this entire issue is. We don't know. We need to do some fact gathering. Again I am not disagreeing with provider's choice the problem is the health department announced in January we were doing this. There is no way we can have the information and be ready to go at the local level by July. The responsibilities are very different. This bill started out with a 15 month delay and 2.5 million dollars. The 1.5 million needs to be up front than this is negotiated down to a 6 month play. This is our only safe net that is why we came to the legislators saying we are going to have a problem here. The email from Dr Rice is good news. This bill will have to be in our safety net. From August we are undated with kids getting ready for kindergarten. If we are changing those systems we need time to do that. At the local level we are going to be happy to work with the state health department in the transition. We are the ones who will have to do the paper work up front. At this point we don't collect all this information. There were no funds allocated for FTE's or any administration funds at the local level. This bill is vital. I am confident things can be worked out just not that quickly.

Representative Price: This task force that has been alluded to, so this is made up of health department and public health administrators. Anyone else? Is this a sit down working group for the details?

Ms clute: Three local public health units and 3 private providers that will be determined somehow. Yes, if we run into problems we all get together. We did ask for commitments, and we said this would be a time consuming group.

Representative Pollert: The more we talked the more I don't remember some of the first part of the session, and you talked about a 15 month delay of 2 ½ million. More funding would be where the 4.2 million comes from.

Senator Lee: I don't know if we need more information we just have to figure out how to do it. Part of it may be what we need to look at restoring that funding. The ultimate goal is to make sure we are not having any children no vaccinated. We aren't even thinking about older people having phenomena vaccination. What is the most cost effective way to make the change? Let's make sure we don't loose any kids.

Chairman Pollert: With a 15 month delay because we are hearing that 6 months is not enough time. So what is the time frame? Is it 9 months or is it 12. I have a hard time with 15 months.

Senator Lee: The longer we delay the more money it will cost us? Where are we in the 317?

Ms Smith: What the 317 would be on

Chairman Pollert: This October that is still three months right? Is the three months figured into these figures. You figured 1.7 million to 300,000 and in October it will take 1.4 million drop. Do you know what that amount will be? Do you know when that information will become available?

Mr Kurby: No we don't we will not go down 300,000 in one year. It will be fazed over in 5 years. They may take a percentage every year.

Representative Price: In going down with your logic of October 1 we are not going to have enough money to do back to school even with no reduction in 317. You are telling us this

won't happen until October 1 you don't have enough money in your kitty to do the back to school than do you, and how much are you short? You never had plans to do it undr the current scenario.

Mr. Kurby: That would be right.

Senator Lee: Could we consider some sort of trigger depending on what the feds do after we get out of here.

Chairman Pollert: How soon can we have that information for our next meeting in a couple of days? We will be adjourned.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1435

House Human Services Committee

☑ Check here for Conference Committee

Hearing Date: April 19, 2007

Recorder Job Number: 6143 & 6144

Committee Clerk Signature Judy Schock

Minutes:

Chairman Pollert: We will call the meeting to order on HB 1435, and let the record show all are present.

Representative Price: I have proposed amendments, and these were worked off of version 0300, and I will explain them. See attached. We want to use 317 funds where appropriate before we go to general funds from the state, and we get the third party payers system worked out. If for some reason something totally falls apart in the next two years that the health has the option to go to the emergency commission for money if needed. In section 2 we have asked the task force and the department to report back to legislative council on two things. How is it affecting the public health unit also how is the department moving forward in the task force? We are setting up a protocol and getting through their things. The deputizing, and the billing and the 317 funds have w lost any? What the progress is in that and where do you think you will be next session. How are immunization rates going because obviously we don't want to loose kids being immunized? Just keep us informed during the interim. The intention of the money is when it came out of the house it was 2 ½ million the senate was 1.8. We just settled at 2 million total for the biennium with the intention that 1.5 would be for the first 6 months if needed and the second 500,000 would be for the rest of the biennium. However if you don't

need it all in the first 6 months and you need a bit more you can't use it but it has been put into the health department budget the amount we settle on it is a special line item so that it is a back seat line item. At the end of 2 years you use 1.2 million, the other 800,000 goes back to the general funds. So it is specific to this.

Senator Warner: The tone of this bill originally since you do child immunizations I think that was probably a miss conception on my part because section 2 has never been very specific to childhood immunization. Are we talking about potential break through immunizations so a senior meningococcal and other immunizations later in life beyond the childhood school admission group of immunizations? Are they covered with this appropriation?

Representative Price: It really is considered a childhood immunization bill. It doesn't say you can't do this and we could have the health department address that . It is intended for a kid's bill.

Senator Lee: Understanding what Representative Price is saying is there anything that would require dollars from this money we pretty much wanted to stay focused on kid's immunizations.

Representative Price: I think the fact that we talked about it saying immunization services previously funded through the 317, that is the children specific part.

Representative Kaldor: Is the meningococcal vaccine, do we have that somewhere else?

Representative Price: In section1 was addressed in 1136.

Avery Smith, Deputy State Health Officer: In answer to Representative Prices question we came up with a schedule. See attached. This provides one scenario. The question to be what this would cost us the gap between VFC and BC covered vaccines if we used general funds to pay for them. This schedule provides you with that. I will walk you through the schedule. On foot note 5 we did not adjust it with the heavy school load for the school start. When we calculated we were assuming no 317 money left. The 360 is not a solid number.

When we had left over money on a grant last year they cut us by 15%. We don't know if or how much they will cut again. For each 10% they cut you can reduce that by 42,500. Our remaining costs if we did this with general funds would be almost 1 million bucks for a 6 month period. We have not built in for the school start, extra activity that we usually see.

Senator Lee: The kinds of adjustments in our language would need to be done in order to accommodate that bubble right before school starts.

Ms. Smith: I don't think language would do anything, but it just affects this total a bit. If you go for the proposed amendments that will be fine. I do have questions on what is our leeway to use that if we have extra.

Representative Price: We did not eliminate line 17-23 on the first page, so that six month period is still in the bill. We worked off of 0300. That is pretty strong message from the public health unit.

Ms. Smith: If mandated 6 month delay so that we can't start anyone before 6 months?

Representative Price: If everything falls into place if they wish to go ahead they can. If you don't et the billing all set up or other things don't happen we wanted a cushion in there.

Senator Lee: The county budgets are a big issue. They are already locked in. They can't make immediate adjustments to those budgets, because they are already approved.

Representative Pollert: If I can ask than if I just flow through the chart with the 2 million in these amendments If I am correct does the mean we are a million or 715,000 a possible extra funds? Out of the 2 million that is in these proposed amendments, which would mean the 700 roughly thousand possibly around that area?

Ms. Smith: Yes, the million 285 is going to be a minimum we need out of that. If some things fall through it will go up.

Representative Price: The same bill I am adamant about is obviously who is going to do the billing is going to require some sort of fee. We don't know if our administrative cost is going to cover everything. We will have glitches. The major of the money it is my intention is for the next 2 years money is used to hold public health harmless. That they don't end up in at the end of their budget year depending on the size of the unit and any where from 5-50,000 dollars short because this provider choice didn't happen as we all hoped it would. Even if it does I think there will be unpaid bills out there. Every medical provider writes off bad debts. As we work through this we are giving them a cushion so at least they have some track record coming in to the next session.

Ms. Smith: We are working to hold them harmless even on a cash flow bases so that they are not waiting for 6 months for something to be collocated that they get reimbursed fully monthly, other than an admin fee for the payment processor.

Representative Price: Another concern I want to stay in the minutes is that with the new purchasing requirement from the feds that if there is some leeway needed. Because some of these may become out dated if they can't sell it to each other we don't know exactly what the rules are going to be for training and some of the unknowns that public health is walking into I want the task force to have the opportunity to set up the protocols and work together on making this work for the next 2 years. That is all part of this cushion.

Senator Lee: I think we have recognized that BC/BS decision last week to cover these administration fees is really terrific. I think it is real important that we not look at them being the only one to participate in this. I don't think it is fair that someone does it and someone doesn't.

Ms. Smith: BC's agreement was they would step up to the plate but you have to try and get the others involved. We sent out letters to the others and we got one positive response, and one negative and no response from the rest.

Representative Price: Maybe we could get the insurance commissioner involved because they have to review most of those plans and maybe there is something they could do to help us get the information. It is kind of late to do mandate bills, but it will be something on the list for next year.

Senator Lee: I am not crazy of putting legislative intent in here but I want to make it clear we intend.

Ms. Smith: That is why provider's choice because it forces them into this as well, and that is why we want to do provider choice and I know BC feels the same way. They are the ones paying their share and others are getting off the hook.

Chairman Pollert: I would suspect we will have an interim committee on health care. I would say it is not out of the realm to ask for up dates. So we can find out what is going on and do we want to involve the insurance DA department at that time. Do we need further discussion as far as the department asking?

Dave Peske, with ND Medical Association: We have identified some people to serve, and we are happy to participate.

Keith Johnson, with Local Public Health: Local Public Health is happy. This has been a great collaboration and I think everyone has the same end in mind and that is not letting that immunization levels drop. I think the state deserves a pat on the back for stepping up to the plate when the feds walk away. We will do our best to make this work and I think we can. I think the amendments will get us there. We want to make sure we are adequately funded so we don't impact those immunization ranks.

Representative Price: Do you feel to than even tho we have the 6 months in here just incase that if things work and you guys are ready to roll October 1 that that should not be a problem?

Mr. Johnson: The 6 month deal is kind of a two way street and I think it isi in there for a reason. I think we can get started ahead of the 6 month. What the 6 month thing says is that you can't mandate it. There will be pilot projects, the preparatory work that can all be done in the interim, but on the other side it also says after 6 months if there is a local public health out there that says no we like it the way it is and we are just not going to do it , it imposes that dead line that says yes you will be doing it.

Dan Ulmer, with BC: We are part of the task force now so we don't have a problem. We are happy to make the resolution and hope it works.

Senator Warner: Do you know of anywhere in insurance law or practice where we mandate first dollar coverage of a service? Is it in the realm that the state could mandate the vaccinations would be first dollar coverage?

Mr. Ulmer: Yes, you could. There is a couple mandated.

Chairman Pollert: We will recess for a few minutes. We will again call the conference committee on HB 1435 to order again.

Senator Kilzer: I will make a insight into the future. If the feds continue to cut vaccines for all the states it is going hurt other states at least equally or even worse than our state. There will need to be some stimulants for the feds to put some money back into the program. My prediction is this fall that there will probably be a relatively small out break of meningococcemia some place that will inspire the fes to restore someof this vaccine. The reason I picked that is because for decades that is the way this organism behaves. It usually strikes kids in a rural area. In the past it has been new college students or new recruits in the army. People will get sick, meningococcal involves the central nervous system so they actually get all the signs of

neurological changes, and they die rather rapidly with in a couple days. The treatment used to be sulfa. There is and has been immunization available and it is just one of the diseases that is really bad if you allow it to show its ugly face. I think we need to be prepared for fiscal catastrophes as we need to be prepared clinically for disease capacity, and I support the amendment.

Senator Lee: With that thought in mind I move that the Senate recede from its amendments and that reengrossed house bill be amended as shown in 0304, seconded by **Senator Warner**. The roll was taken with 6 yeas, 0 nays, and 0 absent. **Chairman Pollert** will carry the bill to the floor.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1435 (, as (re)engrossed): Date: 4/13/07

Your Conference Committee House Human Services

attend	For the Senate:	YES	NO	attend	For the House:	YES	NO
	Sen Lee				Chairman Pollert		
	Sen Kilzer				Rep Price		
	Sen Warner				Rep. Kaldor		

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1404 - 1409

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____

CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

Prepared by the Legislative Council staff for
Representative Price
April 19, 2007

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1435

That the Senate recede from its amendments as printed on page 1409 of the House Journal and pages 808 and 809 and page 965 of the Senate Journal and that Reengrossed House Bill No. 1435 be amended as follows:

Page 1, line 1, replace "amend and reenact subsection 1 of section 23-07-17.1 of the North Dakota" with "provide for an immunization program and immunization task force; to provide for reports to the legislative council;"

Page 1, line 2, remove "Century Code, relating to child immunizations;"

Page 1, remove lines 4 through 16

Page 2, line 4, after the period insert "The department shall distribute the vaccines in accordance with the department's protocol established in consultation with the immunization task force.

3. The state department of health and local public health units shall attempt to access federal and third-party payer funds before using funds from the immunization program. If the funds appropriated to the state department of health for the 2007-09 biennium for the immunization program are insufficient, the state department of health shall request a transfer of spending authority from the state contingencies appropriation."

Page 2, after line 4, insert:

"SECTION 2. STATE DEPARTMENT OF HEALTH - IMMUNIZATION TASK FORCE - REPORTS TO LEGISLATIVE COUNCIL.

1. The state health officer shall appoint an immunization task force to meet during the 2007-08 interim to establish a protocol on how to transition from a universal select immunization program to a provider choice immunization program and to recommend to the state department of health that this protocol be implemented. The protocol must seek to retain the state's high rates of vaccinations using the most cost-effective protocol.

2. The task force must consist of at least seven members, including at least three members representing local public health districts, three members representing private health care providers, and representatives of the state department of health. The state health officer shall appoint the task force members representing local public health units from a list of names submitted by an organization representing public health administrators. The state health officer shall appoint the task force members representing private health care providers from a list of names submitted by the North Dakota medical association.

3. During the 2007-08 interim, the task force shall provide periodic reports to the legislative council regarding the impact of the immunization program transition on the local public health units. During the 2007-08 interim, the state health officer shall provide periodic reports to the legislative council regarding the fiscal impact of the immunization program transition."

Page 2, line 5, remove "**- LEGISLATIVE**"

Page 2, line 6, remove "**COUNCIL REPORT**"

Page 2, line 7, replace "$2,500,000" with "$2,000,000"

Page 2, line 10, replace "$1,000,000" with "$500,000"

Page 2, line 12, remove "The department shall report to the legislative council as"

Page 2, remove line 13

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Price
April 19, 2007

Conference Committee Amendments to Reengrossed HB 1435 (70748.0305) - 04/19/2007

That the Senate recede from its amendments as printed on page 1409 of the House Journal and pages 808 and 809 and page 965 of the Senate Journal and that Reengrossed House Bill No. 1435 be amended as follows:

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Page 2, line 10, replace "$1,000,000" with "$500,000"

Page 2, line 12, replace "2" with "1" and remove "The department shall report to the legislative council as"

Page 2, remove line 13

Renumber accordingly

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1435 (, as (re)engrossed): Date: 4/19/02

Your Conference Committee House Human Services

attend	For the Senate:	YES / NO		attend	For the House:	YES / NO	
✓	Sen Lee	✓		✓	Chairman Pollert	✓	
✓	Sen Kilzer	✓		✓	Rep Price	✓	
✓	Sen Warner	✓		✓	Rep. Kaldor	✓	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1404 - 1409

___, and place _____ on the Seventh order.

___, adopt (further) amendments as follows, and place _____ on the Seventh order:

1030 ?

___, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: 4/19/02
CARRIER: Pollert

LC NO.	of amendment
LC NO.	of engrossment
Emergency clause added or deleted	
Statement of purpose of amendment	

MOTION MADE BY: Senator Lee

SECONDED BY: Senator Warner

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1435, as reengrossed: Your conference committee (Sens. J. Lee, Kilzer, Warner and Reps. Pollert, Price, Kaldor) recommends that the **SENATE RECEDE** from the Senate amendments on HJ pages 1404-1409, adopt amendments as follows, and place HB 1435 on the Seventh order:

That the Senate recede from its amendments as printed on page 1409 of the House Journal and pages 808 and 809 and page 965 of the Senate Journal and that Reengrossed House Bill No. 1435 be amended as follows:

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Page 2, remove line 13

Renumber accordingly

Reengrossed HB 1435 was placed on the Seventh order of business on the calendar.

2007 TESTIMONY

HB 1435

Immunization Funding

Arvy Smith CPA CM
Deputy State Health Officer

NORTH DAKOTA
DEPARTMENT of HEALTH

Childhood Immunizations

- Important
- Complex
- Expensive

NORTH DAKOTA
DEPARTMENT of HEALTH

Changes to Immunization Program

- Costs to vaccinate a child are increasing dramatically
- Federal funding is expected to decrease
- Vaccine distribution system is changing

Need to explore all options to determine the most cost-effective way to vaccinate all North Dakota children

NORTH DAKOTA DEPARTMENT of HEALTH

Types of Funding

- VFC Vaccines for children – federal entitlement for
  - Medicaid eligible
  - Uninsured
  - American Indian/Alaska Native
  - Underinsured served at federal qualified or rural health clinic

NORTH DAKOTA DEPARTMENT of HEALTH

Types of Funding

- 317 Funding
  - federal funding for special projects
  - Not intended for VFC eligible or privately insured
- Private insurance
- State funding

NORTH DAKOTA DEPARTMENT of HEALTH

Costs to Vaccinate a Child

Year	Amount *
1999	$186
2004	$476
2005	$618
2006	$1,156

* Assumes federal purchase rate

NORTH DAKOTA DEPARTMENT of HEALTH

Reasons for Increases

- New Vaccines
  - Four in 2006
    - Menactra
    - Rotavirus
    - HPV
    - Varicella 2nd dose
  - Ten (or more) new vaccines in progress, costing potentially additional $2,000 per child
- Price increases

NORTH DAKOTA DEPARTMENT of HEALTH

Costs of New Vaccines

	Vaccine Cost *	One Rec. Age Group	Catch-Up
Menactra	$68	$570,000	$4.0 M
Rotavirus	$156	$1,307,000	0
HPV	$288	$1,257,150	$8.8 M
Varicella 2	$57	$477,000	$5.7 M

* Assumes federal purchase rate

NORTH DAKOTA DEPARTMENT of HEALTH

Varying Costs Per Child

- Federal $1,156
- Negotiated State * $1,389
- Private $1,628

* Cross between multi-state compact, private and federal rate where allowed

NORTH DAKOTA DEPARTMENT of HEALTH

Categories of Children

VFC	36%
BCBS	47%
Other	17%

Assumes we get all undersinsured covered by VFC in FQHCs

NORTH DAKOTA DEPARTMENT of HEALTH

Total Costs to Vaccinate
(In Millions)

	2005 Actual	2006 Est.	2007 Est.	2008 Est.
VFC	$2.2	$2.8	$2.7	$3.2
Non VFC	$2.4	$4.0	$5.9	$6.2
Total	$4.6	$6.8	$8.6	$9.4

Assumes 79% vac. rate, no catch-up, 2008 4% inflation.

NORTH DAKOTA DEPARTMENT of HEALTH

Total Funding Gap
(In Millions)

	2005 Actual	2006 Est.	2007 Est.	2008 Est.
Non VFC	$2.4	$4.0	$5.9	$6.2
317 Est.	$2.0	$1.9	$1.7	$.3
Total Gap	$.4	$2.1	$4.2	$5.9

Assumes 79% vac. rate; no catch-up; 2008 4% inflation.

NORTH DAKOTA DEPARTMENT of HEALTH

Total Funding Gap W/Catch-up

(In Millions – provider choice)

	2005 Actual	2006 Est.	2007 Est.	2008 Est.
Non VFC	$2.4	$4.0	$9.9	$10.0
317 Est.	$2.0	$1.9	$1.7	$.3
Total Gap	$.4	$2.1	$8.2	$9.7

Assumes 79% vac. rate; 2008 4% inflation; 25% catch-up rate per year.

NORTH DAKOTA DEPARTMENT of HEALTH

Total Funding Gap W/Catch-up

(In Millions - general fund purchase)

	2005 Actual	2006 Est.	2007 Est.	2008 Est.
Non VFC	$2.4	$4.0	$8.0	$8.3
317 Est.	$2.0	$1.9	$1.7	$.3
Total Gap	$.4	$2.1	$6.3	$8.0

Assumes gap is covered with general funds and get federal contract rate; 2008 4% inflation; 25% catch-up rate per year.

NORTH DAKOTA DEPARTMENT of HEALTH

Other Considerations

- Maintain the medical home
- All children vaccinated
- Maximize use of VFC funding
- Ease of administration
- Low administration costs
- Minimize insurance premium increases
- Equity to children and payers
- Coverage for underinsured
- Insurance mandates

NORTH DAKOTA DEPARTMENT of HEALTH

Potential Options

- VFC Only (all other vaccines in private market at private rates)
  - No state general fund cost
  - Insurance premium increases higher
  - Providers bear risk, order and bill
  - Medical home not protected
  - Not equitable to children or payers
  - May affect vaccination rates

NORTH DAKOTA DEPARTMENT of HEALTH

Potential Options

- Universal Coverage (VFC plus state general funds for all other children)
  - General fund cost at least $16 million per biennium plus future costs to add new vaccines; assumes only 25% catch-up rate per year
  - Insurers don't pay so no increase in premiums
  - State administers, orders, bears financial risk for insufficient funds
  - All children covered
  - Medical home protected
  - Easy administration for providers

NORTH DAKOTA DEPARTMENT of HEALTH

Potential Options

- Provider Choice (VFC plus state purchases non VFC to achieve best rate for non VFC using funding from providers who bill insurers for costs)
  - General fund cost $222,000 per biennium (2 FTE, administration)
  - Provides some insurance premium relief
  - Providers bear risk
  - State brokers the purchase for best rates
  - All children covered
  - Medical home protected

NORTH DAKOTA DEPARTMENT of HEALTH

Conclusion

- Provider Choice

Why?

- Low general fund cost
- Provides some insurance premium relief
- Low total cost
- Medical home protected
- All children covered
- Lowest state financial risk
- No insurance mandate required
- Equitable to children and payers

NORTH DAKOTA
DEPARTMENT of HEALTH

Same as Senate Human Services and Senate Approps

Testimony
To the
House Human Services Committee
On
HB 1435
January 29, 2007

Good afternoon Chairman Price and members of the committee. I am Lisa Clute, Executive Officer of First District Health Unit. First District provides local public health services to Bottineau, Burke, McHenry, McLean, Renville, Sheridan and Ward counties.

House Bill 1435 was created to address some of the issues that impact the consumers of child immunizations and local public health units as North Dakota transitions from a Universal Select State to Providers Choice. 1435 extends our present system of delivering vaccines for one year. Its purpose is to make the transition to Providers Choice as seamless as possible for both consumers and providers in hopes of maintaining our high vaccination rates in North Dakota. The appropriation is a "one time" cost to the State.

This Bill is a "big deal" because North Dakota has a history of high vaccination rates. The public knows the importance of immunizing their children and knows how to get it done. Immunizations have been a primary function of local public health units since their establishment. When people are asked what public health does their first response is typically "that's where I take my child to get their shots." Public health is the "expert" on immunizations for our communities.

The need to transition from a Universal Select State to a Provider's Choice State is apparent because of the reduction of federal funds. We can no longer do "business as usual". However it is our obligation as providers and policy makers to make that transition as painless as possible for our consumers. It is also important to minimize the financial risk to local public health units. If the financial risk is too large public health units may choose not to provide immunizations.

The transition from a Universal Select State to a Provider's Choice State creates several issues for local public health units and the population they serve.

Consumer issues:

1. Substantial rate increase for consumers that do not have BCBS. The cost to immunize a child from birth to age 6 will increase from $140 to $1040 (assuming vaccine costs don't rise). A client who does not have Blue Cross Blue Shield insurance or is not VFC eligible (Medicaid, Native American, Native Alaskan or has no insurance) will have to pay the entire cost.
2. When immunizations are administered by private medical facilities the client is charged for an office visit as well as the immunization fee. Appointments are also required. Today clients can walk into First District Health Unit without an appointment and receive childhood vaccinations for a fee of $10 per shot.
3. The convenience of mass vaccination clinics in schools will not be available for consumers. Currently seventh graders receive their state required vaccinations at one of these clinics.

Local Public Health Unit issues:

1. Local public health units will need to purchase the vaccine "up front". The estimated start up costs for three months of vaccine for all local public health units is approximately $1,000,000. Very few Health Units have cash reserves that could be utilized to purchase the vaccine. As of today we have no assurance of recouping those costs.
2. The population that does not qualify for VFC vaccine nor have Blue Cross Blue Shield will have to pay the full cost of the vaccine or be denied immunizations. We do not know what percentage of the population that is but I am very concerned that the percentage may be high in the smaller counties. The First District Health Unit Board of Health will need to establish policies that address people that can not afford immunizations. They will need to determine if they will subsidize or sponsor families with local tax dollars to assure their population is adequately vaccinated.
3. First District Health Unit will need to hire additional staff for billing.
4. First District Health Unit staff will be required to "categorize" each client prior to immunizing them; this will require additional staff time and paperwork.

The State Health Department originally planned to implement Providers Choice on September 1, 2007. Prior to the implementation of Providers Choice the following need to be addressed:

1. Agreements established with rural health clinics so that Public Health Units can be "deputized" to administer immunizations.
2. A billing system developed and implemented so that Public Health Units can bill private insurances. This will include the hiring and training of staff and the establishment of reimbursement rates and the implementation of collection procedures.
3. Recruitment of additional providers to administer immunizations.
4. Public education on the new immunization system. Last year First District Health Unit administered 3643 childhood immunizations to the population we serve. Once procedures and policies are established the public will need to be educated on when and where to vaccinate their children.
5. Hiring, training and funding of additional staff at the local level to administer the new system.

First District Health Unit can not accomplish the above items by September 1, 2007. Our budget for 2007 is in place and we are not prepared to financially support this transition. We also need to gather information and determine the number of children that are not VFC eligible or that do not have BCBS and make plans for the population. Those plans will include difficult policy and financial decisions.

It is the responsibility of public health to protect the public against communicable diseases. Immunizations are an important component of that protection. It is vital that this transition from one system to another work well to assure our immunization rates do not fall. HB 1435 will provide the time and money we need to prepare our providers and consumers for the Provider Choice system of delivering immunizations.

Thank you for your time and attention to this important issue. I will be happy to answer any questions you may have.

Testimony

House Bill 1435

House Human Services Committee

Monday, January 29, 2007; 2:30 p.m.

North Dakota Department of Health

Good morning, Chairman Price and members of the House Human Services Committee. My name is Kirby Kruger, and I am the state epidemiologist for the North Dakota Department of Health. I am here today to provide information about House Bill 1435 and to offer some suggestions to help clarify the bill.

It is our understanding that the intent of the bill is to delay Provider Choice until October 2008 and provide a three-month start-up inventory for local public health units. We are suggesting several amendments that are either technical clarifications or that improve the logistics of this proposal.

Our suggestions are as follows:

- Page 1, Line 11, we suggest adding the words "age appropriate" after "received" to clarify that certain vaccinations are recommended to limited age ranges and are only needed for child-care or school requirements during that timeframe.

- Page 1, Line 13, we suggest deleting the "1 and 2" behind "varicella" since the law speaks to the diseases that children need to be immunized against, not vaccination doses.

- Page1, Line, 13, we suggest replacing "conjugate vaccine (MCV4) for" with "disease." This makes the wording consistent by addressing diseases and not particular vaccines.

- Page 1, Line 14, we suggest deleting the word "meningitis."

- Page 1, Line 18, we suggest changing the start date from October 1, 2007, to July 1, 2007. This will ensure the vaccines are available for all North Dakota children starting July 1. Otherwise there will be a three-month period when some vaccines that are currently provided will be available only for VFC-eligible children.

- Page 1, Line 19, we suggest inserting "vaccine purchased using these" after "distribute." Without this change, the bill would require the Department of Health to provide grants to local health units to purchase vaccine. If local public health units purchase the vaccine, they will have to pay the higher private rate, whereas the Department of Health can purchase the vaccine at the federal contract rate at a substantial savings. Our current business practice is to purchase the vaccine and send the vaccine to all immunization providers.

- Page 1, Line 19, we suggest inserting "and other immunization providers" after "units." Our current business practice is to distribute vaccines to all immunization providers.

- Page 1, Line 24, we suggest deleting "$3,495,634" and replacing it with "$4,268,077."

- Page 2, Line 2, we suggest replacing "immunization program grants" with "vaccine" for the reason I mentioned earlier.

- Page 2, Line 2, we suggest adding "and other immunization providers" for the same reason.

- Page 2, Line 3, we suggest deleting "Of the amount appropriated" through "vaccinations." and inserting "The amount appropriated replaces lost section 317 funding, new vaccination recommendations for non-VFC and non-BCBS children, and a three-month vaccine inventory start-up for local public health units."

The dollar figures in this bill were provided by the Department of Health. Some of the assumptions used to calculate the figures have changed and the amounts included in this testimony have been recalculated. The calculations include vaccines required for school starting July 1, 2007, but do not include HPV vaccine until the Provider Choice system begins October 1, 2008. Spreadsheets of our calculations are attached.

Another scenario that has been discussed would be a six-month rather than a 15-month delay in starting the Provider Choice system. The cost for a six-month delay would be $1,999,111.

The proposal to delay Provider Choice is dependent on Blue Cross Blue Shield continuing to reimburse the Department of Health for vaccines through September 30, 2008, and the providers recording all vaccines on the North Dakota Immunization Information System so that BCBS reimburses the Department of Health for the appropriate amount.

This concludes my testimony. I am happy answer any questions you may have.

Total cost to operate at current level from July 1, 2007 to September 30, 2008	
Replace federal 317 funding	$1,700,000
Vaccine costs	**$1,656,610**
Total costs of vaccine/317	**$3,356,610**
Total Costs to initiate Provider Choice in 2008	
Start up Costs	$911,467
Total for vaccine and start up	**$4,268,077**

Calculations for Menactra	Cohort	Price/Dose	# of Doses	Uptake	Cost/Cohort/year	Cost/Cohort/Month	Cost/15 Months	
11 year olds	1573	$68.00	1	1.0	$106,964	$8,914	$133,705	
12 year olds	1573	$68.00	1	1.0	$106,964	$8,914	$133,705	
15 year olds	1573	$68.00	1	1.0	$106,964	$8,914	$133,705	
Seniors/college freshman	1573	$68.00	1	1.0	$106,964	$8,914	$133,705	
Total for 4 age cohorts					$427,856	$35,655	$534,820	
Calculation for Varicella 2 (second dose chickenpox)								
5 year olds	1931	$74.85	1	1.0	$144,535	$12,045	$180,669	*
6 year olds	1931	$56.90	1	1.0	$109,874	$9,156	$137,342	**
7 year olds	1931	$56.90	1	1.0	$109,874	$9,156	$137,342	**
8 thru 18 (11 cohorts)	21241	$56.40	1	0.25	$299,498	$24,958	$374,373	
Total for all cohorts					$663,781	$55,315	$829,727	
Calculations for Hepatitis A								
School Entry 5 year old	1931	$12.10	2	1	$46,730	$3,894	$58,413	
2 thru 4 year olds (3 cohorts)	5793	$12.10	2	0.25	$35,048	$2,921	$43,810	
6 thru 18 year old (13 cohorts)	25103	$12.10	2	0.25	$151,873	$12,656	$189,841	
Total for all cohorts					$233,651	$19,471	$292,064	
Total for above vaccines					**$1,325,288**	**$110,441**	**$1,656,610**	
Calculation for optional HPV (cervical cancer prevention) by cohort								
11 year old	1573	$96.00	3	1	$453,024	$37,752	$566,280	
12 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
13 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
14 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
15 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
16 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
17 year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
18 Year old	1573	$96.00	3	0.25	$113,256	$9,438	$141,570	
					$1,245,816	$103,818	$1,557,270	

Notes
* use MMRV (measle, mumps, rubella and varicella)
** use varicella only
To cover the non-VFC and non-BCBS doses that are newly required for school entry
Assumes BCBS ND will particpate in current program one more year
Current federal contract prices for all vaccines

Routine Vaccine Schedule	Insured Doses @ LPHU	Provider Choice Rate	3 Month Cost	Doses @ LPHU for 12 Months	12 Month Cost
HEPA	496	$12.10	$6,002	1,984	$24,006
HIB, PRP-OMP, IM	249	$22.77	$5,670	996	$22,679
PNEUMOCOCCAL, PED < 5, PREVNAR	336	$73.70	$24,763	1,344	$99,053
ROTAVIRUS, ORAL	118	$63.25	$7,464	472	$29,854
DTAP	241	$13.25	$3,193	964	$12,773
DT < 7, IM		$17.50	$0	0	$0
MMRV, SC	215	$117.61	$25,286	860	$101,145
POLIOVIRUS, IPV, SC, IM	145	$22.80	$3,306	580	$13,224
TDAP	922	$30.75	$28,352	3,688	$113,406
CHICKEN POX, SC (For MMR kids)	56	$77.11	$4,318	224	$17,273
TD > 7, IM	5	$16.62	$83	20	$332
DTAP-HEP B-IPV, PEDIARIX	225	$43.75	$9,844	900	$39,375
PNEUMOCOCCAL, ADULT/ILL		$14.65	$0	0	$0
MENINGOCOCCAL, MENACTRA	922	$82.00	$75,604	3,688	$302,416
HPV	1,438	$120.00	$172,598	5,753	$690,394
HEPB PED/ADOL 3 DOSE IM	133	$9.00	$1,197	532	$4,788
Sub-Total	5,501		$367,679	22,005	$1,470,717

Catchup	Insured Doses @ LPHU	Provider Choice Rate	Cost	Provider Choice Rate	12 Month Cost
Menactra	1,614	$82.00	$132,307	6,454	$529,228
HPV	3,236	$120.00	$388,346	12,945	$1,553,386
Varicella	168	$71.11	$11,946	672	$47,786

Influenza	Insured Doses @ LPHU	Provider Choice Rate	Cost	Provider Choice Rate	12 Month Cost
Influenza	822	$13.61	$11,187	3,288	$44,750
Grand Total			$911,467	45,364	$3,645,867

C:\Documents and Settings\kkruger\My Documents\2007\Legislation stuff\[Cost estimate continuance per 15 mo.xls]Start up costs

Calculation of cohorts not covered by VFC or BCBS for selected catch up doses
and doses needed for vaccines that are now only VFC (menactra, 2nd dose varicella) (1-12-07)

Age Group	<1	1 to 2	3 to 6	7 to 18	
Total Cohort	8381	8020	6824	7283	Cohorts based on regisistry data
% 317 and other	30.0	30.0	28.3	21.6	Percentages based on registry data
Population of 317 and other	2514	2406	1931	1573	

Attachment #1

Testimony

House Bill 1435

Senate Human Services Committee

Monday, March 12, 2007; 11 a.m.

North Dakota Department of Health

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Arvy Smith, Deputy State Health Officer with the North Dakota Department of Health. I am here today to provide information about provider choice and House Bill 1435 and to offer some suggestions to help us implement the bill.

House Bill 1435 amends NDCC section 23-07-17.1 regarding immunization requirements for school and day-care attendance and provides an appropriation to the Department of Health to provide vaccines to local public health and other immunization providers while we transition to a provider choice immunization program. Of the $2.5 million dollar appropriation, $1.5 million is to fund continued universal vaccination coverage in North Dakota through December 31, 2007, and $1 million is available to the department, if needed, to continue to purchase vaccines after December 31, 2007, until the provider choice program is implemented.

The executive recommendation for the Department of Health budget assumed provider choice would be implemented by July 1, 2007. Provider choice is a work in progress and details continue to unfold as we proceed. Although we have begun to put many of the pieces of provider choice together, there are still several details to work out, some that we cannot proceed on until we are certain that provider choice is approved in the legislative process. House Bill 1435 was drafted because of local public health unit concerns that if the details of provider choice are not worked out by July 1, the local public health units could be in the position of either denying vaccines to children or absorbing the additional costs of the vaccines.

It is our goal to use as little of the funding in House Bill 1435 as possible. We are optimistic that we will be able to implement provider choice by October 1, 2007. We are tentatively considering a three-month pilot period from June 2007 through August 2007, after which we expect to implement the program. The appropriation in House Bill 1435 is helpful to make sure we have a contingency plan for immunizing all children appropriately. However, the language in House Bill 1435 is very prescriptive. It *requires* us to delay the provider choice program until January 2008 and provides funding to pay for vaccines during the interim. The Department of Health would like

to see the language provide some discretional leeway so that we can cover the costs of vaccines to the extent necessary, cover any unanticipated costs, or pay expenses related to implementing the program in a different manner that is also earlier and cheaper than House Bill 1435 prescribes.

For example, one of the biggest unknowns is the number of individuals who have insurance policies that cover immunizations but with high deductibles that may result in no actual coverage for the vaccine. If families are unable to pay these amounts, uncollectible accounts at local public health units could soar, particularly when dealing with vaccines that cost as much as $360. This is one of the main reasons local public health pursued this bill. We are still exploring options to deal with this, such as sliding fee scales, increases to administration fees to cover uncollectible amounts or payment up front to local public health units for more expensive vaccines. We have also proposed holding local public health units harmless by covering the amounts uncollectible, which would be far less than the cost of providing the vaccines for a six-month period. Once we have more information as to how extensive this issue is, we can build the cost to cover uncollectible amounts into the administration fees and no longer use state funds to cover it. The current language does not allow us to do this.

Proposed Amendments

If the committee agrees to provide the funding flexibility needed to implement provider choice, we suggest that section 2 be removed and that section 3, page 2, line 8 be amended to delete "providing vaccines to" and inserting "implementing the provider choice program including the purchase of vaccines for". In addition, as indicated in our testimony on House Bill 1136, we suggest that section 1 of this bill be deleted and the immunization requirements for school and day care be addressed in House Bill 1136.

Conclusion

Provider choice is a complicated issue. While there are still details to be worked out and we can't guarantee our success by a certain date, we are confident we can implement the program sometime between July 1, 2007, and December 31, 2007. We appreciate the contingency and flexibility House Bill 1435 could offer in this period of change as we work to ensure all children in North Dakota are appropriately vaccinated.

This concludes my testimony. I am happy to answer any questions you may have.

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NORTH DAKOTA
DEPARTMENT of HEALTH

Federally Qualified Health Centers and Rural Health Clinics that provide NDDoH vaccine
Current as of March 2, 2007

Federally Qualified Healthcare Centers		
Name of Clinic	**City**	**Phone Number**
Coal Country Community Health Center	Beulah	701-873-4445
Family Health Care Center	Fargo	701-239-7111
Valley Community Health Center	Larimore	701-343-6418
Northland Community Health Center	McClusky	701-363-2296
Valley Community Health Center	Northwood	701-587-6000
Northland Community Health Clinic	Rolette	701-246-3391
Northland Community Health Clinic	Turtle Lake	701-448-9225
Rural Health Clinics		
Name of Clinic	**City**	**Phone Number**
AMC Clinic	Ashley	701-288-3448
Beach Medical Clinic	Beach	701-872-3777
Garrison Memorial Hospital Missouri Slope Clinic	Beulah	701-873-4242
St. Andrew's Bottineau Clinic	Bottineau	701-228-9400
West River Health Clinic	Bowman	701-523-3271
Towner County Medical Center	Cando	701-968-3337
CliniCare	Cavalier	701-265-8461
Cooperstown Medical Center	Cooperstown	701-797-2128
Johnson Clinic P.C.	Dunseith	701-224-5694
Meritcare Clinic Edgeley	Edgeley	701-493-2245
Avera United Clinic – Ellendale	Ellendale	701-349-3666
Southeast Medical Center – Ellendale	Ellendale	701-349-3331
Southeast Medical Center – Forman	Forman	701-724-3221
Garrison Family Clinic	Garrison	701-463-2245
Grafton Family Clinic	Grafton	701-352-2000
Southeast Medical Center – Gwinner	Gwinner	701-678-2263
Garrison Memorial Hospital Hazen Family Clinic	Hazen	701-748-2256
Meritcare Clinic Hillsboro	Hillsboro	701-436-5311
Kulm Community Clinic	Kulm	701-647-2345
Meritcare Clinic Lamoure	Lamoure	701-883-5048
Southeast Medical Center – Lamoure	Lamoure	701-883-5048
Southeast Medical Center – Lidgerwood	Lidgerwood	701-538-4189
Johnson Clinic P.C.	Maddock	701-438-2555
West River Health Clinic	Mott	701-824-2391
Napolean Clinic	Napolean	701-754-2322
West River Health Clinic	New England	701-579-4507
Southeast Medical Center – Oakes	Oakes	701-742-3267
First Care Health Center	Park River	701-284-7555
Rolla Clinic	Rolla	701-477-3111
Johnson Clinic	Rugby	701-776-5235
West River Health Clinic	Scranton	701-275-6336
Mountrail County Rural Health Center	Stanley	701-638-2505
Tioga Medical Center Clinic	Tioga	701-664-3305
Johnson Clinic P.C.	Towner	701-537-5436
Washburn Family Clinic	Washburn	701-462-3396
McKenzie County Healthcare Systems Clinic	Watford City	701-842-3771
Wishek Clinic	Wishek	701-452-2364

Attachment # 3

Testimony on HB 1136 and 1435
Stephen McDonough MD March 12, 2007

Madam Chairman and members of the North Dakota Senate Health and Human Services Committee: Dr. Twogood, president of the North Dakota Chapter of the American Academy of Pediatrics, asked me to provide testimony today. I am a pediatrician licensed to practice medicine in North Dakota since 1980, 12 years in private practice and 15 years at the North Dakota Department of Health from 1985 to 2000. Immunizations are a high priority for pediatricians at Medcenter One and we receive annual awards from the NDDH for our high immunization rates.

Immunizations are among the three most important public health functions along with vital records and a safe water supply. During the years I spent at the NDDH, North Dakota had one of the best immunization programs in the county. North Dakota was the only state to be measles free during the national measles outbreak in the late 1980s, an outbreak that shamed the United States to improve immunization programs. North Dakota was the first state to eliminate the most common cause of meningitis in children (Hib) in the early 1990s. These accomplishments were a result of state general funding to supplement federal dollars, good public health departments and private physicians and strong leadership from the NDDH.

The NDDH also provided immunizations during emergencies. The flooding in the Red River Valley necessitated tetanus immunization to residents returning to their damaged homes. The deadly outbreak in Williston of a childhood blood infection from meningococcus resulted in a mass immunization of all children ages 2 to 18 in Williston during one week.

New vaccines are being added on a regular basis and it is a challenge to keep up and provide high quality care. HB 1136 adds vaccines that are well accepted by parents. Rotavirus is the most common cause of dehydration in infants. Pneumococcal disease causes pneumonia, sinusitis, blood infections and ear infections. Hepatitis A vaccine prevents a form of food borne illness. Meningococcal disease can cause deadly outbreaks in college students and young children, as seen in Williston.

Unfortunately, our state and nation's immunization program is unraveling from inadequate funding and poor leadership. We constantly struggle, every year, with an inept or marginal influenza immunization program. When the Centers for Disease Control should have been working on influenza, they were concentrating on smallpox bioterrorism wasting billions of dollars and valuable time. Now the CDC is proposing a national warehouse for immunizations and cutting federal aid to North Dakota's immunization program.

The next natural disaster may be pandemic influenza. If anyone tells you that we are adequately prepared for "bird flu" in the next few years, they either do not know what they are talking about or are not telling the truth. Health care facilities will be overwhelmed and there will be panic. There will not be enough immunizations, medications, testing materials, or hospital beds.

HB 1435 will assist the NDDH over the next biennium until some new immunization program is hopefully developed. North Dakota can ill afford further weakening of our public health system.

Other Information

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

Vaccine ▼ / Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		see footnote 1	HepB				HepB Series		
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib		Hib			
Pneumococcal[5]			PCV	PCV	PCV	PCV				PCV PPV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MPSV4	

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- ActHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*

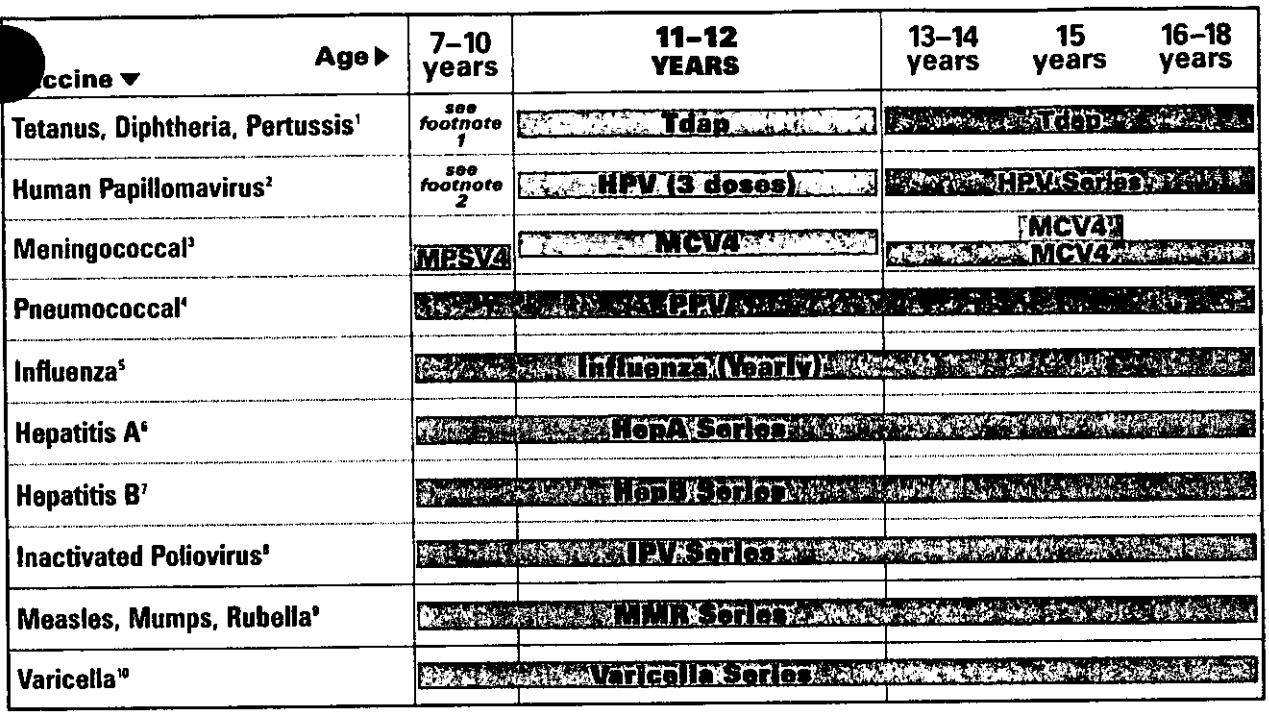
- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

SAFER • HEALTHIER • PEOPLE™

CS103184

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at **http://www.cdc.gov/nip/recs/child-schedule.htm.** Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])*
- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). *(Minimum age: 2 years)*
- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*
- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*
- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Other Information

Recommended Adult Immunization Schedule, by Vaccine and Age Group
UNITED STATES • OCTOBER 2006–SEPTEMBER 2007

Vaccine ▼ / Age group ▶	19–49 years	50–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap)[1,*]	1-dose Td booster every 10 yrs Substitute 1 dose of Tdap for Td		
Human papillomavirus (HPV)[2]	3 doses (females)		
Measles, mumps, rubella (MMR)[3,*]	1 or 2 doses	1 dose	
Varicella[4,*]	2 doses (0, 4–8 wks)	2 doses (0, 4–8 wks)	
Influenza[5,*]	1 dose annually	1 dose annually	
Pneumococcal (polysaccharide)[6,7]	1–2 doses		1 dose
Hepatitis A[8,*]	2 doses (0, 6–12 mos) or (0, 6–18 mos)		
Hepatitis B[9,*]	3 doses (0, 1–2, 4–6 mos)		
Meningococcal[10]	1 dose		

*Covered by the Vaccine Injury Compensation Program. NOTE: These recommendations must be read with the footnotes (see reverse).

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

This schedule indicates the recommended age groups and medical indications for routine administration of currently licensed vaccines for persons aged ≥19 years, as of October 1, 2006. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/nip/publications/acip-list.htm).

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule and contraindications for vaccination is also available at www.cdc.gov/nip or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Recommended Adult Immunization Schedule, by Vaccine and Medical and Other Indications
UNITED STATES • OCTOBER 2006–SEPTEMBER 2007

Indication ▶ / Vaccine ▼	Pregnancy	Congenital immunodeficiency, leukemia,[11] lymphoma, generalized malignancy, cerebrospinal fluid leaks; therapy with alkylating agents, antimetabolites, radiation, or high-dose, long-term corticosteroids	Diabetes, heart disease, chronic pulmonary disease, chronic alcoholism	Asplenia[11] (including elective splenectomy and terminal complement component deficiencies)	Chronic liver disease, recipients of clotting factor concentrates	Kidney failure, end-stage renal disease, recipients of hemodialysis	Human immunodeficiency virus (HIV) infection[3,11]	Healthcare workers
Tetanus, diphtheria, pertussis (Td/Tdap)[1,*]	1-dose Td booster every 10 yrs Substitute 1 dose of Tdap for Td							
Human papillomavirus (HPV)[2]		3 doses for females through age 26 yrs (0, 2, 6 mos)						
Measles, mumps, rubella (MMR)[3,*]			1 or 2 doses					
Varicella[4,*]			2 doses (0, 4–8 wks)					2 doses
Influenza[5,*]	1 dose annually			1 dose annually	1 dose annually			
Pneumococcal (polysaccharide)[6,7]	1–2 doses		1–2 doses					1–2 doses
Hepatitis A[8,*]	2 doses (0, 6–12 mos) or (0, 6–18 mos)				2 doses	2 doses (0, 6–12 mos) or (0, 6–18 mos)		
Hepatitis B[9,*]	3 doses (0, 1–2, 4–6 mos)				3 doses (0, 1–2, 4–6 mos)			
Meningococcal[10]	1 dose			1 dose	1 dose			

*Covered by the Vaccine Injury Compensation Program. NOTE: These recommendations must be read with the footnotes (see reverse).

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Contraindicated

Approved by
the Advisory Committee on Immunization Practices,
the American College of Obstetricians and Gynecologists,
the American Academy of Family Physicians,
and the American College of Physicians

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
CDC

Footnotes

Recommended Adult Immunization Schedule • UNITED STATES, OCTOBER 2006–SEPTEMBER 2007

1. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination.** Adults with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid–containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. Administer a booster dose to adults who have completed a primary series and if the last vaccination was received ≥10 years previously. Tdap or tetanus and diphtheria (Td) vaccine may be used; Tdap should replace a single dose of Td for adults aged <65 years who have not previously received a dose of Tdap (either in the primary series, as a booster, or for wound management). Only one of two Tdap products (Adacel® [sanofi pasteur]) is licensed for use in adults. If the person is pregnant and received the last Td vaccination ≥10 years previously, administer Td during the second or third trimester; if the person received the last Td vaccination in <10 years, administer Tdap during the immediate postpartum period. A one-time administration of 1 dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for postpartum women, close contacts of infants aged <12 months, and all healthcare workers with direct patient contact. In certain situations, Td can be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be given instead of Td to a pregnant woman after an informed discussion with the woman (see www.cdc.gov/nip/publications/acip-list.htm). Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management (www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm).

2. **Human papillomavirus (HPV) vaccination.** HPV vaccination is recommended for all women aged ≤26 years who have not completed the vaccine series. Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, women who are sexually active should still be vaccinated. Sexually active women who have not been infected with any of the HPV vaccine types receive the full benefit of the vaccination. Vaccination is less beneficial for women who have already been infected with one or more of the four HPV vaccine types. A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose. Vaccination is not recommended during pregnancy. If a woman is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose regimen should be delayed until after completion of the pregnancy.

3. **Measles, mumps, rubella (MMR) vaccination.** *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication, documentation of ≥1 dose, history of measles based on healthcare provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) have been recently exposed to measles or in an outbreak setting; 2) have been previously vaccinated with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in ahealthcare facility; or 6) plan to travel internationally. Withhold MMR or other measles-containing vaccines from HIV-infected persons with severe immunosuppression.

   Mumps component: adults born before 1957 can generally be considered immune to mumps. Adults born during or after 1957 should receive 1 dose of MMR unless they have a medical contraindication, history of mumps based on healthcare provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) are in an age group that is affected during a mumps outbreak; 2) are students in postsecondary educational institutions; 3) work in a healthcare facility; or 4) plan to travel internationally. For unvaccinated healthcare workers born before 1957 who do not have other evidence of mumps immunity, consider giving 1 dose on a routine basis and strongly consider giving a second dose during an outbreak. *Rubella component:* administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate women who are pregnant or who might become pregnant within 4 weeks of receiving vaccine. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.

4. **Varicella vaccination.** All adults without evidence of immunity to varicella should receive 2 doses of varicella vaccine. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., healthcare workers and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g., teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers). Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for healthcare workers and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a healthcare provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, healthcare providers should seek either an epidemiologic link with a typical varicella case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on healthcare provider diagnosis; or 5) laboratory evidence of immunity or laboratory confirmation of disease. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive dose 1 of varicella vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility. Dose 2 should be administered 4–8 weeks after dose 1.

5. **Influenza vaccination.** *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or HIV); any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. *Occupational indications:* healthcare workers and employees of long-term–care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term–care and assisted living facilities; persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged 0–59 months, or persons of all ages with high-risk conditions); and anyone who would like to be vaccinated. Healthy, nonpregnant persons aged 5–49 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered influenza vaccine (FluMist®) or inactivated vaccine. Other persons should receive the inactivated vaccine.

6. **Pneumococcal polysaccharide vaccination.** *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy (if elective splenectomy is planned, vaccinate at least 2 weeks before surgery)); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection [vaccinate as close to diagnosis as possible when CD4 cell counts are highest], leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, or organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids; and cochlear implants. *Other indications:* Alaska Natives and certain American Indian populations and residents of nursing homes or other long-term–care facilities.

7. **Revaccination with pneumococcal polysaccharide vaccine.** One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, or organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination.

8. **Hepatitis A vaccination.** *Medical indications:* persons with chronic liver disease and persons who receive clotting factor concentrates. *Behavioral indications:* men who have sex with men and persons who use illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)–infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at www.cdc.gov/travel/diseases.htm) and any person who would like to obtain immunity. Current vaccines should be administered in a 2-dose schedule at either 0 and 6–12 months, or 0 and 6–18 months. If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months.

9. **Hepatitis B vaccination.** *Medical indications:* persons with end-stage renal disease, including patients receiving hemodialysis; persons seeking evaluation or treatment for a sexually transmitted disease (STD); persons with HIV infection; persons with chronic liver disease; and persons who receive clotting factor concentrates. *Occupational indications:* healthcare workers and public-safety workers who are exposed to blood or other potentially infectious body fluids. *Behavioral indications:* sexually active persons who are not in a long-term, mutually monogamous relationship (i.e., persons with >1 sex partner during the previous 6 months); current or recent injection-drug users; and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for persons with developmental disabilities; all clients of STD clinics; international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/diseases.htm); and any adult seeking protection from HBV infection. Settings where hepatitis B vaccination is recommended for all adults: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; healthcare settings providing services for injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities. *Special formulation indications:* for adult patients receiving hemodialysis and other immunocompromised adults, 1 dose of 40 μg/mL (Recombivax HB®) or 2 doses of 20 μg/mL (Engerix-B®).

10. **Meningococcal vaccination.** *Medical indications:* adults with anatomic or functional asplenia, or terminal complement component deficiencies. *Other indications:* first-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis;* military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [December–June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj. Meningococcal conjugate vaccine is preferred for adults with any of the preceding indications who are aged ≤55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 5 years might be indicated for adults previously vaccinated with MPSV4 who remain at high risk for infection (e.g., persons residing in areas in which disease is epidemic).

11. **Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used.** Hib conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had splenectomies; administering vaccine to these patients is not contraindicated.

Lee, Judy E.

From: Jon Rice [Jon.Rice@bcbsnd.com]
Sent: Friday, April 13, 2007 5:24 PM
To: Lee, Judy E.; Dan Ulmer
Subject: Immunization thoughts
Follow Up Flag: Follow up
Flag Status: Red

Judy,

I just wanted to make sure you had the latest information from the BCBSND perspective on immunization.

We have developed a great working relationship with the Department of Health. We have developed a mechanism to pay for vaccines provided by the DOH whether they are provided through Public Health or private providers. We pay the Department about $185,000 monthly. Since the beginning of the program (some of it going back to Oct 2005), we have paid the DOH over 2.5 million dollars. These are claims cost that had previously not occurred to BCBSND. Premiums will be adjusted in the future to reflect the increased medical costs to our members. Because the Department has not been successful in recruiting other insurers to cover their costs of vaccinations; our competitors are not paying for the vaccines that we are covering. Effectively BCBSND is subsidizing its competitors at the expense of our members.

The development of provider choice system will allow the Department to charge each provider for the vaccine that that the Department supplies. This will help eliminate the subsidy. However, because the administration fees are kept artificially low by rules requiring that administration fees be kept at Medicaid rates for free vaccine, and free vaccine will go away with this program; vaccine administration fees are about to dramatically rise also. BCBSND is estimating an additional $1.2 million annually in administration fees at rates based on the current CPT code system. This will be an additional burden pushed to the insured member.

We are working at developing a system for vaccine reimbursement and vaccine administration reimbursement for the public health units. Because most PHUs do not have payable providers (MDs, NPs, PAs) BCBSND has not contracted with them. We are working on a limited contract for immunization services to help avoid any barriers to immunizations across the state.

I will be Out of State at a meeting next week, but should be available by cell phone 701.200.1381 if any of these comments need clarification. BCBSND is working hard to do the right thing in regard to immunizations, including enhancing our benefit plans for immunizations for all ages. The immunization costs are increasing dramatically. We hope that we can continue to provide immunization services to all the citizens in ND in the most cost effective manner possible and with a fair and level playing field for all parties.

Hope your session is going well, although I certainly have plenty to do, I do miss the activity of the legislative session.

Thanks.

North Dakota Department of Health
Costs of Required Vaccines
July through December 2007

	Jul - Dec 2007		
Currently Required Vaccines	2,850,326		
Newly Required Vaccines			
Menactra	1,190,316		
Rotavirus	741,000		
Hep A	111,328		
Varicella 2	1,177,491	3,220,135	Total Cost of Newly Required Vaccines
Total Vaccine Cost	**6,070,461** (1), (5)		
Less VFC Covered (w/o underinsured)	(1,756,846)		
Less BC/BS Covered	(2,625,885) (2)		
Nov-Covered Vaccines	**1,687,730**		
Less Available 317 Funds			
July through September 2007	(360,000) (3)		
October through December 2007	(340,000) (4)		
Amount Necessary to Pay for Non-Covered, Required Vaccines	**987,730**		(Assumes general fund purchase so uses federal rates. If general funds are not used, multi-state agreement rates must be used and cost would be $1,285,243.)

Footnotes

1.) Uses new federal contract prices effective April 16, 2007 for VFC and non-covered. The multi state agreement rates were used for BC/BS vaccines.

2.) Assumes BC/BS will continue covering in the interim.

3.) The July - September 317 vaccine is calculated based on $600,000 remaining of $1.7 million annual estimation, divided by the remaining 5 months, multiplied by 3. Last year the final amount of vaccine was suddenly cut by 15% so we are not positive this amount will be collected.

4.) The 317 funding for October through December, 2007 was calculated at a 20% reduction from $1.7 million currently projected to receive. We do not know what the reduction will be. For each additional 10% reduction, $42,500 can be added to the cost of the remaining non covered (by VFC or BC/BS) vaccines.

5.) The total vaccine cost reflects average monthly vaccine usage and has not been adjusted for the increased usage during July and August for school start.