2011 SENATE HUMAN SERVICES

SB 2276

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
1-24-2011
Job Number 13307

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to creating a state vaccine fund and a ND vaccine group purchasing board.

Minutes: Attachments included.

Senator Judy Lee opened the hearing on SB 2276.

Senator Judy Lee introduced SB 2276. The legislature has struggled for the last several years with changes in the requirements for funding of the vaccines. There have been some real cumbersome processes and procedures that have been in place for various reasons for public health units. There was nothing positive in those changes in the effort to make sure that recommended vaccines and immunization are available for the children of ND.

Arvy Smith, ND Department of Health, provided background information and supporting testimony for SB 2276. Attachment #1 She explained the different portions of the bill and pointed out that it is a work in progress. They are aware of some minor concerns that may need to be clarified or adjusted. Amendments would be coming later.

Senator Judy Lee asked if the board would be limited to approving only one brand of vaccines.

Ms. Smith responded that they could approve more than one. That board would be the ND Immunization Advisory Committee.

Senator Tim Mathern asked if the board would have any authority beyond the authority of the health officer.

Ms. Smith replied that it is designated by the health officer and it is a board within the health department. It would be through the health department other than what is specifically indicated here.

Discussion continued on the authority of the chief health officer. **Mike Mullen**, Office of the Attorney General, explained that this bill establishes the vaccine board which has the authority to establish the operating plan and set the assessments etc. The state health officer does not have this authority in the absence of this legislation. What the health

department wants to achieve through this legislation is to have the vaccine board which is composed of representatives from the Department of Health and health insurers or third party administrators of self funded health plans. They want the stakeholders to play a role in determining the operation of the fund. The goal is not to have the state health officer make independent decisions and run the whole program.

Lisa Clute, Executive Officer of First District Health Unit, testified in support. Attachment #2

Discussion followed on problems of storing vaccines, expiration dates, transferring vaccines etc.

Senator Judy Lee asked if the patient will be better served with the system as it is now or with what is being proposed.

Ms. Clute personally believes they will be better served with this proposal.

Other topics of discussion: The billing system provided by UND and the difficulties and problems involved with it. ND public health is not uniform. Some public health units don't do the current system because of how cumbersome it is. They only offer VFC vaccines. The universal system would provide vaccine to all providers in the state – both public and private.

Rod St. Aubyn, BCBS, provided supporting testimony with amendments. Attachment #3

Terry Traynor, ND Association of Counties, also testified in support of moving to universal vaccinations. The system now is burdensome and expensive and is not working.

Joel Gilbertson submitted opposing testimony on behalf of BIO written by **John Murphy**. Attachment #4 includes legal concerns surrounding ND proposed use of private funds to buy through VFC program.

Senator Gerald Uglem asked if he saw the negotiated federal rates changing if most states go to this type of program.

Mr. Gilbertson pointed out the statement from BIO seems to indicate that is what they think will happen.

Discussion then followed on the possibility of losing the benefit of the cheaper vaccines.

Jim Carlson, President of BIO North Dakota, spoke in opposition. He talked about vaccines and the changing technology. He was concerned about changing the law now for an economic means when down the road it might get in the way of proper health care. .

Senator Dick Dever said that Mr. Carlson seem to recognize there is a problem but doesn't feel this bill fixes that problem and wondered if he had other ideas that would.

Mr. Carlson didn't have an answer to what the problem is. He talked about not being opposed to finding an appropriate way to reduce costs. When the state may have new dynamic technology coming in the next years, he didn't want to see the state departments be restricted.

Discussion continued on how this would impede what the state is doing.

There was no neutral testimony.

The hearing on SB 2276 was closed.

Committee discussion followed on the testimony they had heard earlier.
A summary was given. There is a desire to have a fairly comprehensive universal vaccination program good for our state and to get these vaccines at the federal negotiated price. People in the research industry of vaccinations say that the federally negotiated price is too low to support the industry of research.
This should not be represented as a threat to pharmaceuticals and research. It is more of a process issue.
There was a suggestion about putting somebody from R & D on the board.

The committee was adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
2-1-2011
Job Number 13828

☐ Conference Committee

Committee Clerk Signature DMonson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments included.

Senator Judy Lee brought the committee to order for the purpose of a conference call with representatives from GlaxoSmithKline, Vaccine Division, – Isabelle Claxton, Shannon Dzubin, and Aaron Rech.

Shannon Dzubin, spoke about public clinic vaccine inventory management, billing, etc. These issues also apply to private.
She addressed the problem of needing different refrigerators for public and private stock and clarified that participating providers in the state supply vaccine program must separate the vaccine to prevent fraud. They don't actually need to have separate refrigeration units. There is nothing in federal requirements that calls for separate unit separation. She talked about different ways of managing the stock.

Another issue she talked to was how hard it is to estimate the supply needs specifically on managing private supply and the concern of risk of expiration. One benefit of being a VFC only supply is that is does allow for swapping between inventories.

Thirdly, she mentioned the issue of billing. CDC is addressing this issue. There is a grant process that has gone out to test various methods of billings to try to determine which protocol would work the best.

Isabelle Claxton said their concern, after reading testimony presented for the committee from the department and BCBS, was that issues on the table in public clinics won't be resolved by this bill as currently drafted.

Aaron Rech pointed out that there is still a need for accountability in a private providers office in terms of what the funding source is for the vaccine used. He talked about shortages and problems with purchasing all vaccines off of one contract. The challenges of ordering and charging wouldn't go away for a public or a private clinic in a universal program. There is still the secondary step of the administration fee and billing for that.

Ms. Claxton pointed out that going to universal purchase does not insulate either a health care provider in a public clinic or private office from many of the issues that are being seen now. Those issues could even be compounded.
She talked about the rating of the state of ND in the number of children getting age appropriately immunized.

Other issues they addressed dealt with insurance pools. With the passage of the affordable care act insurance pools, assessments of insurers, changed for several reasons as a financing mechanism for maintaining universal purchase.

1. The state assesses the insurer based on claims. Under the federal contract law that is a clear resale and it is illegal.
2. If the state assesses the insurers in advance and uses that money to purchase, it poses a potential issue for the insurers in that the assessment is a tax. Basically that is money the insurers are not going to get credit for.

Ms. Claxton told about how they have worked in other states bringing together providers, payers, public health clinics, etc. to talk about how to make the transition.

Senator Tim Mathern asked which vaccines GSK provides.

Ms. Claxton answered that they have TDEP, Hepatitis A, Hepatitis B, HPV, Combination Vaccines, and Influenza.

Molly Sander, Department of Health, responded to some of the issues that were brought up: Separate inventories, supply needs, billing, estimating, accountability, and rates.

The state ranking was discussed and what was included in the standards.
Ms. Sander also addressed the legality of what they are trying to do. She read a statement from the CDC that read that the VFC statute does not specify the source of the states funding as a condition on the use of VFC contract.

Ms. Claxton said the issue is not the source of the fund but how the fund is assessed.
It's the time and matter of assessment. You are not allowed to re-sell vaccine purchased off the federal contract.

The conference call was ended. Attachment #5 is information provided later by Ms. Claxton.

Discussion on the "timing – there is an assessment up front, not after the fact. There could be an adjustment after the fact.

Discussion continued on what the state had four years ago and before and the switch over to the present system. **Lisa Clute** said there was a need at the time to switch. What is being done now is not very cost effective. The issues being talked about have been studied and the recommendations on improvement on all stakeholders' interests are to go back to universal.

Keith Johnson, Custer Health, told the committee that the difficulties with accountability versus the different pots of vaccine used under a universal scheme would be taken care of by entry into NDIIS, ND Immunization Information System. He hoped that entry into that system was going to be required. An amendment was being offered to make sure the providers put it in within four weeks of administration of a shot.

The CDC bid is meant for low income people.

The difference in purchase cost of vaccines was addressed.
States using universal vs. VFC was brought up. States moving away from universal is partly because of budget restraints. Some states have never been universal.
It used to be policy that CDC would not let states purchase these vaccines off the federal contract. They can no longer tell states that is not an option.

Amending to place a member of the bio tech industry on the board was brought up.
The amendments from BC/BS were explained by Rob St. Aubin. Attachment #6

The committee was adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
2-9-2011
Job Number 14264

☐ Conference Committee

Committee Clerk Signature DMoxson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments.

Senator Judy Lee opened SB 2276 for committee work.

Amendment .01001 was reviewed.
An additional suggestion to amend was to add some versatility of customizing vaccines.

Senator Tim Mathern also had suggestions for an amendment on pg 3 line 4 dealing with a board member. Attachment # 7

The committee discussed the proposed amendments - .01001. Insurance assessments are going to pay for the vaccine. Insurance companies cannot be billed after the fact. There can be an assessment like there is for CHAND. There has to be some consideration on how it is worded so the health insurance providers can do what they are supposed to do. There is a reconciliation process. Purchase of vaccine happens throughout the year so there could be determination if the assessment is adequate.
Also discussed was adding the "entry within four weeks into the NDIS data".

The two suggestions from Senator Tim Mathern were discussed. It was decided to use a combination of the two.

Senator Tim Mathern moved to **amend that the business community representative would be one "involved in biotechnology with an emphasis on immunization vaccine research".**

Seconded by **Senator Dick Dever.**

Roll call vote 5-0-0. **Amendment adopted.**

Senator Gerald Uglem moved to **amend pg. 7 line 14 by inserting "within four weeks of vaccination".**

Seconded by **Senator Tim Mathern.**

Roll call vote 5-0-0. **Amendment adopted.**

Senator Dick Dever moved to **accept amendment .01001**.

Seconded by **Senator Gerald Uglem.**

Roll call vote 5-0-0. **Amendment adopted.**

Senator Tim Mathern moved a **Do Pass as Amended.**

Seconded by **Senator Gerald Uglem.**

Roll call vote 5-0-0. **Motion carried.**

Carrier is **Senator Judy Lee.**

FISCAL NOTE

Requested by Legislative Council
05/03/2011

REVISION

Amendment to: Reengrossed SB 2276

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$1,500,000		$2,980,000	
Appropriations			$1,500,000		$2,980,000	

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill creates a new section of the century code relating to the immunization program, and provides for collection of immunization data.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The federal government provides an allotment of vaccines through the Vaccines for Children Program (VFC) and Section 317 Program to the North Dakota Department of Health (NDDoH). They do not provide funding to purchase the vaccines. Consequently, the revenue and expense for use of the federal vaccines is $0 and no appropriation is necessary. However, the Section 317 vaccines which may currently be used for the non VFC or insured children are not sufficient to vaccinate all of the insured children who are currently vaccinated at local public health units. The language in SB 2276 provides for $1.5 million in general fund appropriation to purchase vaccines for insured children beyond the availability of the Section 317 vaccine allotment. If there will be inadequate funds to fund this purchasing program the department shall petition the emergency commission for a transfer from the state contingency fund in order to fund this purchasing program. The Section 317 vaccine allotment is expected to decline and may be unavailable in future years.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Vaccines will be received through the federal vaccine purchasing contract at the federal Centers for Disease Control and Prevention vaccine contract on behalf of the local public health units in ND. Vaccine is estimated to cost approximately $1.28 million for the first year of the biennium and $1.35 million for year two which includes a 5%

increase. Total vaccine purchases of $2.63 million for the 2011-13 biennium will be funded using the Section 317 allottment of vaccine and $1.5 million of general funds.

Vaccine costs for the 2013-15 biennium have been inflated 5% each year for a total cost of $2.98 million. The Section 317 vaccine allotment is expected to decline and may be unavailable in future years to fund vaccine purchases.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Included in section 3 is an appropriation of $1,500,000 from the general fund to the department. The funding or the appropriation for this project is not included in the Health Department's appropriation bill (HB 1004).

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	04/27/2011

FISCAL NOTE

Requested by Legislative Council
04/25/2011

Amendment to: Reengrossed SB 2276

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$22,929,063		$25,279,292
Expenditures				$22,929,063		$25,279,292
Appropriations				$22,929,063		$25,279,292

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for the creation of a North Dakota vaccine group purchasing program within the Department of Health and collection of an assessment from insurers and third party administrators.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The North Dakota vaccine fund located within the North Dakota Department of Health would provide payment for up to ten percent of the vaccines ordered from the federal Centers for Disease Control and Prevention vaccine contract on behalf of providers in North Dakota. This contract is established for the purchase of vaccines by immunization programs that receive CDC immunization grant funds (such as state health departments). Administrative costs are allowed and include costs associated with establishing and operating the fund.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Revenue consists of assessments to insurers and third party administrators, based on immunization cost data that will be deposited into the North Dakota vaccine fund. These funds will be utilized to purchase no more than ten percent of the vaccines from the federal contract, which is the lowest available rate for purchasing vaccines. Additionally, these funds will be utilized to purchase the remaining vaccines from private contracts for doses provided in North Dakota. We estimate total collections to be $22.9 million for the 2011-13 biennium and $25.3 million for the 2013-15 biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Vaccine costs for the 2011-13 biennium include $11.2 million for the first year of the biennium and $11.7 million for year two which includes a 5% increase. Total vaccine purchases would be $22.9 million. Several staff members will be utilized in the implementation of the North Dakota vaccine group purchasing program and additional duties related to the structure of assessments and purchasing of vaccines.

Vaccine costs for the 2013-15 biennium have been inflated 5% each year for a total of $25.3 million.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Included in the Health Department's appropriation bill (HB 1004) was $19.4 million in the operating line item which was removed by the House. The Department will need this appropriation to carryout this activity.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	04/25/2011

FISCAL NOTE

Requested by Legislative Council
03/28/2011

Amendment to: Reengrossed SB 2276

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill creates a new section of the century code relating to the immunization program, providing immunization data, and provides for a legislative management study.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The federal government provides an allotment of vaccines through the Vaccines for Children Program (VFC) and Section 317 Program to the North Dakota Department of Health (NDDoH). They do not provide funding to purchase the vaccines. Consequently, the revenue and expense for use of the federal vaccines is $0 and no appropriation is necessary. However, the Section 317 vaccines which may currently be used for the non VFC or insured children are not sufficient to vaccinate all of the insured children who are currently vaccinated at local public health units. The language in SB 2276 does not provide for vaccination of insured children beyond the availability of the Section 317 funding so it is assumed that after the Section 317 vaccine is exhausted either children would be referred to a private provider or local public health units would begin purchasing vaccine privately and billing insurance for the vaccines as well as the administration. The Section 317 vaccine allotment is expected to decline by 18% per year and may not be available in future years.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and*

appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.

As the federal government provides an allotment of vaccines through the Vaccines for Children Program (VFC) and Section 317 Program, there is no appropriation request necessary to carry out this program.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	03/28/2011

FISCAL NOTE

Requested by Legislative Council
01/21/2011

Bill/Resolution No.: SB 2276

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$17,600,000		$19,500,000
Expenditures				$17,600,000		$19,500,000
Appropriations				$17,600,000		$19,500,000

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for the creation of a North Dakota vaccine group purchasing program within the Department of Health and collection of an assessment from insurers and third party administrators. A vaccine group purchasing board would provide guidance to the implementation of the program.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The North Dakota vaccine fund located within the North Dakota Department of Health would provide payment for vaccines ordered from the federal Centers for Disease Control and Prevention vaccine contract on behalf of providers in North Dakota. This contract is established for the purchase of vaccines by immunization programs that receive CDC immunization grant funds (such as state health departments). Administrative costs are allowed and include reimbursement to board members for necessary mileage and travel expenses while attending board meetings, costs associated with establishing and operating the fund and potentially consulting costs.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Revenue consists of assessments to insurers and third party administrators, based on immunization cost data that will be deposited into the North Dakota vaccine fund. These funds will be utilized to purchase vaccines from the federal contract, which is the lowest available rate for purchasing vaccines. We estimate total collections to be $17.6 million for the 2011-13 biennium and $19.5 million for the 2013-15 biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Vaccine costs for the 2011-13 biennium include $8.5 million for the first year of the biennium and 8.9 million for year two which includes a 5% increase. Total vaccine purchases would be $17.4 million. An additional amount of $200,000 is provided, should the North Dakota vaccine group purchasing board determine that they would require the services of a consultant. Minimal amounts of time for several staff members will be utilized in the implementation of

the North Dakota vaccine group purchasing board and additional duties related to the structure of assessments and purchasing of vaccines.

Vaccine costs for the 2013-15 biennium have been inflated 5% each year and include consulting costs of $200,000 for a total of $19.5 million.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Included in the Health Department's appropriation bill (HB 1004) is $19.4 million in the operating line item. This will be sufficient to cover vaccine and contractual services the board may wish to purchase.

Name:	Kathy J. Albin	**Agency:**	Health
Phone Number:	328.4542	**Date Prepared:**	01/22/2011

Sen. Mathern 2-9-11

#7

PROPOSED AMENDMENT TO SENATE BILL NO. 2276

Page 3, line 4, after "community" insert "involved in immunization vaccine research"

OR

Page 3, line 4, after "community" insert "involved in biotechnology"

Date: 2-9-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2276

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number Combine Sen. Mathern's suggestions

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

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

Date: 2-9-11

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2276

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number pg 2 line 14 - w/in 4 wks of vaccination

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Uglem Seconded By **Sen.** Mathern

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

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

11.0713.01001
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
January 31, 2011

#6

PROPOSED AMENDMENTS TO SENATE BILL NO. 2276

Page 1, line 14, remove "and "insurer" have the same meaning as provided under"

Page 1, replace line 15 with "means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

a. Health insurance coverage does not include any one or more of the following:

(1) Coverage only for accident, disability income insurance, or any combination of the two;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workforce safety and insurance or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

b. Health insurance coverage does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without

regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan."

Page 1, line 17, after "7." insert ""Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

8."

Page 1, line 21, replace "8." with "9."

Page 2, line 1, replace "9." with "10."

Page 2, line 4, replace "10." with "11."

Page 2, line 6, replace "11." with "12."

Page 2, line 7, after "state" insert ", who receives vaccinations from a North Dakota provider,"

Page 2, after line 8, insert:

"13. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee."

Page 2, line 9, replace "12." with "14."

Page 2, line 11, replace "13." with "15."

Page 4, line 7, after "c." insert "Establish a policy for conducting a reconciliation process to ascertain that assessments were fair and equitable and to consider adjustments to future assessments;

d."

Page 4, line 8, replace "d." with "e."

Page 6, line 11, replace "must" with "may"

Page 6, remove lines 21 through 25

Page 6, line 29, after the underscored period insert "All interest and earnings of the fund must be retained in the fund."

Page 6, line 29, after "credit" insert "for this assessment"

Renumber accordingly

Date: 2-9-2011

Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2276

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .01001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Dever Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

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

Adopted by the Human Services Committee

February 9, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2276

Page 1, line 14, remove "and "insurer" have the same meaning as provided under"

Page 1, replace line 15 with "means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

a. Health insurance coverage does not include any one or more of the following:

(1) Coverage only for accident, disability income insurance, or any combination of the two;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workforce safety and insurance or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

b. Health insurance coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without

regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan."

Page 1, line 17, after "7." insert ""Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

8."

Page 1, line 21, replace "8." with "9."

Page 2, line 1, replace "9." with "10."

Page 2, line 4, replace "10." with "11."

Page 2, line 6, replace "11." with "12."

Page 2, line 7, after "state" insert ", who receives vaccinations from a North Dakota provider,"

Page 2, after line 8, insert:

"13. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee."

Page 2, line 9, replace "12." with "14."

Page 2, line 11, replace "13." with "15."

Page 3, line 4, after "community" insert "involved in biotechnology with an emphasis in immunization vaccine research"

Page 4, line 7, after "c." insert "Establish a policy for conducting a reconciliation process to ascertain that assessments were fair and equitable and to consider adjustments to future assessments;

d."

Page 4, line 8, replace "d." with "e."

Page 6, line 11, replace "must" with "may"

Page 6, remove lines 21 through 25

Page 6, line 29, after the underscored period insert "All interest and earnings of the fund must be retained in the fund."

Page 6, line 29, after "credit" insert "for this assessment"

Page 7, line 14, replace "an" with "a required"

Page 7, line 14, remove "required by this"

Page 7, line 15, replace "section" with "within four weeks of vaccination"

Renumber accordingly

Date: 2-9-11

Roll Call Vote # 4

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2276

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0713.01002 Title 02000

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. J. Lee

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

REPORT OF STANDING COMMITTEE

SB 2276: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2276 was placed on the Sixth order on the calendar.

Page 1, line 14, remove "and "insurer" have the same meaning as provided under"

Page 1, replace line 15 with "means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

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(1) Coverage only for specified disease or illness; and

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Renumber accordingly

2011 HOUSE HUMAN SERVICES

SB 2276

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2276
March 23, 2011
Job # 15887

☐ Conference Committee

Committee Clerk Signature Marilyn Kienzle

Explanation or reason for introduction of bill/resolution:

Relating to creating a state vaccine fund and a North Dakota vaccine group purchasing board: to amend and reenact sections 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data: to provide a penalty; and to declare an emergency.

Minutes: See Attached Testimonies #1 -2-3-4-5-6-7-8-9

Chairman Weisz: Opened the hearing on SB 2276.

Sen. Judy Lee District 13: Sponsored and introduced the bill. (See Testimony #1)

Rep. Porter: Who picks which vaccines are available for the program to push out to the clinics and the public health units, is that a board function?

Sen. Judy Lee: It is the ACIP that determines what immunizations are recommended. There are 16 vaccines that are now required for children that are entering school and child care. This is a Federal Committee.

Rep. Porter: How do the technology changes with what types and the number of times to receive a shot happen and move with the board? When the one shot cost ten dollars and the new one cost twenty dollars on the same contract, is there a formulary that is developed by this board to see which vaccines are available to this program or is it still just whatever the physicians want to give?

Sen. Judy Lee: She deferred question to Molly or Arvy from the Health Department to provide the details for you. The Senate did review that but I would feel more comfortable to have them explain that to you.

Rep. Porter: On the board itself, looking at the makeup of the board itself, I do not see a physician or pediatrician as a member on the board, who would be the ones immunizing the children. Was that discussed in the Senate?

Sen. Judy Lee: I don't recall that we discussed it. I can't imagine there would be any objection to that and is probably a good addition to that board.

Rep. Kaldor District 20: Testified in support of the bill. (See Handout #2) This is an article from the Sunday's Bismarck Tribune written by Edward Lotterman who writes on economic issues and this week's issue was about vaccination. It basically states as to how important it is to get as many children immunized as possible as it does affect our economy. On the second page Rep Kaldor pointed out the third paragraph. In his article he has justified that by identifying what important aspect of good health and immunization is and how important it is. It also relates to the fact that our current system, while not being universal, families with high deductibles has to pay out of pocket for the vaccine and administration up front. We need to do everything we can, not to deter vaccination. Some say this legislation will interfere with the free market. I would like to point out, we not only have the right to develop this purchasing mechanism, but I think it is a responsibility to negotiate for the best price for the state. Other states with financial constraints, suffering from economic woes and certainly not in as good shape as we are in North Dakota, are entertaining what we are doing here today. If North Dakota gives up this opportunity, we will be subsidizing those states that are participating in this purchasing agreement. This is not only good for our children and our health but is also good and important for our taxpayers. I hope this committee gives this favorable recommendation on the floor.

Arvy Smith Deputy state health officer for the North Dakota Department of Health: Testified in support of the bill. (See Testimony #3) As Senator Lee mentioned there was an in depended quality improve study on the immunization program over the past interim. That interim study indicated that it is best for North Dakota to move forward with a universal vaccine supply system. Arvy discussed the question on the board. The board that the bill creates is more to manage the assessment and does not decide what vaccines to cover and brand issues. Our vision in this was to keep that process with the vaccine advisory commission which is composed of physicians and such. The more barriers we can remove from vaccinating children the easier it will be to get more children vaccinated. This would also be a saving in insurance premiums. Arvy went through the bill.

Rep. Louser: In the fiscal impact paragraph that you had 19.4 million in the budget that came out. On the previous page it showed that the private amount was about 11.5 million. Why the difference?

Arvy Smith: The 11. 5 million is annual figure and the 19.4 is the biennial figure. So the 19.4 was the estimate for two years at the federal rate, whereas the 11.5 is one year at the private rate.

Rep. Devlin: It seems only the government tries to fix a problem that doesn't appear to be particularly broken. I don't understand in 2008 when we had universal coverage to speak we were 45th and now we are third and the research I have done, none of the top 5 states with immunization success has universal coverage. So why would we want to go this way?

Arvy Smith: I am unsure of the exact standing in 2008 and would have to have the program director assist me with that.

Molly Sander the Immunization Program Director: A lot of the stats depend on what vaccine you are looking at. There are a lot of vaccines recommended for kids and in 2008 there were a lot of new vaccines recommended bring the states really close together as to

what their rates were. So it didn't say much to say you were 45th in the nation. The legislature also added numerous child care and school requirements in 2008 for these new vaccines and that is why our rates went up significantly.

Rep. Devlin: When I look it up, it still looks like none of the five states have universal coverage and I am wondering why do we want to go there? If we are not going to get more success than be number three in the nation why would we want to make that change?

Molly Sanders: If we had universal coverage it would be easier for public health care to go into schools and do mass health clinics. We have good providers and will vaccinate regardless what our policy is but I do think that having a universal process they will be able to increase our rate even more.

Arvy Smith: I'm wondering too if those rates are from 2009 and these states universal statistics are all fairly new, isn't it?

Molly Sanders: Some of them are and some of them aren't. Washington State has been universal for a number of years and they are probably last in the nation. The reason is their population and they have a high rate of exemptions.

Arvy Smith: What are some of the newer states?

Molly Sanders: All the newer ones who are doing this have been universals but are just beginning to use the insurance assessments.

Rep. Devlin: I don't read it quite the way you do as far as deciding what vaccines are used. I read it as the health officer or health officer's designee will make that decision. They will consult with the North Dakota Immunization Advisory Committee. This is sortof the same as: it kind of flies in our face where we have always been with doctors being able to do a brand necessary type thing.

Arvy Smith: Could you give me what page you are on?

Rep. Devlin: Top of page 4.

Arvy Smith: We rely heavily on those members of that advisory committee. That wording may be able to be improved and we are willing to put some guidelines about brand choice in the bill if that is helpful.

Molly Sanders: The immunization committee is made up of a lot providers throughout the state. Any provider can be a member. Vaccine manufacturers also may be able to join all of our conference calls. We meet monthly. We have what is called vaccine selection guidelines which we base on safety of vaccine. We do try to base it on cost but a lot of the combination vaccines that Rep Porter spoke of are vaccines has multiple diseases those tend to be more expensive but the child needs less shots. I'd say 95% of the vaccines there is the capability to have a choice of what you want to use. There were couple of providers have decided that it is not best to offer choice as an example HPV one of the brands protects against 4 strains against HPV and the other brand protects against 2

strains, so the providers decided that they should use the one that protects against the 4 strains. For tetanus vaccine we provide for all the brands but the list goes on and on as where there is a choice of brand that they can choose from.

Rep. Devlin: Arvy, why do you want to exempt yourself from the administrative rules process?

Arvy Smith: I believe that this is how many of these boards are set up. I do know we did consult with the Attorney General's office in writing this.

Rep. Porter: Since we are putting that Immunization Advisory Committee into the century code now where it hasn't been in the past. We aren't saying who are and who aren't members, and we aren't saying anything about the makeup of the committee. All we are saying is that suddenly the committee now exists. In the past it may or may not have existed and their authority may or may not be existed or what their selection choices are. I need clarification on that component. If we are adding this to the Century Code we don't want to be that vague with what their authorizes are for this important of a process. That needs more work. In the makeup of the vaccine purchasing group themselves we have a little bit of lopsidedness, with three members representing insurers. In your estimation who would they be and how would the selection choice be made?

Arvy Smith: First of all, with the membership of the advisory committee, we would view that as a friendly amendment to add any language addressing that.

Rep. Porter: Do you have bylaws or outlines of their existence inside of your department currently?

Arvy Smith: We have vaccine guidelines that we have developed set up by an informal group since Dr. Dwelle became Health Officer. We had these decisions to make, so we wanted involvement from the physicians. Our main focus was to get their input. Maybe it is time to formulize that group a little more. We would be open to that.

Rep. Porter: Your makeup of the board with 9 members and 3 coming from insurers. They seemed to be the only group inside of here that has multiple members so they have the majority of not the vote but of membership. I was wondering how it was selected and how you envisioned process of who they would be.

Arvy Smith: As the bill is set up the health officer would appoint those members. I would think it would be asking who is interested and would probably get most interest from our three largest insurers BC/BS and Stanford and Medica. When we envision this board, its main function is determining that mechanical assessment of the insurer and how much that should be. So we were careful to make sure we had enough insurer membership on this board. We wanted a public health unit as a provider, administrator and also a business person from the private health care practices because again we are viewing this piece more as an administrative process to make sure whatever this group decides works for the providers administrating as well.

Rep. Porter: Then you wouldn't see the purchasing board having the authority to override the immunization advisory committee?

Arvy Smith: We are not envisioning it that way.

Rep. Porter: But that is the way it is drawn up it could happen.

Arvy Smith: Not to override the vaccine choice. For starters as far as which vaccines it would be all ACIP recommended vaccines. Many of the insurers have policies to cover all ACIP recommended and then you look to the state laws, so it is only that brand choice. It does not say anything in the bill about brand choice, that is all left to the other group.

Rep. Porter: Do we need then to make something specific that says all ACIP recommendations are in place and are authorized in the state of North Dakota?

Arvy Smith: I think that is already in place.

Rep. Porter: So that is kind of a mandate?

Arvy Smith: Yes all ACIP recommended vaccine for school age children except for flu and HPV, is that right? Someone in the back ground said right. That is already in Law.

Rep. Porter: That could be a ten shot regiment and not the newest and greatest.

Arvy Smith: That deals with diseases you are going to cover not how it is formulated into a vaccine.

Rep. Porter: Looking at page 5 on the bottom, the admistrative costs are in the revolving fund. I'm unclear if inside of the pool if we are charging more than what the vaccines actually are out to public health and private third party payers. There is a surplus of funds that comes into the operating fund that fund can pay for all the administrative costs associated with the operations of this board. From a legislative standpoint do we than appropriate back into that board or because you have full authority to spend inside of their, than we have no financial over sight once this would be created?

Arvy Smith: There would be an appropriation limiting it. It was 19.4 and if you look at the fiscal note it is down to 17.6 million. So that reduction could be made for this biennium. And that by our estimate 17.4 is for the vaccine and the other 200 thousand is limited for admin and that would be a decision by the group wither they need it for a study or a consultant to review for detail and advise the group.

Rep. Porter: In your testimony you made a comment on the savings back to the private insurers to being 2.5 to 3 million dollars per year reducing the cost to insurers. How do we as policy makers, make sure that this money goes back to the insurer?

Arvy Smith: By the way it is set up, as an example I will use Blue Cross. They cover all ACIP recommended vaccines. They are either going to be billed as currently as they are being billed by all the providers at the private rate. When we do this we are limiting the

fund we are purchasing the vaccines at the federal contract rate. This fund can only be used to purchase these vaccines and then we left 200 thousand for admin costs. They can't possibly be spending more. Anything more would have been billed to them at the private rate by the providers.

Rep. Porter: I understand they won't be paying more but how you assure us that rates subscriber will be paying less.

Arvy Smith: I will let Blue Cross talk about the rules that will cover this.

Rep. Devlin: You said you talked to CDC as to what you were planning to do. I don't think you would have started down this road at all unless you had some documentation that you can use the federal VFC contract. Do you have that letter?

Arvy Smith: Yes we do it is in the form of an e-mail.

Lisa Clute Executive Officer of First District Health Unit: I am testifying in support of the bill. (See Testimony #4)

Dan Ulmer: Representing Blue Cross/Blue Shield of ND testified in support of the bill. (See Testimony #5)

Rep. Porter: Your comment that there are still some concerns with the bill. Are they the ones you identified or are there others?

Dan Ulmer: I think we should say we had some concerns. Basically I think they were addressed in the Senate.

Rep. Porter: Inside of the Administrative cost that Ms Smith identified that there is about two hundred thousand dollars that is being charged back to you as one group of administrative costs with establishing this. Is that still well within a reasonable administrative costs and how your company looks at reasonable expense to administrate this program.

Dan Ulmer: Yes it is.

Rep. Porter: The comment was made already as you representing one of the companies of that industry. How do we go back to our constituents and say we saved you 75 cents on your premium? How do we find that net value for our constituent by switching this into a universal program?

Dan Ulmer: We collect 1.4 billion dollars in premium in a year. This is a 2 million dollar impact and you can do that math in terms of percentage. We could also lay this out to about five dollars per year. We are looking at trending utilization rates that are exceeding eight to ten percent. We are working with many of the providers to hold the medical inflation in North Dakota to 6 1/2%. Over the past ten years we have looked at eight percent per average.

Rep. Paur: What is the average cost of a provider to process a claim with Blue Cross?

Dan Ulmer: About 8 cents. On average we have a 92 to 93 loss ratio. So my quick calculation it would be about 7 to 8 cents. For every dollar you give us we give 92 to 93 cents back in health care.

Rep. Paur: Sanford Health puts in a claim to BC/BS it must cost Sanford Health something as they have a whole department that deals with that.

Dan Ulmer: I don't have any idea as for the provider cost. You would have to ask Sanford Health.

Terry Traynor County of Associations: testified in support of the bill. (See Testimony #6)

OPPOSITION

John Murphy from Biotechnology Industry Organization: Testified in opposition of SB 2276. (See Testimony #7) Dr. Koch wanted to be here to testify, but couldn't be here. John handed in the testimony of Timothy Cooke, Ph.D. (See Testimony #8)

Rep. Porter: As this type of program expands across the country do you think the contracted rate for the immunizations with the federal government is going to adjust and change upwardly to reflect that gap between where the private pay and government contract rate currently reside?

John Murphy: I would hope from a policy respective not because the larger those price negotiations go up with the federal government the harder it is to access for the under insured children. I think the practical reality is that when you balance the interest of the commercial market it is very expensive to sustain these companies' research and development protocols. If states starts take advantage of this sort of pricing beyond the uninsured children it is going to be more and more difficult for the federal government to come in and say we want a discount for the uninsured market and on the back end you are going to say in fact, the commercial market is drying up. We are not recouping our investments and we are not able to fund ongoing investments. Vaccines in particular are very unique in that they can be administered to prevent diseases before they even occur. A lot of people think that therapeutic vaccines are sort of the wave of the future. In fact investments now for therapeutic vaccines for HIV prevention and certain cancers are ongoing. These are sort of the things we want to foster but you can't get past the fact that those cost a lot of money to develop. The only way to fund that sort of future development is some sort of competitive market place with existing vaccines.

Rep. Porter: As this model moves across the country, there is a convention of Insurance Commissioners that will be talking about this, there will NCSL will be talking about this model Legislation to do this to save all this money and have this program in place. I think this is just the tip of the ice berg of how this is going to go. How does contract between the pharmaceutical manufacturers and the federal government work? Is it up for bids every year? Is it up for pricing restructuring every ten years? How does it work so that if this does become the national model, the pharmaceutical industry can say the commercial market is

down because this model is the new model and priced by feds and paid for by the states and the only way for the industry to make money is to raise the price. How is that contract negotiated and dealt with?

John Murphy: It is a company by company basis. It is not really dome thing that Bio gets involved with in re negotiating that contracting. It is a judgment amongst the companies on how they do that. I can't comment on if that is a one year thing or a ten year contract. I would sort of dispute that this model would be peculating around the country as being the new model. The reason I say that is that this is the only bill I have seen around the country since the passage of federal health care reform and the reason is because there is going to be so much attention given to vaccines in the commercial market place due to the federal health care reform. We would think that this model, in fact, isn't the wave of the future. The wave of the future is now there will be attention paid by commercial market place to children vaccines but also to adult vaccines, which has been largely ignored going forward.

Jeb Oehlke: From Chamber of Commerce testified in opposition of the bill. (See Testimony # 9)

Chairman Weisz: Closed the hearing on 2276.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2276
March 23, 2011
Job # 15898

☐ Conference Committee

Committee Clerk Signature Marilyn Kiefl

Minutes: "Attached testimony #1 and 5 vote sheets."

Chairman Weisz: We have two bills that need to be heard so we will start with 2276.

Rep. Devlin: This has been an issue that was made ever since the legislative changes in 2005. It has created problems for the Health Department with the billing and inventory. As we talked through this thing, I think there is a way to do this. If we cover every child that comes into Public Health using the VFC and 317 funds, we are taking care of all the billing and inventory problems they now have. We seem to have gotten to a bigger program than what we need to address that problem.

Chairman Weisz: I believe the study itself asked for universal coverage and that is what identified in that respect.

Rep. Devlin: I make a motion that all children that come into the Public Health are covered by VFC and 317 funds.

Rep. Damschen: Second the motion.

Rep. Kilichowski: So that would mean that they would not have to keep separate the different vaccines?

Chairman Weisz: That is correct. It would limit the current bill strictly to Public Health Units.

Rep. Kilchowski: So people who would want to go to the Public Health, they could just pay for the vaccine? I was told they could not because of the billing system through UND.

Chairman Weisz: Oh you mean currently. Currently there are all kinds of issues.

Rep. Kilchowski: Will this eliminate the billing through UND?

Chairman Weisz: Correct. This would not move it to universal for the current pay private providers.

Rep. Kilichowski: If the universal immunization worked prior to 2004 why can't it work again?

Chairman Weisz: There are two reasons it was changed we thought we were losing the 317 funds or having a drastic cut back. The other thing is the legislature at that time added a lot of mandatory, so the cost went up. The Blues made up some of the difference. This was where the push came from to go to the system we have today. The bill could go back to complete universal and we can do that. I do believe the issue is that if every state does it the contract rate discount rate will go away. Then the advantage of the VFC and the 317 also goes away.

Rep. Kilichowski: That is just an assumption on our part, isn't it?

Chairman Weisz: It is. You can guarantee anything. If the rules change the negotiation will change.

Rep. Kilichowski: Will this have any affect with Public Health going into the schools to do immunization on all the children?

Chairman Weisz: I think this would still have the same effect as if we passed the whole bill. They still have to determine if they are VFC or not. They won't have to bill anyone if it is in their office or if they go into a school. They will collect an administrative fee like they did in 05 and like they will under this bill. The difference will be the local doctor and he won't be under the universal.

Rep. Kilichowski: The way it is under this bill, if they went into the school, they wouldn't have to worry about these children if they are under insured or not insured.

Chairman Weisz: They still would get the vaccine under the amendment. They still have to keep that record and determine if they are under VFC or under insured. They would not have to worry about the billing and inventory as they do today.

Rep. Devlin: This buys us a little time and takes care of our problem with Public Health and within that time we will know if the Federal Health Law is constitutional or not. I think this is where we need to be because public health is the big issue.

Chairman Weisz: Asked for any further questions. Asked for a voice vote for the motion and it carried. Asked for further amendments.

Rep. Porter: I have a few points that I would like to make for discussion with the committee. If I look through the makeup of how this is going to function and who is ultimately going to decide on the vaccine recommendation. Currently there is no such thing as the North Dakota Immunization Advisory Committee except inside of the State Health Department. Now we are throwing in a definition of who they are and what there commendations mean. On page 3, line 8 I want everyone to look at that definition and make sure they think that makeup is what it needs to be as far as making those recommendations. On page 4 on the top, sub 3, I do have an issue, which is that if we are going to statutorily create a committee and we are going to task them with picking brands of

vaccines that are in the best interest of our children. That should hold a little bit of water in wither or not the State Health officer takes it as a consultation or a recommendation of fact. I wrote down on the line that after the word designee, we cross out the word consultation and put in there "that they shall act on the recommendation of the North Dakota Immunization Advisory Committee when determining which brands of vaccines are purchased under this chapter. So that their recommendation is in fact, what the State Health Department has to go by.

Chairman Weisz: You're language is saying that the State Health Officer or his designee shall act on the recommendation of the North Dakota Immunization Advisory Committee when determining which brands of vaccines are purchased under this chapter.

Rep. Porter: If someone comes up with better verbiage that would be okay with me. I think that the language would empower that committee as to what the Health Officer should be doing and would make it a meaningful committee. Not just a recommendation that could be trumped or played on by the Health Officer.

Rep. Devlin: I would really like some kind of language in there that the provider/doctor would have the right to select any vaccine that they want.

Chairman Weisz: The committee should have had an amendment hand out that will have some suggested choice language.

Rep. Porter: Starting with the first amendment passing that this is really only focused to public health. We and the Health Department are the oversight of choosing those vaccines. The private sector can do whatever they want yet. I am looking at it from the stand point of Public Health and what vaccines are going to be picked now by the health officer to purchase through this program to redistribute to Public Health. I think that this committee of private health care providers, local public health units, the staff and others is key to making sure that it is the latest and the greatest and not just what is off the shelve.

Chairman Weisz: Let's take Rep. Porter's idea first.

Rep. Porter: I make a motion to the wording described above.

Rep. Schmidt: Seconded the motion.

Motion carried

Rep. Devlin: I am still not convinced in my mind that it is going as far as I would prefer. I would prefer that the doctors and the Public Health have the vaccine that they want. I want to make sure that they don't take things away that the doctors want to use.

Chairman Weisz: Took a voice vote which passed.

Rep. Devlin: I am fine with this after going over it.

Chairman Weisz: Just so everyone understands this is only for Public Health. The private provider can chose whatever they want.

Rep. Paur: Is there much latitude for the Public Health?

Chairman Weisz: Asked for Molly Sanders for the answer.

Molly Sanders: Currently the health unit on the same situation is private providers for when they order VFC vaccine. All of the childhood vaccines are available on the federal contract for order. The Immunization Advisory Committee reviews those vaccines twice a year, unless some new vaccines are developed, and then determines which vaccines to offer and then advises which vaccines to offer to order. Ninety-five percent of the time we offer brand choices, presentation choice for all the vaccines. There will be times the provider still feels strongly that one vaccine is superior to another. They decide wither or not they want offer a choice and then that is what the Health Department goes with.

Chairman Weisz: Clarify if you will, if I am a Public Health Unit, if I am going to order 10 dose of a vaccine, do I order it through you, the Health Department, or do I order it directly?

Molly Sanders: They order directly from the Health Department and the Health Department forwards it to CDC. Annually I have to predict what the providers are going to order and forecast that. So if they order more than what was predicted, then CDC will stop the orders until I correct what my prediction was.

Rep. Devlin: I move that we offer subsection 2 and 3 for North Dakota.

Rep. Porter: Second the motion.

Voice Vote: Motion Carried

Rep. Porter: On page 6, I make a motion that we remove subsection 3, which is the exemption of the administrative rules process.

Chairman Weisz: With the adoption of Rep Devlins amendments the purchasing board goes away.

Rep. Porter: At the end of the bill, because this is a working in progress and we don't know how this is going in conjunction with a federal health program and/or other changes that may come from the feds, we should include study language to examine the full implementation of the Universal Vaccination Program in North Dakota. We may want to include wording for a legislative study during the next interim. This is a motion.

Rep. Schmidt: Second.

Voice Vote: Motion Carried

Rep. Devlin: I want to make sure that on page 8 we still have all the reporting requirements when someone is immunized.

Chairman Weisz: The only thing I would say about that amendment is if you have a private provider who does not do VFC's is there any leverage for them. Do we need a penalty for those providers who do not offer VFC?

Rep. Porter: You could tie it back to their licensure from their board. You could say something about being habitually late with their reports or are failing to keep their records up to date, they will be subject to their licensing board.

Chairman Weisz: How would this read. How much time are we going to give them? Would four weeks be the amount?

Rep. Porter: I would say that would work and I make a motion on that working.

Rep Anderson: Seconded the motion.

Motion Carried.

Chairman Weisz: We will meet tomorrow morning to take the vote.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2276
March 24, 2011
Job # 15914
☐ Conference Committee

Committee Clerk Signature Marilyn Keenzle

Minutes: Proposed Amendments and vote

Chairman Weisz: Opened the committee meeting to vote at SB 2276. Vicky handed out the purposed amendments.

Rep Porter: Discussed all the new language and changes to the bill discussed on 3-23-2001. I would move the amendment 03001 with the exclusion of page 2, subsection 2, B sub 1 and then renumber.

Rep. Devlin: Seconded the motion.

Rep Porter: Mentioned that the study was not included on the amendment.

Motion Carried.

Rep Porter: Made a further amendment to include the study language that was discussed earlier.

Rep Pietsch: Seconded the motion

Motion carried.

Chairman Weisz: There will be a need to get a new fiscal note. It is needed because of the dollars that will have to flow through.

Rep Porter: I make a motion for a DO PASS for Engrossed SB 2276 as amended and rerefer to appropriation.

Rep. Devlin: Seconded the motion.

DO PASS amendment and re refer to Appropriations Yeas 11 Nays 1 Absent 1

Motion carried. Rep Weisz is the carrier.

Date: 3-23-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Damschen

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote motion carried

Date: 3-23-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Schmidt

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote

Date: 3-23-11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote
Motion carried

offer Subsections 2 & 3

Date: 3-23-11
Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Schmidt

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote
Motion Carried

Date: 3-23-11
Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Anderson

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote
Motion Carried

11.0713.03001
Title.

Prepared by the Legislative Council staff for
Representative Weisz
March 23, 2011

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; and to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Immunization program - Provider choice - Purchasing.

1. As used in this section:

   a. "Department" means the state department of health.

   b. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

   c. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

   d. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

   e. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

   f. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

   a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

   b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

      (1) In determining which brands of vaccines are purchased under this program, the state health officer or the state health officer's designee shall act on the recommendation of the North Dakota immunization advisory committee.

      (2) The department shall supply public health units with the purchased vaccines. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(3) A public health unit that receives vaccines under this subdivision may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(4) The department shall fund this purchasing program through participation in the vaccines for children program and the federal section 317 immunization grant program."

Renumber accordingly

Date: 3-24-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Devlin

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote
Motion Carried

Date: 3-24-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Pietsch

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. CONKLIN		
VICE-CHAIR PIETSCH			REP. HOLMAN		
REP. ANDERSON			REP. KILICHOWSKI		
REP. DAMSCHEN					
REP. DEVLIN					
REP. HOFSTAD					
REP. LOUSER					
REP. PAUR					
REP. PORTER					
REP. SCHMIDT					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote
Motion Carried add study language

Adopted by the Human Services Committee

March 24, 2011

VR
3/24/11
1803

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; and to provide for a legislative management study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Immunization program - Provider choice - Purchasing.

1. As used in this section:

   a. "Department" means the state department of health.

   b. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

   c. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

   d. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

   e. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

   f. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

   a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

   b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

      (1) The department shall supply public health units with the purchased vaccines. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

      (2) A public health unit that receives vaccines under this subdivision may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this purchasing program through participation in the vaccines for children program and the federal section 317 immunization grant program.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-2012 interim, the legislative management shall consider studying the North Dakota immunization program and the feasibility and desirability of extending the program's vaccine purchasing program to provide vaccines to private health care providers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

Date: 3-24-11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2276

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Devlin

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN	✓	
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON	✓		REP. KILICHOWSKI		✓
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	✓				
REP. LOUSER	A				
REP. PAUR	✓				
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 11 No 1

Absent 1

Floor Assignment Rep. Weisz

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

REPORT OF STANDING COMMITTEE

SB 2276, as reengrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). Reengrossed SB 2276 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; and to provide for a legislative management study.

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2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of immunization administered to a patient and may be exchanged regardless of the date of the immunization.

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Immunization program - Provider choice - Purchasing.

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b. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

c. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

d. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

e. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

f. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

(1) The department shall supply public health units with the purchased vaccines. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(2) A public health unit that receives vaccines under this subdivision may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this purchasing program through participation in the vaccines for children program and the federal section 317 immunization grant program.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-2012 interim, the legislative management shall consider studying the North Dakota immunization program and the feasibility and desirability of extending the program's vaccine purchasing program to provide vaccines to private health care providers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

2011 SENATE HUMAN SERVICES

CONFERENCE COMMITTEE

SB 2276

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-11-2011
Job Number 16475

☒ Conference Committee

Committee Clerk Signature Allotson

Explanation or reason for introduction of bill/resolution:

Relating to creating a state vaccine fund and a ND vaccine group purchasing board.

Minutes:

Senator Judy Lee opened the conference committee on SB 2276.
All members were present: Senator Judy Lee, Senator Gerald Uglem, Senator Tim Mathern, Rep. Robin Weisz, Rep. Bill Devlin, and Rep. Richard Holman.

Rep. Weisz explained the changes the House made on SB 2276. It was basically a hog house. They took the universal and trimmed it down to just apply to the public health units. The major difference when they went to that was in the current bill. It covers those private pay that go into a public health unit with federal 317 funds. According to the numbers they came up with, if the current funding would stay, there would be enough 317 funds to cover the current rate of private pay that is being handled in the public health units.
They are really setting up a universal system for the public health units where everything will be purchased off federal contract rate leaving the private sector in the current situation.

Senator Judy Lee said that her view of the definition of "universal" is it would be all encompassing for everybody who would be receiving them.
She asked if there were any concerns on the part of the House about this driving the private provider medical home patients into the public health units because that's where the less costly vaccines or immunizations would be available.

Rep. Weisz replied that they did have discussions on that. Assuming PPACA does happen with the first dollar coverage, the thought was that from the standpoint of the client it won't matter where they go. There was discussion on the provider's standpoint of whether the provider will, especially in rural areas, decide it's more advantageous to just send them over to the public health units.

Senator Tim Mathern asked the House members what they see the fiscal impact of their changes and if the House is willing to fund it.

Rep. Weisz replied that he didn't understand where the state would be funding anything. Currently they are either paid by VFC or 317 and that wouldn't change under this scenario.

There wouldn't be a fiscal impact to the state's general fund. This wouldn't pick up the savings that would be realized by having a true universal for everyone.

Senator Judy Lee asked if the House was concerned about the fact that somebody paying privately or the insurance company paying has additional expense.

Rep. Weisz said the House had a lot of discussion having to do with the fact that the intent of the federal contract rate was for the underinsured and uninsured and whether they should be purchasing private pay off that. They were well aware of other states already doing it or planning to do it. In the end the House thought the private billing should be negotiated among the pharmaceutical companies and leaving the public end to purchase off the federal contract rate.

Senator Judy Lee recalled that the health department tried to get the pharmaceutical manufacturers to negotiate an in between rate for the benefit of other users and they refused.

Senator Tim Mathern said that the Senate received a fair amount of testimony about the benefit to the state generally when people receive these vaccines. He thought the data around the country shows, to the degree that this is not universal, there is a drop off in the number of persons who take the vaccine. From that drop off there are some people who actually end up in a situation of needing extensive health care and somebody has to pay for that.

Rep. Weisz talked about the current system. ND is second in the nation in the immunization rate which says a lot for both the health dept. and public health units even with some of the issues they are currently facing. The House didn't see anything in what they did in this bill that would make that go backward. It is still an improvement over the current system particularly for the public health units where they have heard the greatest concern. Now he is hearing concerns with private providers that haven't been heard in the past.

Senator Judy Lee asked what happens with the billing.

Rep. Weisz said it would go back to the way it was. The Department of Health will purchase everything and do it the same way they were doing it prior.

Senator Gerald Uglem thought the only question would be if it will be universal for all or universal for the public health services. Other states are going to fall into line and use the cheaper source which will either force CDC to limit or adjust their contracts. He thought we should take advantage of it while we can for the benefit of all the citizens.

Rep. Devlin said that when there was universal before the data showed we were 25th in the nation in 2007 and 44th in 2008. Now there is no question that we are second in the nation. The House felt their charge was fixing the public health problems with the billing and the inventory. He felt this was the best they could come up with at this time.

Senator Judy Lee asked if there was much discussion in the House committee about the interim study and the consultant's report received during the interim.

Rep. Weisz responded that they did discuss the report but there was not a lot of discussion.

Senator Judy Lee said they would plan on rescheduling and adjourned the meeting.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-13-2011
Job Number 16554

☒ Conference Committee

Committee Clerk Signature Hamilton

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee called the conference committee on SB 2276 back to order. All members were present.

Senator Judy Lee reported that the Senate conferees feel pretty strongly that it isn't just an issue for the public health units. They hoped to find something that was more broad-based.

Rep. Weisz asked the Senate to expand on their perspective of addressing other needs that have been a problem.

Senator Judy Lee said the Senate side felt pretty strongly on what the definition of universal was. It would have an impact on providing vaccines in a streamlined fashion for the entire state. The federal ruling said it was possible to do that. The thought was to return to the system they had before 2008 which they thought worked pretty well and to get rid of the billing system that isn't working.
It is a concern that we not cause some shifting to take place from one provider to a public health unit for some of this and the idea of consistency and making sure these children have their vaccines in particular. It's not right to stick it all to the insurance companies. That raises the price of health care for everybody.
She said that if we can't provide some benefit to others beyond those served by the public health units we are missing out on trying to have an impact on vaccines all through the spectrum.

Senator Tim Mathern supported what Sen. J. Lee said. He also pointed out hearing concerns about the business community that is developing vaccines and in need of being properly reimbursed. They did more specifically look at this moving ahead with the universal concept but making sure they are aware of the other concerns. On page 4, line 24-25, the Senate had added the language of making sure that somebody involved in research would be involved in the nine member board so there would be input from the industry.

Rep. Weisz pointed out that the House didn't hear any issues presented from the private providers and wondered if the Senate had. Everything the House heard dealt with the issues of billing and the public health units.

Senator Judy Lee didn't recall any testimony but had conversations in the hall with individuals who are involved with health care organizations. She felt it was important to keep in mind that there was a thorough study paid for which the interim committee was very enthusiastic.

Rep. Devlin said that all of the conversations he had with the people in the public health arenas was the public health problems of billing and inventory. That is really what the House went in to fix. When he looked at the ratings of those that have universal immunizations none were in the top five. He didn't think the House has interest in going further than what they did.

Senator Judy Lee pointed out that the data from 44 to 2 isn't valid because a lot of it is because of how the records are kept. ND had good coverage then and has good coverage now and they are not looking to do something to damage it. That is not a good reason to not go universal. It is important to note that when the health dept. did approach the manufacturers about some kind of negotiated rate between the federal and the private rate the manufacturers refused to do it.

Senator Gerald Uglem didn't feel they shouldn't try to improve further just because they are at second. He felt it would only make it better by going universal and didn't see where it would hurt the industry – they want to promote the industry. The industry can negotiate with the federal government to assure their profit on the federal rate.

Rep. Devlin thought there was a difference between the industry and the small bio tech companies that are just getting a footing in states like ND. There is a fear that they will be destroyed. They had testimony from those bio tech industries that felt, if we go this way, it will destroy the private market and those employment opportunities and those research opportunities.

Senator Tim Mathern said that those industries are at the table with the Senate version of the bill. ND is being very supportive of those industries and to the extent that states promote this concept of universal immunization it will benefit those bio tech companies.

Rep. Weisz said the House perspective was to take a small step of doing public health units. The idea of the study was to look at it to see if the state should go to total universal or even if what they were attempting to do in the amendments by the House were successful.
He said the point of a new study was not to relook at what the comprehensive study did. It would just look at what they did, are there issues, is it working, should we make the final step. It would be more of an evaluation.

The meeting was adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-15-2011
Job Number

☒ Conference Committee

Committee Clerk Signature PAMorrison

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee reopened the conference committee on SB 2276 for discussion. All members were present.

Rep. Weisz said that one of the concerns after they had passed this out of the House did seem to be with the 317 funds. While there might be enough money to cover what they did in their amendments there does seem to be a strong feeling that that money will either be cut back sharply or going away completely. Then there would only be the VFC. If that would happen, it would be a cost to the state under the current version. If they work with that version they should look at doing an assessment like they do on CHAND.

Senator Judy Lee asked if he would be looking at the assessment being in parallel with the 317 or only kicking in after the 317 vaccine runs out.

Rep. Weisz responded that if they go that route they would probably just separate the 317 back out the way they are. Then they wouldn't be used to cover any of the private pay in the public health unit at all. It would be an assessment for all the private pay.

Senator Gerald Uglem asked if that would bring back the problem with the billing.

Rep. Weisz – No, because the health dept. would be purchasing them all off the federal contract rates. In the end they would be short a certain amount of dollars and that would just end up being assessed back for that amount. There would be no separation of inventory or billing. It would work the same as it did prior.

Senator Judy Lee asked if they would be looking at full retail for everybody who either pays out of their own pocket or who goes to a health care facility for vaccines.

Rep. Weisz – No, everything that would go to a public health unit, private pay, or VFC would be purchased under the federal contract rate. If they went to a private provider that

physician or clinic would have purchased them off whatever group or private rate they had access to.

Senator Judy Lee asked if he saw that as providing challenges in cost shifting and breaking up the connection between the health care provider and the patient – the medical home kind of set up.

Rep Weisz replied that from the public health unit standpoint either version should encourage those who quit doing it to come back in. It has been kind of on-going that the private pay in the small communities don't do enough so are starting to shift to public health units. From a client standpoint it shouldn't make a difference where they go.

Senator Judy Lee said that part of her concern is the cost that comes from those patients who are going to private providers. They not only can charge for the vaccine but they can put a fee on top of that in addition to the administrative fee.
One of the benefits of providing the vaccines through the state is that nobody is going to have to pay for the vaccine itself at anything other than a negotiated rate.

The meeting was adjourned and will be rescheduled.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-18-2011
Job Number 16733

☒ Conference Committee

Committee Clerk Signature Pamorrison

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee called the conference committee on SB 2276 to order.
All members were present.

Senator Judy Lee reported that she had no amendments or proposals. She did have a thought about a group purchasing pool for vaccines that she shared for discussion. She asked if there was any interest in pursuing that kind of alternative.

Rep. Weisz asked her to clarify how she would look at implementing it.

Senator Judy Lee said she was open to suggestions but just as an example she said maybe they would have 40% of the vaccines purchased off the federal rate. That could include the VFC. That would have to be worked out not only for all the conferees but, if there is interest, they would need some idea from the Health Department on how something like that could work.
She asked Molly Sander from the Health Department if she had any input on that concept.

Molly Sander (Department of Health) said it could work. She explained how the program could work.

Senator Judy Lee asked if that could mean that nobody would have to divvy up and inventory separately in their facilities.

Ms. Sander said that was correct.

Senator Tim Mathern asked where they would purchase the private and how it would be charged out to the users of vaccines.

Ms. Sander said they wouldn't even know how much it costs. They would just order all their vaccine from the state. In the background which they wouldn't see, it would be percentaged out VFC verses non VFC. The state on a quarterly basis would just replenish

that virtual inventory at CDC. They could purchase off any contract directly from the manufacturers or a different distributor and those doses would be sent to CDC to replace what was used.

Senator Tim Mathern – Essentially the state of ND would make up the difference between the two costs but everyone who was a user would be paying the same.

Ms. Sander – The insurance assessment would be the funds she would use to purchase the vaccine so it would be at CDC when the providers order all their vaccine.

Senator Judy Lee asked how the 317 fits in.

Ms. Sander replied that the 317 can fit in however they see fit at the state discretionary fund. They could use a portion of it for this. She didn't want to rely on it because it probably would be going away or slowly decreasing.

Rep. Weisz asked if she would be purchasing 100% off federal contract rate.

Ms. Sander replied that she wouldn't necessarily be purchasing anything. The provider would order and 33% would be VFC and the rest would be state. She could replenish all of that at whichever contract price they decided or whatever percentage they wanted to be at private verses federal.

Senator Judy Lee was trying to determine if there could be some kind of balance that would consider the private as well as the federal rate.

Rep. Weisz wanted to know if, initially, she was purchasing off the private or if it all was coming off the inventory and replacing it.

Ms. Sander said it was all replenishment.
That is how they are able to not have an issue with the inventory separation.

Senator Gerald Uglem asked what the percentage is right now with the system being used.

Ms. Sander – 33% would be the federal rate and a small percentage, which would be 317, would also be at the federal rate.

Senator Judy Lee – Then it would be kind of proportional to what is going on today.

Senator Tim Mathern asked what the fiscal note would be to the Senate version of the bill going to a version of 40/60 federal to private.

Ms. Sander said if they do the insurance assessment there would not be a fiscal note with the bill. Everything would be purchased using the insurance assessment.

The meeting was adjourned and will be scheduled.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-19-2011
Job Number 16775

☒ Conference Committee

Committee Clerk Signature JAMoxson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened the conference committee meeting on SB 2276.
All members were present.

Senator Judy Lee asked the Department of Health to present the information that had been requested of them.

Molly Sander (Department of Health) explained the possible amendments drafted at 40% purchased off the federal contract for insured children. That percentage could change as the committee saw fit. Attachment #1
Information on costs and savings depending on how much vaccine was purchased off the federal contract is outlined on the tables in Attachment #2.

Senator Tim Mathern asked for clarification on the annual costs savings in the 3rd column of the first sheet. Who saves that money?

Ms. Sander said that in theory it should be people of the state. Insurance companies would be charged a lower amount for the vaccines through the assessment. The hope would be that that would be passed on to their clients.

Senator Judy Lee asked if the anticipated number for the pool of 6.9 million is what has been anticipated before.

Rod St. Aubin said that assuming the savings would be on the federal pricing they assume that is correct.

Discussion continued on the savings shown on the charts.

It was clarified that they were working off the .03000 version of the bill – as the bill left the Senate.

Rep. Weisz said it was an interesting concept and appeared that technically it could work.

Senator Judy Lee thought there was enough data for them to want some time to look it over and see if it had merit. There are a couple of different possibilities – the MMCAP and some kind of blend of federal, contract, and private rate for a purchasing group. One way to look at it is if the structure has any merit.

Discussion followed on other technical things such as board and director that may be needed.

Senator Gerald Uglem asked if the 317 funds are used to buy on the federal contract or the private rate.

Ms. Sander replied that this would just be for insured children so the VFC is separate and not included in these percentages. The 317 would be in addition to this if they used it for insured children.
The charts are only for private insured now and for the assessment.

The meeting was adjourned and will be rescheduled.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-21-2011
Job Number 16832

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee opened the conference committee meeting on SB 2276. All members were present.

Rep. Weisz – In the spirit of compromise between what the Senate sent out and where the House was to talk about at least purchasing everything through the Health Dept. and having a discussion on how much of that should be federal contract and how much should be private. He had the dept. put together data and numbers for him and he asked Molly Sander to present those for the committee.

Molly Sander (Department of Health) There is a state immunization registry that all of the providers enter the doses into. In 2010 the total doses administered minus H1N1 vaccine was 341,254 doses to children. Of those doses 9.22% were administered to insured children at local public health units. If that 9.22% was purchased from the federal contract, the annual cost savings would be a little over $863,000 per year. The remainder would be at a different contract rate.

Senator Judy Lee asked if she would then have the ability to determine where the most favorable rate might be in these other areas.

Ms.Sander said that would be correct.

Rep. Holman asked how this would solve the administrative problem that we now have.

Ms. Sander said a provider would order all their vaccine through the state health dept. so the provider wouldn't even see how it was working. They would just order all their doses and not have to keep separate inventories for VFC and private.

Rep. Weisz said concerns have been raised having to do with the ordering process. If they have to go through the health dept. they won't be able to order as often and they would have to maintain more inventory. He asked Ms. Sander to address the ordering issue.

Ms. Sander answered that the CDC requires that providers order a maximum of once per month and allow them to have a maximum of three months of inventory.

Rep. Weisz – if the health dept. is going to handle all the vaccinations those rules would realistically apply to all even though some will be private pay.

Ms. Sander said that was correct. She thought the issue is right now, at least in a large health system, that they have a main pharmacy where they probably keep a private inventory of vaccine. Every couple of weeks they can order from that inventory at their pharmacy. At the specific clinic they probably don't keep as much inventory on hand whereas this way the clinic will probably have to have a larger amount of inventory on hand.

Rep. Weisz asked if they can still do it the same way – keep it in one location and farm it out to the clinics as needed.

Ms. Sander said it has to go to the direct clinic. They can transfer amongst each other.

Senator Tim Mathern asked if they went with the Senate version and made these changes in terms of percentages if it would preclude any licensed provider in the state from making a request and getting vaccine from a vendor outside of the system.

After some discussion it was thought that it probably would not preclude them from getting the vaccine. An option is being created for most people but it does not preclude a person from striking out on their own.

Rep. Holman asked Ms. Sander how she would adjust her inventory with the proposed changes.

Ms. Sander responded that behind the scenes CDC works on a replenishment model. She gave an example. When she replenishes she would replenish part off the federal contract at whatever percentage is in the law and the rest off of a different contract on the back end and then have that sent to CDC.

Senator Judy Lee asked how this would affect the local public health units in the interest of streamlining things for everybody.

Ms. Sander replied that the health units along with all providers would not have to have separate inventories of VFC and private vaccine for all their childhood vaccine. As far as the billing issue goes there would still be an administration fee so the health units would still have to bill insurance or the patient for the administration fee for the vaccine.

Senator Judy Lee asked **Keith Johnson** (Administrator for Custer Health) to comment. He said that whatever percentage is settled on it is a good bill. He gave an example of what the cost savings would have been for one specific individual.

Senator Judy Lee asked if he could see any unintended consequences affecting the administration or the processing of the program in the local public health units.

Mr. Johnson could only think of positive consequences with this bill.

Rep. Weisz - The health department would be the purchaser, much like the Senate bill, but still requiring them to purchase off the private rate. From the House perspective they would want the numbers to match what they sent over as far as federal contract versus private. The House would want to look at the 9.22% range of the total dosages across the state. If there weren't all of the federal programs that are intertwined they probably wouldn't be dealing with immunizations through the health department.
Immunizations are mandated – none of the market is a free market. Now they have to make sure kids are immunized in the most efficient and cost effective way possible.

Senator Judy Lee said the group purchasing is a good change to consider even though they have differences in percentages etc. If they can consider putting it in place, having data to look at in two years, changes can be in two years if needed. It is important to keep in mind the end goal which is maintaining the excellent rate of immunizations and not creating barriers for families who have high deductibles.

Amendments will be drawn up.

The meeting was adjourned and will be scheduled to meet again.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-22-2011
Job Number 16852

☒ Conference Committee

Committee Clerk Signature PAMotsor

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments.

Senator Judy Lee reconvened the conference committee on SB 2276.
All members were present.

Rep. Weisz explained amendment .03003 and the committee reviewed it. Attachment #3

Senator Judy Lee asked how the amendments would affect the stakeholders – public health units, Department of Health, and BC/BS.

Keith Johnson said that as far as he could tell these amendments did what was talked about at the end of the previous session. He thought they addressed many of their concerns and thought they were a good compromise. He didn't see any unforeseen consequences as a result of the language.

Senator Tim Mathern wondered if Section 4 was too restrictive.

Mr. Johnson responded that there will be a couple of issues. One will be getting rid of the current inventory. There has to be a starting date and since CDC distributes vaccine on a replacement basis it would make sense to have the present inventory gone by the time they start replacing. Oct. 1 seems reasonable.

Senator Judy Lee felt pain with the 9.5% instead of 10% and asked Molly Sander how she perceived it.

Molly Sander restated that the cost saving from what she had reported the day before on the 9.22%. The 9.5% would be a little more. She was a little concerned whether or not the manufacturers would honor the MMCAP rate when she goes to order vaccine. If they don't she will have to purchase at the private rate.
The date works well because the CDC fiscal year for the vaccine contract year runs Oct. through Sept.

She asked for clarification on Part B where it refers to Section 317 and asked if the intent was that the 317 all be used for pediatric.

Senator Judy Lee said it was her recollection that they wanted to have some flexibility there.

Rep. Weisz said they hadn't had discussion on that. The language was just to make sure the 317 didn't come under the 9.5% total.

Senator Judy Lee said they could clarify that with language then.

Ms. Sander asked if there was still a board.

Rep. Weisz responded no. The Director would determine the assessment.

Ms. Sander asked if the assessment was still in the bill somewhere.

Ms. Sander pointed out that if this is passed then the fiscal note or the spending authority in 1004 would have to be increased.

Senator Tim Mathern asked about the savings without this 9.5% amendment.

Ms. Sander replied that in the Senate version the savings would be about $2.8 million. The difference between this and the Senate version is the percent purchased off the federal contract. The Senate version 100% of the vaccines would be purchased off the federal contract at the lower rate which would make the savings approximately $2.8 million. The suggested amendments with her calculation of 9.2% purchased off the federal contract and the remainder off MMCAP – the savings would be $863 thousand. If the pharmaceutical companies don't honor the MMCAP rate, the savings would be $391 thousand a year.

Senator Tim Mathern sees this like a hog house amendment. He asked if she had a need or a concern about the Board.

Ms. Sander said it was more that the insurers wanted a board to determine how the assessments would be done.

Rod St. Aubyn said there are a lot of questions based on what the purchases are going to be in terms of if there are going to be savings. The big unknown is the assessment. Another issue is the extra territorial issue – a legal question on whether you can really collect.
If they don't get the savings from MMCAP it could end up costing the state instead of savings to the residents.

Mike Mullen (Attorney General's Office) suggested that in Subsection B3 it say "health" insurers to clarify it.

Attachment #4 – Another proposed amendment was reviewed by Laura Olson (Department of Health)

Differences in the two amendments were discussed – the board language, how the assessment would be done, definitions etc.

Rep. Weisz explained from the House perspective the reason they took out the board. The Advisory Committee is still in effect. From a cost/simplicity standpoint, determining the assessment didn't seem to be that complicated so they thought it made more sense that the department would calculate the assessment based on the premiums paid to determine the percentage to the market they have.

Senator Judy Lee wondered how the process would work. She was reluctant to have this go through rule because of the time frame.

Rep. Weisz said they basically know what the assessment is going to be up front based on the numbers within a small variance. The thought in the House was that it will be self regulating. It there appears to be unresolved issues that come up it can be looked at again next session.

Discussion on the uncertainty of whether the manufacturers will honor the MMCAP.

Rep. Weisz clarified what he meant when he said they know what the assessment is. He said they know the range they are dealing with – it is easy to determine what the assessment will be. There could be substantial differences whether it is purchased on MMCAP or retail rate.

Senator Judy Lee thought there was merit to see if they could merge some of the things from each amendment.

Rep. Devlin said the House was clear about not going above the percentage it is now which is 9.22% so they just set it for 9.5%. No one jumped on board at 10%.

The committee recessed so the chairmen could talk to Legislation Council about merging the amendments.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-25-2011
Job Number 16862

☒ Conference Committee

Committee Clerk Signature TMonson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee reconvened the conference committee meeting on SB 2276.
All members were present.

Senator Judy Lee presented amendment .03004 and reviewed it with the committee.
Attachment #5

Senator Tim Mathern asked if they had addressed the issue of adult vaccines and wondered if there should be an appropriation.

Senator Judy Lee explained that the assessment is what will pay for it. She asked a representative from the Department of Health to address his questions.

Laura Olson (Department of Health) said they would have a fiscal note with this for spending authority only. The first biennium would be $22.9 million to purchase the vaccines from that fund based on the assessment. It's only the authority to spend what they collect in assessments for purchase of vaccines. The second biennium 2013-2015 would be $25.3 million. The second through the fourth years include the 5% inflator on the price of vaccine.

Senator Tim Mathern asked if there needs to be wording to authorize the expenditure of these funds.

Ms.Olson replied that it is the authority only that would be required to expend the funds for purchase of vaccine. The 317 and VFC is not part of that spending authority.
No further wording is needed in this bill.

Molly Sander (Department of Health) reported that she had talked to Legislative Council about the issue with 317 and still being able to use it for adults with no insurance. They didn't see that this prevented them from doing so. She did not see it as an issue.

Rep. Devlin asked why they needed the exemption from the administrative rules process with the emergency rule making process they have now.

Pam Crawford (Attorney General's Office) answered that the health dept. is already subject to administrative rule making and it is felt that the purpose of the rules would probably be to address the assessment issue and any of the concerns and appeals the providers may have. Initially, if there is a process for the providers to give input into the assessments it would not be necessary to have lengthy administrative rules to administer the program.

Discussion continued on whether the section was really needed and that it could be removed. **Rep. Devlin** stated that he is never comfortable with exempting anybody from the administrative rules process. He asked for some time to confer with John Walstad from Legislative Council concerning the exemption.

Laura Olson (Department of Health) presented amendments and explained them. Attachment #6

There was discussion on the rule making process. **John Walstad** (Legislative Council) explained the emergency rule making process.

Rep. Weisz moved to eliminate 6 on page 5 of the amendment, leave the study in, and add the language on pg. 4 subsection 2 from Laura Olson (Department of Health) and the change from "will" to "shall".

Seconded by **Rep. Holman.**

Roll call vote 6-0-0 – **Amendment adopted**.

Senator Judy Lee asked for input from the public health units about any challenges they might see.

Lisa Clute told the committee that this would work better because it will get rid of the vaccine pots they currently have. The current process is very costly.

Molly Sander (Department of Health) didn't see any other issues.

Rep. Devlin asked if any other state does this.

Ms. Sander replied that there are about seven other states that are purchasing all off the federal contract. This is some off the federal contract and some not. They are doing the insurance assessment and providing everything. There are also other states that are also universal but they have state funding to purchase vaccines off the federal contract.

Rod St. Aubyn (BC/BS of ND) stated that one of the issues talked about was for the self funded plans and the 3rd party administrator. Originally the amendment talked about premiums. He thought the Department of Health amendments that were adopted addressed that. There are still some issues with the 3rd party administrators or self funded. There is a real question whether they have to comply with this.

In respect to the study, he suggested that in this particular case it might not be a bad idea to still have a study to monitor how this is going during the interim since it is a new process.

Discussion followed on reporting or monitoring. No changes were made to the wording.

Senator Tim Mathern thought a good job had been done on this bill except he felt the 10% wasn't a true compromise. .

Rep. Weisz moved that the **House Recede from its amendments and amend with .03004 with changes adopted earlier**

Seconded by **Senator Gerald Uglem.**

Rep. Holman said he would support this because of the administrative change. He wasn't entirely excited about this but is excited about the potential of what they are starting.

Senator Tim Mathern thought a compromise between 0 and 100 would be closer to 50. He was resisting the conference committee report.

Rep. Weisz pointed out that this does move from the House version where they only looked at public health units and now they are looking at taking in the whole picture. There is also some resistance to doing that. While the percentage did not move to 50/50 the process moved from part to 100 of everybody being involved.

Senator Judy Lee said she appreciated the fact they were able to work together to try to come up with a different way of doing it that may have some acceptance.

Roll call vote 4-2-0 – **Motion carried.**

Carriers – **Senator Judy Lee** and **Rep. Weisz**.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2276
4-27-2011
Job Number 16915

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to creating a state vaccine fund and a ND vaccine group purchasing board.

Minutes: Attachment

Senator Judy Lee opened the conference committee on SB 2276. SB 2276 was returned to committee because the House rejected the Conference Committee Report.
Attendance: Senator Judy Lee, Senator Gerald Uglem, Senator Tim Mathern, Rep. Robin Weisz, Rep. Jim Schmidt (replacing Rep. Bill Devlin), and Rep. Richard Holman.

Senator Judy Lee asked Rep. Weisz to explain the proposed amendments which were presented to the committee in e-mail form. Attachment #7

Rep. Weisz explained that the amendment was basically identical to the House version except for the crossed out portion and with one addition. They added an appropriation of $1.5 million to ensure funding for what was passed out of the House – to take care of the Public Health Units vaccination program. There will be enough money to fund it between VFC, 317, and the $1.5 million. If they are still short, they have the ability to go to the emergency commission and ask for additional funding to finish out the biennium.

Senator Tim Mathern wondered why the emergency commission was in the bill. It's available to any state entity. It has no consequence whether it is in the bill or not.

Rep. Weisz agreed but at the same time thought the language may be important from the standpoint of making it clear that if they run out of money that doesn't mean they have to stop the program. The intent is that, if needed, they can go to the emergency commission.

Senator Tim Mathern wanted the finances of the entire change of this proposal from the Senate proposal clarified.

Molly Sander (Department of Health) Currently 317 vaccine can be used at the state's discretion. Some of it goes to insured kids already. She estimated that a little less than 500,000 go to adults who don't have insurance or whose insurance doesn't cover immunizations. Also needed to be taken into consideration last biennium there was $1.2 million appropriated to cover losses at the local public health units for their billing system.

Senator Tim Mathern asked if the $1.5 million is still needed to keep them whole or purchase enough for the public health unit.

Ms.Sander responded that the $1.5 million in this amendment would be to purchase vaccines for insured children at the local public health units off the federal contract.

Discussion continued on the savings and expenditures.

Senator Tim Mathern compared this to the water bill they just passed in the Senate and said it was the same thing. They are trying to do a public project that benefits a whole group of citizens and also takes in the effect of the benefits to the private.
Approaching it from the perspective of all working together it kind of saves the system over $7 million. What would be the rationale for not doing it?

Rep. Weisz said the committee did send out a compromise which he supported. He recognized that compromise wasn't near where the Senate wanted to be but the House didn't support it. For good or bad that is where they are at and he is hoping to salvage something for the public health units.
Does this bill have potential problems and issues? Yes, and they will find that out over the next 18 months. Based on where the previous compromise was rejected he didn't have a lot of other ideas and options. This, at least, does address the public health unit issue and if other problems crop up they will have to address them next session.

Senator Judy Lee showed appreciation for Rep. Weisz and other conferees in trying to figure out where to go with this.

Rep. Weisz made a motion that the House recede from its amendments on SB 2276 and amend with the .03007 amendments.

Seconded by **Rep. Schmidt**.

Senator Tim Mathern wondered what the administrative fee would cost.

Rep. Weisz answered that he thought a VFC was $13.90 and a non VFC $21.00 that they can charge but it doesn't mean they have to. They do have the ability and on VFC they can ask for it but they can't require it.

Senator Tim Mathern also voiced his appreciation for the work of the conference committee.
He thought they were losing a wonderful opportunity of instituting a program where they work together in the private and public sectors in the interest of the citizens. He didn't think there are sufficient numbers of citizens in the state to have an efficient and cost effective system to go it alone.
He said he was going to vote against the conference committee motion and would ask the Senate to reject the conference committee report and ask the House members to move further on a wonderful project.

Roll call vote 5-1-0. **Motion carried**.

Carriers: **Senator Judy Lee** and **Rep. Robin Weisz**

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Human Services

Bill/Resolution No. 2276 as (re) engrossed

Date: 4-11 to 4-15

Roll Call Vote #: _____

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) _____

- ☐ 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

Motion Made by: _____ Seconded by: _____

Senators	4-11	4-13	4-15	Yes	No	Representatives	4-11	4-13	4-15	Yes	No
Sen. Judy Lee	✓	✓	✓			Rep. Weisz	✓	✓	✓		
Sen. Uglem	✓	✓	✓			Rep. Devlin	✓	✓	✓		
Sen. Mathern	✓	✓	✓			Rep. Holman	✓	✓	✓		

Vote Count: Yes _____ No _____ Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Human Services

Bill/Resolution No. SB 2276 as (re) engrossed

Date: 4-18 to 4-21

Roll Call Vote #: _____

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) _____ -- _____

☐ 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

Motion Made by: _____ Seconded by: _____

Senators	4-18	4-19	4-21	Yes	No	Representatives	4-18	4-19	4-21	Yes	No
Sen. Judy Lee	✓	✓	✓			Rep. Weisz	✓	✓	✓		
Sen. Uglem	✓	✓	✓			Rep. Devlin	✓	✓	✓		
Sen. Mathern	✓	✓	✓			Rep. Holman	✓	✓	✓		

Vote Count: Yes _____ No _____ Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Adopted by the Conference Committee

April 25, 2011

4-25-11
615

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new chapter to title 23 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; to provide for a legislative management study; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of

immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new chapter to title 23 of the North Dakota Century Code is created and enacted as follows:

Definitions.

As used in this chapter:

1. "Department" means the state department of health.

2. "Health insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

   a. Health insurance coverage does not include any one or more of the following:

      (1) Coverage only for accident or disability income insurance, or any combination of the two;

      (2) Coverage issued as a supplement to liability insurance;

      (3) Liability insurance, including general liability insurance and automobile liability insurance;

      (4) Workers' compensation coverage or insurance;

      (5) Automobile medical payment insurance;

      (6) Credit-only insurance;

      (7) Coverage for onsite medical clinics; and

      (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

   b. Health insurance coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

      (1) Limited scope dental or vision benefits;

      (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

      (3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan.

3. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, and health maintenance organization and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

4. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

5. "Program-eligible child" means any child who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

6. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee.

7. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

8. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396S].

Immunization program - Provider choice.

As part of the North Dakota immunization program the department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered

through the state using federal or state funds may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This section does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

Immunization program - Vaccine ordering program - Funding - Limitations.

1. As part of the North Dakota immunization program the department shall establish a program through which the department orders vaccines through the federal government.

   a. The department shall supply all providers with the ordered vaccines. A provider that receives vaccines under this vaccine ordering program shall administer the vaccines to program-eligible children.

   b. A provider that receives vaccines under this vaccine ordering program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

2. The department shall fund this vaccine ordering program first through participation in the vaccines for children program and the federal section 317 immunization grant program and then through assessments collected from insurers and third-party administrators. The department shall identify methodology and procedures for determining assessments that are fair and equitable for insurers and third-party administrators, including a third-party administrator for a self-insurance plan. The department may assess a subgroup of insurers and third-party administrators based on immunization volume or other factors as approved by the department. The department shall provide for any additional matters necessary for the implementation and administration of the fund.

3. In addition to the vaccines supplied to providers under the vaccines for children program and the federal section 317 immunization grant program under the federal vaccine purchasing contract, no more than ten percent of the remaining vaccines the department supplies under this section may be purchased under the federal vaccine purchasing contract.

Vaccine ordering program - Assessment.

1. An insurer or third-party administrator shall pay the insurer's or third-party administrator's annual assessment on the dates specified by the department. The department shall establish payment dates that are at least quarterly but which may be more frequent.

2. Within sixty days of the department sending the notice of assessment to the insurer or third-party administrator, that insurer or third-party administrator shall pay the department the assessment.

3. For late or nonpayment of an assessment by an insurer or third-party administrator, the department shall impose interest at the rate of one percent of the unpaid assessment due for each month or fraction of a month during which the assessment remains unpaid, computed from the due date of the assessment to the date paid, excepting the month in which

the assessment was required to be paid or the assessment became due. If an insurer's or third-party administrator's assessment remains partly or fully unpaid for more than ninety days from the due date, the department may impose a penalty not to exceed two times the amount of the unpaid assessment. In addition, the department may refer the insurer or third-party administrator to the insurance commissioner who may use any sanctions available to penalize for nonpayment of the assessment.

4. For good cause, an insurer or third-party administrator may request that the department grant a deferment from all or part of an assessment. The department may defer all or part of the assessment if the department determines the payment of the assessment would place the insurer or third-party administrator in a financially impaired condition, as provided under title 26.1. If all or part of an assessment against an insurer or third-party administrator is deferred, the amount deferred may be assessed against the other insurers and third-party administrators in a manner consistent with the basis for assessment provided under this section. The insurer or third-party administrator receiving the deferment remains liable to the North Dakota vaccine fund for the amount deferred and may be referred to the insurance commissioner who may use any sanctions available.

5. The department shall use all funds received through these assessments for the purposes expressly authorized by this chapter. The department may not use these assessment funds for any purpose that is not expressly authorized under this chapter.

North Dakota vaccine fund.

There is created in the state treasury the North Dakota vaccine fund. Moneys in the North Dakota vaccine fund must be appropriated by the legislative assembly solely for purposes established by this chapter. All interest and earnings of the North Dakota vaccine fund must be retained in the fund. Any entity subject to this assessment is not entitled to a credit for this assessment against tax due under section 26.1-03-17. Administrative costs associated with establishing and operating the North Dakota vaccine fund must be paid out of the fund.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-12 interim, the legislative management shall consider studying the North Dakota immunization program. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective October 1, 2011."

Renumber accordingly

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Human Services

Bill/Resolution No. SB 2276 as (re) engrossed

Date: 4-25-2011

Roll Call Vote #: _____

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☒ HOUSE recede from House amendments and amend as follows

~~Senate~~/House Amendments on (SJ)/HJ page(s) 1022 - 1024

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) SB 2276 was placed on the Seventh order of business on the calendar

Motion Made by: Rep. Weisz Seconded by: Sen. Uglem

Senators	4-22	4-25		Yes	No		Representatives	4-22	4-25		Yes	No
Sen. Judy Lee	✓	✓		✓			Rep. Weisz	✓	✓		✓	
Sen. Uglem	✓	✓		✓			Rep. Devlin	✓	✓		✓	✓
Sen. Mathern	✓	✓		✓			Rep. Holman	✓	✓		✓	

Vote Count: Yes 4 No 2 Absent 0

Senate Carrier Sen. J. Lee House Carrier Rep. Weisz

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

11.0713.03007
Title.07000

Prepared by the Legislative Council staff for
Representative Weisz
April 27, 2011

4-27-11
1 of 3

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of

immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Immunization program - Provider choice - Purchasing.

1. As used in this section:

   a. "Department" means the state department of health.

   b. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

   c. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

   d. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state.

   e. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

   f. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

   a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

   b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

      (1) The department shall supply public health units with the purchased vaccines. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(2) A public health unit that receives vaccines under this purchasing program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this purchasing program through participation in the vaccines for children program, the federal section 317 vaccine program, and state funds appropriated for this purpose. If it appears there will be inadequate funds to fund this purchasing program, the department shall petition the emergency commission for a transfer from the state contingency fund. The emergency commission may grant the transfer request, or so much thereof as may be necessary, to fund this purchasing program.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,500,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the program through which the department purchases vaccines through the federal vaccine purchasing contract, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Human Services

Bill/Resolution No. SB 2276 as (re) engrossed

Date: 4-27-2011

Roll Call Vote #: 1

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☒ HOUSE recede from House amendments and amend as follows

~~Senate~~/House Amendments on (SJ)/HJ page(s) 1022 - 1024

☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) SB 2276 was placed on the Seventh order of business on the calendar

Motion Made by: Rep. Weisz Seconded by: Rep. Schmidt

Senators	4.27			Yes	No	Representatives	4.27			Yes	No
Sen. Judy Lee	✓			✓		Rep. Weisz	✓			✓	
Sen. Uglem	✓			✓		~~Rep. Devlin~~					
Sen. Mathern	✓				✓	Rep. Holman	✓			✓	
						Rep. Schmidt	✓			✓	

Vote Count: Yes 5 No 1 Absent 0

Senate Carrier Sen. J Lee House Carrier Rep. Weisz

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

SB 2276, as reengrossed: Your conference committee (Sens. J. Lee, Uglem, Mathern and Reps. Weisz, Devlin, Holman) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1022-1024, adopt amendments as follows, and place SB 2276 on the Seventh order:

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new chapter to title 23 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; to provide for a legislative management study; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new chapter to title 23 of the North Dakota Century Code is created and enacted as follows:

Definitions.

As used in this chapter:

1. "Department" means the state department of health.

2. "Health insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

   a. Health insurance coverage does not include any one or more of the following:

      (1) Coverage only for accident or disability income insurance, or any combination of the two;

      (2) Coverage issued as a supplement to liability insurance;

      (3) Liability insurance, including general liability insurance and automobile liability insurance;

      (4) Workers' compensation coverage or insurance;

      (5) Automobile medical payment insurance;

      (6) Credit-only insurance;

      (7) Coverage for onsite medical clinics; and

      (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

   b. Health insurance coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

      (1) Limited scope dental or vision benefits;

      (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

      (3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

   c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

      (1) Coverage only for specified disease or illness; and

      (2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan.

3. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, and health maintenance organization and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

4. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

5. "Program-eligible child" means any child who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

6. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee.

7. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

8. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396S].

Immunization program - Provider choice.

As part of the North Dakota immunization program the department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This section does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

Immunization program - Vaccine ordering program - Funding - Limitations.

1. As part of the North Dakota immunization program the department shall establish a program through which the department orders vaccines through the federal government.

a. The department shall supply all providers with the ordered vaccines. A provider that receives vaccines under this vaccine ordering program shall administer the vaccines to program-eligible children.

b. A provider that receives vaccines under this vaccine ordering program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

2. The department shall fund this vaccine ordering program first through participation in the vaccines for children program and the federal section 317 immunization grant program and then through assessments collected from insurers and third-party administrators. The department shall identify methodology and procedures for determining assessments that are fair and equitable for insurers and third-party administrators, including a third-party administrator for a self-insurance plan. The department may assess a subgroup of insurers and third-party administrators based on immunization volume or other factors as approved by the department. The department shall provide for any additional matters necessary for the implementation and administration of the fund.

3. In addition to the vaccines supplied to providers under the vaccines for children program and the federal section 317 immunization grant program under the federal vaccine purchasing contract, no more than ten percent of the remaining vaccines the department supplies under this section may be purchased under the federal vaccine purchasing contract.

Vaccine ordering program - Assessment.

1. An insurer or third-party administrator shall pay the insurer's or third-party administrator's annual assessment on the dates specified by the department. The department shall establish payment dates that are at least quarterly but which may be more frequent.

2. Within sixty days of the department sending the notice of assessment to the insurer or third-party administrator, that insurer or third-party administrator shall pay the department the assessment.

3. For late or nonpayment of an assessment by an insurer or third-party administrator, the department shall impose interest at the rate of one percent of the unpaid assessment due for each month or fraction of a month during which the assessment remains unpaid, computed from the due date of the assessment to the date paid, excepting the month in which the assessment was required to be paid or the assessment became due. If an insurer's or third-party administrator's assessment remains partly or fully unpaid for more than ninety days from the due date, the department may impose a penalty not to exceed two times the amount of the unpaid assessment. In addition, the department may refer the insurer or third-party administrator to the insurance commissioner who may use any sanctions available to penalize for nonpayment of the assessment.

4. For good cause, an insurer or third-party administrator may request that the department grant a deferment from all or part of an assessment. The department may defer all or part of the assessment if the department determines the payment of the assessment would place the insurer or third-party administrator in a financially impaired condition, as provided under title 26.1. If all or part of an assessment against an insurer or third-party administrator is deferred, the amount deferred may be assessed against the other insurers and third-party administrators in a manner consistent with the basis for assessment provided under this section. The insurer or third-party administrator receiving the deferment remains liable to the North Dakota vaccine fund for the amount deferred and may be referred to the insurance commissioner who may use any sanctions available.

5. The department shall use all funds received through these assessments for the purposes expressly authorized by this chapter. The department may not use these assessment funds for any purpose that is not expressly authorized under this chapter.

North Dakota vaccine fund.

There is created in the state treasury the North Dakota vaccine fund. Moneys in the North Dakota vaccine fund must be appropriated by the legislative assembly solely for purposes established by this chapter. All interest and earnings of the North Dakota vaccine fund must be retained in the fund. Any entity subject to this assessment is not entitled to a credit for this assessment against tax due under section 26.1-03-17. Administrative costs associated with establishing and operating the North Dakota vaccine fund must be paid out of the fund.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-12 interim, the legislative management shall consider studying the North Dakota immunization program. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective October 1, 2011."

Renumber accordingly

Reengrossed SB 2276 was placed on the Seventh order of business on the calendar.

REPORT OF CONFERENCE COMMITTEE

SB 2276, as reengrossed: Your conference committee (Sens. J. Lee, Uglem, Mathern and Reps. Weisz, Schmidt, Holman) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1022-1024, adopt amendments as follows, and place SB 2276 on the Seventh order:

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Immunization program - Provider choice - Purchasing.

1. As used in this section:

a. "Department" means the state department of health.

b. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

c. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

d. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state.

e. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

f. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

(1) The department shall supply public health units with the purchased vaccines. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(2) A public health unit that receives vaccines under this purchasing program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this purchasing program through participation in the vaccines for children program, the federal section 317 vaccine program, and state funds appropriated for this purpose. If it appears there will be inadequate funds to fund this purchasing program, the department shall petition the emergency commission for a transfer from the state contingency fund. The emergency commission may grant the transfer request, or so much thereof as may be necessary, to fund this purchasing program.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,500,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the program through which the department purchases vaccines through the federal vaccine purchasing contract, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

Reengrossed SB 2276 was placed on the Seventh order of business on the calendar.

2011 TESTIMONY

SB 2276

#1

Testimony
Senate Bill 2276
Senate Human Services Committee
January 24, 2011; 9 a.m.
North Dakota Department of Health

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Arvy Smith, and I am the deputy state health officer for the North Dakota Department of Health. I am here today to provide background information on immunizations in North Dakota, describe the features of Senate Bill 2276 and provide testimony in support of the bill.

Immunizations in North Dakota

- Immunizations are recommended by the federal ACIP (Advisory Committee on Immunization Practices).
    - Children are currently recommended to be vaccinated against 16 diseases.
- State law requires all ACIP recommended vaccines for school and child-care attendance, except influenza and human papillomavirus (HPV) vaccine.
    - Exemptions:
        - Medical
        - Religious
        - Philosophical
        - Moral
        - History of disease
- The most recent National Immunization Survey (NIS) data for North Dakota is for 2009. The NIS rate shows the percentage of children who are up-to-date with a series of vaccinations at ages 19 to 35 months. North Dakota's most current NIS up-to-date percentage for the series is 77.8 percent (13th in the nation). This is higher than the U.S. rate for the same series at 75.7 percent.
- The following table shows the cost to vaccinate a child through the age of 18. The increases are due to the number of vaccines recommended, combination vaccines and vaccine price increases.

Year	Cost/Child (Federal Rate)	Cost/Child (Private Rate)	Comments
1999	$186		
2004	$476		
2005	$618		
2006	$1,156		4 new vaccines recommended, includes HPV vaccine for females
2009	$1,519	$1,991	New combination vaccines, influenza vaccine recommended for all children
2011	$1,757	$2,332	New combination vaccines, new pneumococcal vaccine, additional dose of meningococcal vaccine

Vaccine Funding

- The North Dakota Department of Health (NDDoH) does not receive federal funding to purchase vaccines; we receive an allocation or allotment of vaccines.
- The Vaccines For Children Program (VFC) is a federal entitlement program that provides all ACIP recommended vaccines for children who are Medicaid-eligible, American Indian, uninsured or underinsured (have insurance, but it does not cover a particular vaccine).
    - 33.33 percent of children ages 18 and younger in North Dakota are VFC-eligible.
    - Providers may not charge patients for the cost of VFC vaccine, but may charge a maximum administration fee of $13.90.
- Insured children receive privately purchased vaccine. Local public health units and private providers bill insurance companies for the cost of the vaccine plus an administration fee. Local public health units have contracted with the University of North Dakota School of Medicine and Health Sciences to perform billing and accounts receivable on their behalf.
- The federal Section 317 Program is a discretionary program available to children and adults. The state can decide which vaccines to offer through this program.
    - The North Dakota Immunization Advisory Committee decides which vaccines to offer through this program.

- Current vaccines offered include hepatitis B birth dose for all newborns, hepatitis A and B vaccine for high-risk adults and various vaccines for uninsured and underinsured adults.
- Providers may not charge patients for the cost of 317 vaccine, but may charge a maximum administration fee of $13.90.
- Section 317 vaccine allocations have decreased each year, due to North Dakota being historically overfunded. In 2004, North Dakota received a Section 317 allocation of $2.1 million per year. -We were informed by the federal government that our Section 317 allocation could be reduced to $300,000 by 2008. Although this significant of a cut did not happen, our 2011 Section 317 vaccine allocation is more than $800,000 less at $1,283,451.

History

In 2004, North Dakota was considered a universal state, which means the Department of Health provided all vaccines for all children, including those with insurance. The federal allotment of VFC and Section 317 vaccines was sufficient to immunize all the children in North Dakota. As new vaccines were recommended by the ACIP, vaccine prices increased and North Dakota's Section 317 vaccine allotment declined, it was becoming difficult to maintain our universal vaccine status.

Part way through 2005, BlueCross BlueShield of North Dakota agreed to provide funding to the NDDoH to purchase vaccines to fill the growing gap. They agreed to do this only for a limited time feeling they, alone, should not bear this cost; it should be shared with other insurers in the state. Other insurers were asked to voluntarily provide funding as well and they did not elect to participate.

North Dakota had to discontinue universal vaccine status starting in 2008 because funding was not available to fill the gap between the federal allotment of vaccines and the need for vaccines. Private health-care providers and local public health units started purchasing private supplies of vaccine to immunize insured children and then billing insurance for the cost of vaccines and administration. The Department of Health continued to supply VFC and Section 317 vaccines.

This change in vaccine supply has been complicated and time consuming for all parties involved. Significant education to providers and the public was conducted. Providers had to learn how to screen for VFC eligibility, order

vaccine, store separate supplies of vaccine, and bill insurance. The public had to be educated about checking insurance coverage for vaccines. Contracts for private vaccine purchases had to be created for private providers and local public health units. A billing system was created for local public health units to bill for immunizations. BlueCross BlueShield of North Dakota established first dollar coverage for recommended childhood immunizations. First dollar coverage means that vaccines are not subject to any deductible or co-pay, that coverage begins with the first dollar billed for vaccines.

In 2009, there was a legislative proposal that the state general fund pay for vaccinations for insured children. The cost to cover this was estimated at $16 million per biennium. This cost would have increased each biennium as vaccine prices increased and new vaccines were recommended by the ACIP. Due to the high cost and concerns about the sustainability of funding for future increased costs, the bill did not pass.

Independent Quality Improvement Study on Immunization

During the 2009-2010 interim, an immunization study to review the state immunization program was completed as required by Senate Bill 2004. A main focus of the study was to improve administrative performance, including the procurement and management of vaccines. The study, which was conducted by a consultant, concluded that the current methods of vaccine procurement and management are time consuming and inefficient mainly due to the federal rules which require separate accounting and storage of vaccine inventories for each source of vaccine (such as VFC). The recommendation stated, "Based on the savings to be realized in terms of cost of vaccine and procurement/management of vaccines for local public health units, we believe a universal vaccine supply policy is best for local public health units and should be pursued if further investigation determines that universal yields a similar impact on private providers and payers."

Senate Bill 2276

Senate Bill 2276 establishes a vaccine group purchasing board, which would be responsible for assessing insurers and third-party administrators for an estimate of the cost of vaccines administered to their covered children. This funding would then be used by the Department of Health to purchase vaccines for insured North Dakota children through the federal contract. These vaccines, along with VFC vaccine, would be supplied to North Dakota providers to be administered to children. Providers would not bill insurers for the cost of the vaccine, but could still bill for the administration fee.

The Department of Health did not attempt this program in the past because previously the federal government would only allow a small number of "grandfathered" states to purchase vaccines from the federal contract with private funds. The federal government has now determined that they cannot prohibit states from doing this. Maine, Idaho, Washington, New Hampshire and Rhode Island all use funds from insurance companies to purchase vaccines from the federal contract.

Benefits

There are three significant benefits of implementing the vaccine group purchasing program included in Senate Bill 2276. The most important benefit is the possibility of increasing vaccination rates. It is much easier to conduct school and other mass vaccination clinics when separate inventories of each vaccine pool do not have to be kept. School and other mass vaccination clinics provide an opportunity to efficiently vaccinate many children, improving vaccination rates in the state.

Another benefit is the ability to reduce health-care costs. Using actual data of vaccines and doses provided to insured children in 2010, we compared the cost at the federal rates to the cost at private rates. The difference was $2,950,277 or 25.8 percent (private $11,424,003 and federal $8,473,726). The actual savings may not reach this amount, however, because local public health units, which administer between 10 and 15 percent of the vaccines, are already purchasing vaccines at a rate below the private rate and many private providers are receiving discounts below the private rate for volume purchasing. On the other hand, some providers are marking up the vaccine, above their cost, and billing insurance for the marked-up amount. This would not be possible if vaccine were provided free. Because of these nuances, we are estimating savings to be from around $2 million to $2.5 million each year. Reducing costs to insurers will reduce the costs they have to pass on to payers.

Thirdly, as we learned from the legislative study and through visits with providers, returning to universal vaccine status will provide administrative efficiencies that could reduce costs to providers. If the NDDoH supplied all vaccines for all children, including those with insurance, providers would no longer have to manage separate inventories of private and public vaccines. This would significantly reduce staff time at provider offices. In addition, providers would no longer have to purchase vaccines privately. All vaccines could be ordered from one source, which also would reduce staff time. Providers would simply administer the vaccines and bill insurance only for the cost to administer

the vaccines. We are unable to estimate the total savings related to administrative efficiencies, but one private provider reported being able to reduce one position in purchasing alone. In addition, the study indicated that eliminating the local public health unit administrative burden associated with maintaining separate inventories and the loss from expired vaccines would result in significant savings.

Fiscal Impact

Since the stakeholders have been considering this type of method for some time, the Department of Health's budget already contains sufficient authority of $19.4 million to purchase the vaccines and provide the administrative support needed. Aside from the program start-up period, minimal staff time will be needed to operate this effectively so there is no additional appropriation needed to implement this bill.

Conclusion

Senate Bill 2276 provides a sustainable mechanism for vaccinating children in North Dakota in the most efficient and cost effective manner. If more vaccines are recommended by the ACIP, the assessment to insurers will increase to cover these vaccines. Under this mechanism, the increases to insurers for the new vaccines will be at the federal contract rate as opposed to the private rate.

Although North Dakota's immunization rates are above the national average, there is room for improvement. And the many complexities for providers are increasing the costs associated with the current system and possibly affecting immunization rates. These complexities and costs can be lowered substantially through this bill to provide a more efficient, cost effective approach to immunizing the greatest number of children possible in North Dakota.

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

#2

Testimony
To the
Senate Human Services Committee
On
SB 2276

Good morning Chairman Lee 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.

First District Health Unit participated in the study conducted on the immunization system. Three independent contractors spent two days at First District with all of my staff involved in the immunization process (nurses, billing staff, inventory managers, receptionists etc). The Contractors also spent several hours after their initial visit gathering information and data. The Study was a very comprehensive review of our delivery system and identified several inefficiencies. For example, First District paid $11,614 to UND to process 5,807 claims which produced $33,120 in gross charges. That results in a 35% cost of billing per claim.

The study provides several recommendations that will improve our current system of delivering vaccines. One recommendation is to transition to a Universal Immunization system. The transition to a Universal Immunization system would address several of the inefficiencies identified in the Study. I have attached a comparative analysis for First District Health Unit between our current immunization system and the proposed universal system. The contractor conducting the study compiled the analysis.

SB2276 also states that all providers of vaccinations are required to enter the necessary data into the ND immunization data system or state supplied vaccine will not be provided. When data is not entered children's complete immunization record cannot be obtained. It is important to have this information entered within four weeks of the administration of vaccine so that second doses can be administered appropriately and children do not receive duplicate vaccinations.

Thank you for your consideration and I would be happy to answer any questions.

ATTACHMENT B

PROtectNDKids Immunization Program
Comparative Analysis
First District Health, Minot

[redacted]

Volume and Billing	2009 Actual # of Claims	2009 Actual Billings $	Universal Vaccine Alternative # of Doses	Admin Fee per Immun.	Universal Vaccine Alternative Billings $
Billed Direct from LPHU - as reported by LPHU					
Medicaid	1011	$ 21,488	1597	$ 13.90	$ 22,204
Private Pay	0	$ -			
Other Payers	0	$ -			
Billed to BCBSND - as reported by LPHU	2657	$ 203,812	4198	$ 21.90	$ 91,938
Sent to UND by BCBSND for Processing - as reported by LPHU					
BCBSND Member Liable	150	$ 10,225	237	$ 21.90	$ 5,190
Private Pay	311	$ 20,181	491	$ 21.90	$ 10,761
Other Payers	0	$ -			
Total	4129	$ 255,706	6524		$ 130,093
Less Write Offs - as reported by LPHU					
Medicaid		$ 3,389			
BCBS/ND		$ 7,362			
		$ 10,751			
Net Billings		$ 244,955			$ 130,093
Revenue Received - as reported by LPHU					
From LPHU Direct Billing					
Medicaid		$ 18,099			
Private Pay		$ -			
Other Payers		$ -			
Fro[redacted]SND Direct		$ 196,448			
Fro[redacted] - (Member Liable/other payers)		$ 21,325	FDHU expects to receive 95% of this revenue		
Total		$ 235,872			$ 123,588
Expenses					
Vaccines					
Private Supply		$ 149,140			$ -
Wasted Vaccine (private vaccine only)		$ 7,750			$ -
317 & VFC					$ -
Sub Total Vaccines		$ 156,890			$ -
Personnel					
Vaccine Procure and Mgmt		$ 23,965			$ 7,870
Data Entry		$ 10,913			$ 8,170 *
Billing / AR Mgmt		$ 31,418			$ 31,418
Sub Total Personnel		$ 66,296			$ 47,458
Billing and A/R Mgmt					
UND Service - **as reported by UND- 5,807 claims**		$ 11,614			
Other Contract Billing Service					
		$ 11,614			$ -
Other Expenses					
		$ -			$ -
[redacted]					
Total LPHU Expenses		**$ 234,800**			**$ 47,458**
Contribution Margin for LPHU		**$ 1,072**			**$ 76,130**

***this only accounts for NDIIS entry - not PHClinic**

#3

Testimony on SB 2276
Senate Human Services Committee
January 24, 2011

Madam Chair and members of the Senate Human Services Committee, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota (BCBSND).

With proposed changes, BCBSND supports this bill. SB 2276 is one of the most important public policy statements that this legislative body will make during this legislative session. Childhood immunizations are so important for the entire health of our State. While our state has successfully maintained a high level of childhood immunizations, this bill will not only create an environment where children's immunizations will be more accessible, but it will save millions of dollars for our citizens. It is expected that our company could save up to $2 million dollars a year for our members if this bill is approved and works as intended.

BCBSND has been an active participant in ND's immunization program and when the Universal Immunization Program was threatened a few years ago, our company "stepped up to the plate" and contributed funding to ensure the continued distribution of state funded vaccines. We have also been an active participant in the Health Department's transition to the current provider choice program. While there have been many "bumps in the road" through this journey, local public health units and BCBSND worked tirelessly to ensure that this program continued the state's high rate of childhood immunizations.

When the State Health Department came to us about this proposal to change to the Universal Vaccine Program, we evaluated all of the pros and cons of different options. We had an internal work group that explored all aspects if this program were to be adopted. While we have some concerns with the current language in the bill, we consider this a "work in progress" and will continue to work with the Health Department in shaping this bill. Our internal work group had conference calls with other states that have adopted programs (Washington and Idaho) similar to this. The differences between these states identified the advantages and disadvantages of each program. Personally, our company would rather the state adopt an actual "claims" process similar to what Washington adopted versus the "assessment" process that Idaho utilizes. However, we were concerned about the added administrative costs associated with the "claims" process which basically ate up much of the anticipated savings. One of our concerns with the assessment process was the effect that this could have on new PPACA requirements for Medical Loss Ratio (MLR) on health insurers. PPACA requires a minimum MLR to limit administrative expenses for health insurers. Our worry was these assessments would have to count as an administrative expense and thus possibly put our company out of compliance with the new Federal law. However, after legal research it is expected that this immunization assessment would not be treated as an administrative expense. It would be helpful to identify this in the new law and that would be included in our proposed amendments that we will offer to the Health Department as we work through this bill.

Our internal work group has identified the following issues that we think should be considered before this bill is acted on by this committee:

- We think the definition of "health insurance coverage" and "insurer" should have its own definition rather than referring to the definitions from CHAND. This reference may have some unintended consequences at a later date.
- We think that the definition of a "third party administrator (TPA)" needs to be added.
- The definition of a "Program-eligible child" needs to make clear that the vaccine must be administered by a ND health care provider within our state. This is very important because of our border cities where ND medical providers may be providing vaccines for out of state children and out of state medical providers may be providing vaccines for ND residents.
- It should be made clear that all ND providers that administer vaccines for program eligible children must utilize the state's vaccine and not be permitted to bill insurers or TPA's for their own acquired vaccines after this program has been implemented.
- We wonder if the "Board" is or should or should not be compliant with any state bidding laws.
- As per discussion with the Health Department, they envision a reconciliation process at the end of each year. This will protect against any double-dipping of an insurer being assessed and yet also billed by a provider. In addition, it will correct any changes within the market that would affect the original assessment estimate. We feel that this is critical to fulfill our fiduciary responsibilities for our plans. This needs to be clearly spelled out in the bill along with the timing of the reconciliation and the entire reconciliation process.
- On page 3, line 31 and page 4, line one, this may be redundant and will probably be covered if the term TPA is defined as earlier suggested.
- On page 6, lines 3-5, we wonder if additional language within the insurance code (NDCC 26.1) needs to be added to give the Insurance Commissioner additional authority and to spell out what options the Insurance Commissioner may have. The same goes with page 6, lines 15 and 16.
- We have some concerns with extraterritorial issues regarding out of state insurers having members within ND.
- On page 6, lines 10 -16, we feel that perhaps the decision if an additional assessment is necessary, the Board should make the decision. What if the potential assessment would be so insignificant it would not be necessary to do the assessment? In addition, if the deferred assessment is collected, it appears that the board would have collected twice - once through the additional assessment and again when the deferment is collected.
- On page 6, lines 21-25, we question if this is necessary since the estimated assessments will be reconciled at the end of the year.
- On page 6, lines 26-30, the language needs to be changed to clarify that this assessment and not the "entity" is not eligible to qualify for the premium tax credit in section 26.1-03-17.
- It is anticipated that programming changes will be necessary to the NDIIS system and some reconciliation programming will be required. BCBSND maintains this system. We would need funding to provide these programming changes and would want some assurance that we would be reimbursed for these programming necessities.

- Make it clear that the state consider the assessment a health care assessment and not an administrative expense for health insurers.
- Spell out that any interest earned within the fund must remain within the fund to help cover administrative expenses of the program.

As I indicated, this bill is truly a "work in progress". Though there may be some obstacles to face and probably many more that no one has contemplated yet, we urge that you adopt amendments to improve this bill and then give the bill a Do Pass as Amended.

I would be willing to answer any questions that the committee may have.

#4

BIO
BIOTECHNOLOGY
INDUSTRY ORGANIZATION

To: North Dakota Senate Human Services Committee

From: John A. Murphy, Esq. Director, BIO State Health Policy

Re: Opposition to Senate Bill 2276

Dear Members of the Senate Human Services Committee:

I am writing on behalf of the Biotechnology Industry Organization (BIO) to state our opposition to the universal vaccine purchase program envisioned in Senate Bill 2276. While we recognize that the state is seeking options to increase the administrative ease of vaccine administration, we believe that the proposed program would have exactly the opposite effect: creating a larger state-run bureaucracy for the purchase and administration of vaccines. Further, the program stands to jeopardize the nation-leading vaccination rates North Dakota already enjoys, decrease the State's attractiveness for biotechnology investment, and potentially places the State's existing contract for vaccines with the U.S. Centers for Disease Control (CDC) in jeopardy. It is for all these reasons that we believe the Committee should reject S.B. 2276.

BIO is a national trade organization, based in Washington, D.C., representing more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in research and development of healthcare, agricultural, industrial and environmental biotechnology products.

Initially, we want to point out that while we recognize that administrative process issues exist with local public health administration and follow-up under the current vaccine program in North Dakota, it is also true that these local public health units account for only about 10% of immunizations given in North Dakota. This bill places in jeopardy a currently-existing immunization program with the third highest immunization rates in the United States in order to deal with billing and administration issues for a very small proportion of the vaccine landscape in the State. Surely there are more narrowly tailored options the state can explore short of a wholesale reorganization of an already very successful program. BIO would be happy to participate in a discussion of these alternative options.

What is more is that a universal purchase program, as envisioned in S.B. 2276, is legally suspect. More specifically, because the Vaccines for Children (VFC) contract that the state has with the CDC to purchase vaccines for certain underinsured individuals has strict prohibitions on the resale of vaccines purchased through the program, the proposed universal purchase option in this

bill, with the corresponding insurance company assessment, risks running afoul of North Dakota's entire VFC contract. More specific detail on this issue is provided in the attached analysis done by BIO's outside legal counsel.

Finally, universal purchase programs like the one envisioned in S.B. 2276 send a message to start-up and established biotechnology companies and investors that a state is hostile to a private market for new and innovative therapies. This is exactly the wrong message any state wants to send during this time of economic recovery and job re-creation. Certainly North Dakota, a state that has invested so much in growing a competitive biotechnology industry, does not want to begin sending mixed messages to new investors.

It is for all these reasons that **BIO opposes Senate Bill 2276**. Surely there are less draconian measures the State can take to address minor administrative issues in certain vaccine administration sectors. And we at BIO stand ready to help in any discussion of alternatives. Please feel free to contact me with any questions or concerns. I am happy to assist.

John A. Murphy, III
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Legal Concerns Surrounding North Dakota's Proposed Use of Private Funds to Buy through VFC Program

Under the Vaccines for Children (VFC) program, created by Section 13631 of Omnibus Budget Reconciliation Act of 1993 (OBRA 93),[1] the Centers for Disease Control and Prevention (CDC) is authorized to contract with vaccine manufacturers to ensure that each state has a sufficient quantity of vaccine to vaccinate specified classes of disadvantaged children—namely uninsured children, Medicaid-eligible children, underinsured children,[2] and children of Indian tribes.[3]

North Dakota is seeking to fund optional purchasing with funds provided to the states by insurance companies or other private entities to address perceived administrative difficulties in certain local health vaccine programs. ***While this may initially seem to be attractive from a state budgetary perspective, these programs—if allowed to proceed— it would likely increase state administrative costs, breach the terms of the VFC contracts, and negatively impact the ability of the state to maximize the use of their immunization funds in the long-term. This would violate the stated purpose of the VFC Program.***

In addition, given that private insurers are now required to cover all ACIP-recommended vaccines at first-dollar, additional resources are not necessary to address vaccine coverage. Accordingly, scarce state resources should be used to implement other portions of the Affordable Care Act (ACA) that are more critical and time-sensitive.

Private Funding of State Vaccine Purchases Violates VFC Contracts

By using private insurance companies' money to fund optional vaccine purchases, states are, in effect, authorizing the sale of vaccine to those companies at discounted prices in violation of the VFC contract. In its contracts with manufacturers, CDC strictly limits the distribution of vaccine purchased through the VFC contracts to those specifically permitted by the VFC statute:

- Vaccines obtained under this contract shall be used only as authorized under section 1928 of the Social Security Act. *Sale of such vaccine to any person or entity is strictly prohibited. Free distribution of such vaccine is also prohibited*, except where such vaccine is administered in the context of Federal immunization program activities or otherwise provided by Federal law.[4]

- Vaccines obtained under this contract shall be used only in children 18 years of age and younger as authorized under Section 1928 of the Social Security Act. *Sale of such vaccine to any person or entity is strictly prohibited. Free distribution of such vaccine is also prohibited*, except where such vaccine is administered in the context of Grantee immunization program activities.[5]

While the term "sale" has been defined in a simple sense as "[t]he transfer of property or title for a price,"[6] the term clearly includes situations where product is paid for or "covered" by a third

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[1] Pub. L. No. 103-66, § 13631, 107 Stat. 312, 636-45 (codified at 42 U.S.C. § 1396s).

[2] This category includes children immunized with qualified vaccine in Federally-qualified health centers or rural health centers who are not insured with respect to the vaccine. 42 U.S.C. § 1396s(b)(2)(A)(iii).

[3] 42 U.S.C. § 1396s(b)(2) (collectively "VFC-eligible children").

[4] *See, e.g.*, CDC VFC Solicitation No. 2010-N-11860 (Flu), § C.1.18, Restrictions on Use of Vaccines (emphasis added).

[5] CDC VFC Solicitation No. 2010-N-11873 (Non-Flu), § C.17, Restrictions on Use of Vaccines (emphasis added).

[6] Black's Law Dictionary (9th ed. 2009).

party such as the private vaccine pooling arrangements contemplated by the states.[7] That is the essence of state insurance funding proposals: an insurance company pays the state to purchase vaccine at a discounted price for the beneficiaries of the state or insurance company immunization program that the company (or the state) otherwise would have had to negotiate directly with the manufacturer.[8]

Over the years, Federal procuring agencies have witnessed many—often creative—attempts by third parties to improperly access Federal contracts for drugs and biologics. Responses to these attempts have been swift and severe[9] because such attempts undermine the government's basic goals when contracting for supplies.

First, these attempts undermine the government's ability to obtain favorable pricing for its procurements. Second, they erode the government's ability to maintain sources of supply that are willing to contract with the government. As a result, such attempts to improperly access a Federal contract ultimately threaten the availability of necessary products for the government's beneficiaries and programs. Contract language prohibiting resale is standard in the government's multiple award contracts such as the CDC VFC contracts. One stark example of this type of language can be found in Federal Supply Schedule (FSS) contracts administered by the General Services Administration and the Department of Veterans Affairs, which place a clear resale limitation on FSS contract users.[10] Just as clearly, CDC states that products obtained from VFC contracts cannot be sold or resold. Simply put, the unauthorized resale of vaccine undermine the CDC's ability to administer the VFC program and provide necessary vaccine to VFC-eligible children.

These strict limits also are of critical importance in terms of maintaining adequate supply of vaccine of children in the specified classes set forth in the VFC statute. By the terms of the VFC contract, vaccine manufacturers must honor orders from state purchasers: "[State optional] orders shall not be subject to refusal by the manufacturers."[11] To permit a dramatic increase in state optional orders through private-funded access to the VFC contracts would decrease the total vaccine available under each contract's maximum order quantity threshold. Put another way, the state pooling arrangements would redirect a large portion of a potentially limited quantity of vaccine to the general population instead of to the specified classes of children who are meant to benefit from the VFC Program.

And, taken to their logical end, state insurance-funded arrangements could result in providing manufacturer-subsidized vaccine to every child in the state—insured or otherwise—thereby greatly reducing an insurance company's costs of immunizing its own beneficiaries that it would otherwise have had to bear on its own. This is simply a windfall for insurers.

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[7] *See, e.g.*, Dep't of Veterans Affairs, Office of Gen. Counsel, "Dear Manufacturer of Covered Drugs Letter" (Oct. 14, 2004) (TRICARE Retail Pharmacy rebates); 10 U.S.C. § 1074g(f) (same); 32 C.F.R. § 199.21(q) (same).

[8] The VFC statute was never intended to replace the existing ability of states to negotiate contracts directly with manufacturers to obtain vaccine for non-VFC children: OBRA 93 was "not intend[ed] to limit [a] State's current ability to negotiate independently for vaccine purchasers, if they do not elect this option."). H.R. Rep. No. 103-111, at 230 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 557.

[9] *See, e.g.*, Dep't of Veterans Affairs, Nat'l Acquisition Ctr., "Dear Contractor Letter" (Oct. 1, 1999) (discussing improper access of Federal Supply Schedule prices by certain Indian tribes).

[10] *See, e.g.*, GSA Order 4800.2F ¶ 7(d)(5) (2009) ("Authorization to use GSA sources of supply under the authority cited in this paragraph does not include purchases for resale unless the contract, grant, cooperative agreement, or funding agreement authorizes such activity.").

[11] CDC VFC Solicitation No. 2010-N-11860, § B; CDC VFC Solicitation No. 2010-N-11873, § B.1.

Furthermore, the implications of this windfall will likely distort the current economic dynamic associated with either the VFC Program, the rest of the vaccine marketplace, or both. Assuming the normal economic trade-offs between the VFC Program and the rest of the marketplace occur, a distortion in the volume of vaccines under the VFC Program would adversely impact the weight and composition of the rest of the vaccine market. Ultimately, over some period of time, and based on the normal economic dynamics of a free market, the state's purchasing power would diminish as a constrained market would likely result in higher costs.

The clear fact is that to allow states to fund vaccine purchases with private insurance money would serve to subsidize the insurance companies and would likely result in unintended market shifts that may ultimately decrease the state's purchasing power. This surely is not what the VFC Program was meant to accomplish. These unintended consequences would be inconsistent with the intent of the VFC Program and would not serve to immunize more children.

Prepared by Hogan & Hartson, Washington, DC for BIO

Presented by Joel Gilbertson on behalf of BIO, January 24, 2011

SB 2276 #5

2 February 2011

Senator Judy Lee
North Dakota Senate
Human Services Committee
State Capitol
600 East Boulevard
Bismarck, North Dakota 58505

Dear Senator Lee,

Thank you for the opportunity to join the Committee's discussion on North Dakota's immunization program yesterday and the proposed transition to a Universal Purchase policy. In thinking through the conversation, in particularly the comments from the Department of Health, we wondered if the Department's overall objective in promoting the legislation is a fundamental preference for Universal Purchase. Ms. Sanders comments seemed to reconfirm our thinking that the issues around storage, forecasting and billing in some of the public clinics either were the result of misinformation (like the refrigerators), could be resolved or at a minimum reduced through some process improvements--and would not necessarily disappear under a Universal Purchase policy

We would like to underscore that the challenges facing North Dakota are not unique to the state but rather are shared across many immunization programs. That doesn't make them less painful for the DoH and others but other states have worked through them short of major changes in public policy.

Just to summarize our thoughts.

Inventory Management

- We understand that some local public health departments have concerns regarding inventory management under a non-universal system and appear to believe that separate refrigerators are needed to separate private and public stocks.
- As we discussed yesterday, and as Ms Sanders affirmed, providers participating in a state-supplied vaccine program must separate public stock from private stock to prevent fraud, *but public health units are not required to maintain separate refrigerators.*
- Rather doctors and clinics can use simple inventory separation techniques including separate shelves, labeled bins, or colored stickers to keep the inventories separate.

Inventory Forecasting

- Wwe understand that there are concerns about public clinics estimating demand among the different funding streams and forecasting separate private pay and Vaccines for Children (VFC) eligible inventories.
- As discussed yesterday and reinforced by Ms. Sanders, in order to avoid missed immunization opportunities and minimize wastage, it is possible to "swap" doses between sources in the short term as long as there is tracking and stocks are resolved in the future.

Accountability for funding

- The issue of accountability for federal funds and vaccines purchased with them was also on the table.. Under the universal program, purchases are blended between both federal and state funds, but accountability of those funds remains the same. There may be one shipment of vaccine that is delivered to a provider's office and they may no longer need to separate out the inventory, but simplifying management of supply under universal purchase policy is a bit of a misnomer.
- While providers will not have physical separation of vaccine stock, the administrative burden of screening and tracking eligibility will not change. Providers will still need to screen each individual patient on each immunization visit for eligibility and account for who receives which vaccine under each category.
- A registry is not normally designed to track inventory ordering and management and would not necessarily help providers in North Dakota manage inventory.

Increased work for DoH

- At the state level, replacing a VFC-only supply policy with a universal supply policy unnecessarily increases the administrative complexity for the Department of Health. Requirements on the Department of Health to forecast vaccine usage, manage usage under budget categories, minimize fraud and vaccine wastage are all increased under a universal supply policy simply by the addition of a third budgeting category. In addition to VFC and Section 317, DoH will assume responsibility for the management of the supply for the entire private sector.
- Ms. Sanders stated that the accountability requirements to the state for the use of federal funds and avoid Medicaid (VFC) fraud remain the same.
- Yet it has not been outlined how the state will ensure this accountability or appropriately order for the entire state. This capability is not normally imbedded in the registry and may cause an undue burden on the state immunization program.

Supply shortage issue

- If the state purchases off of only one contract for the entire pediatric population, the state may be vulnerable to supply disruptions. Since 2000, vaccines that protect against 9 of the 12 vaccine preventable diseases have experienced significant supply shortages, requiring adaptations to immunization schedules to reduce the number of doses that children receive and prioritization of available vaccine to the groups at highest risk.
- If CDC is unable to contract for all required doses, priority will go to VFC children, and not all state requested purchases will be honored. In at least one instance, in recent years, CDC has not been able to supply enough influenza doses for all requests, and doses were allocated first to VFC and then if any remained to other sources.
- In such an instance providers without other ordering capabilities may not be able to provide vaccines and children may be left vulnerable to diseases.

Legal issue for consideration

- Beyond program implementation concerns, there are questions with a universal purchase policy that have been shared through the Biotechnology Industry Organization (BIO), the national association representing vaccine manufacturers.

- If a state assesses or taxes the insurers retrospectively based on claims it constitutes a clear resale of vaccine which is illegal under a federal contract.
- Second, the VFC contract is intended to purchase vaccines for vulnerable children up to age 18. Private purchases erode this intent and as the CDC has acknowledged, may also result in the erosion of discount benefits to the federal contract.
- BIO will be bringing both of these arguments to the Office of Management and Budget in the near future.

If the shared public health objective is to improve immunization rates among all children in North Dakota, then this bill, while well-intentioned, may not be the correct path forward. In fact, creating a universal purchase program would seem to contradict the tremendous improvement in the state's national ranking since switching from universal purchase in 2007 when the state ranked 25th and 2008 when North Dakota was ranked 44th, to is current ranking of 3rd nationally.

We welcome the opportunity to discuss any of these points further and can direct you to other resources that could assist North Dakota in reaching its public health goals of high immunization rates.

Sincerely,

Isabelle Claxton
Director
Public Policy and Advocacy
GSK Vaccines

#1

SB 2276

House Human Services Committee, March 23, 2011

Senator Judy Lee

Representative Weisz and members of the House Human Services committee –

Immunizations recommended by the federal Advisory Committee on Immunization Practices, (ACIP), are required by the state of North Dakota for children entering school or child care, with 2 exceptions, flu and Human Papilloma Virus (HPV).

Two federal programs provide vaccines, Vaccines for Children (VFC) and the 317 program, which can be used for specified recipients and purposes.

Insured children receive privately purchased vaccine. Local Public Health Units (PHUs) and private providers bill insurance companies for the cost of the vaccine plus an administrative fee. The UND School of Medicine has been contracted to handle billing for the Public Health Units, which has not gone well.

SB 2276 re-establishes a universal vaccine purchase program in ND, which means that the Department of Health would provide all vaccines for all children. North Dakota had a universal program for many years, but it was interrupted in 2005, when the federal government determined that they had been providing too much vaccine to the state and the amount of vaccine provided was significantly reduced. As new vaccines were recommended by the ACIP, and as vaccine prices increased, and as the federal allotment declined, the state was forced to seek new solutions. Although Blue Cross/Blue Shield agreed to purchase vaccines for its insured members, other insurance companies did not follow suit. ND had to discontinue universal coverage in 2008. The state continued to be committed to immunizing all children, but the program which evolved, because of federal restrictions, meant that health care providers had to determine which of 3 "payment lines" the child was in and had to bill appropriately. This sometimes meant more than one payment line for 2 children in the same family. Vaccines have to be stored separately, depending on whether they are used for low-income programs or for insured kids. This became an administrative challenge which was not resolved by a billing program established with the School of Medicine. For some public health units, administration has been costing 35-58% of the cost of immunizations, which is not very efficient or acceptable. Some small PHUs have ceased providing immunizations for anyone who is not covered by the VFC and 317 federal programs, eliminating the source of vaccines for families in their areas.

During the past interim, a study was done, including assistance from a consultant to determine how best to manage the immunization program. The report noted the inefficiencies and administrative challenges of the current system. The interim committee concluded that a universal vaccine supply policy was the best solution to what had become a very convoluted system. The ND Medical Association and the public health officials supported the results of the study. During that time, federal attorneys concluded that the Center for Disease Prevention and Control (CDC) could not prevent states from purchasing off the

federal contract using private funds. This meant that ND could again pursue universal vaccine supply, and that is what SB 2276 does.

SB 2276 establishes a vaccine purchasing board which sets assessments that are paid by insurers into a pool to cover the cost of vaccines not covered through federal programs. This program is patterned after that used in our Comprehensive Health Association of North Dakota (CHAND) program, which is the state's high risk insurance pool. It has been very successful for over 30 years in providing health insurance for citizens who have been denied coverage. In both plans, a pool of funds is used to cover the need. In CHAND, it is to pay health claims. In SB 2276, it is to cover the cost of immunizations.

These vaccines, along with those from the federal programs, will be supplied to ND providers to be given to children. Providers will not bill insurers for the cost of the vaccine, but they can still bill for an administration fee which would be set by the providers. It should be noted, however, that private providers now can add a fee to the cost of the vaccine, as well as the administrative fee. If the vaccine is provided through the universal system, the only fee charged would be for administration, reducing costs for parents paying out of their own pockets and also for insurance companies reimbursing providers.

There are three benefits which will result from this plan.

1. Possibility of increasing immunization rates further
    a. School clinics have been difficult to do, because of the billing. I preferred that means, because our children didn't always get shots, when they went to the clinic.
    b. Families with high deductible insurance plans have to pay out of pocket for the vaccine and administrative fee up front, a potential deterrent to vaccination.
2. Health care costs can be reduced
    a. 2010 data show that the difference between the federal and private rates for recommended vaccines for ND kids was **$3,113,585 or 26.9%**. Actual savings might be different, because of rates being negotiated by some groups with greater volumes of purchasing.
    b. Insurance premium stability, due to lower costs being paid by insurance companies
3. Reduced administrative costs for providers.

It is only for the past 2 years that there has even been a private market for vaccines in ND. From 1994-2008 all vaccines, whether kids were insured or not, came off the federal contract.

SB 2276 does not create a government-run immunization program. All decisions will remain between parents and providers. 2276 only provides for group purchase of childhood vaccines at a reduced rate.

If SB 2276 is defeated, an **additional $1.5-$2 million** will need to be added to the Health Dept. budget to cover the costs for local public health units in administering vaccination programs. Last biennium $1.2 million was appropriated; the previous session it was $2.0 million. Why should we spend these additional dollars, when it can be avoided? Why shouldn't those dollars be available for other public health programs needed by ND citizens?

Some have asked why this would not be limited to local public health units only. LPUs already get a reduced rate, between the federal and private rates, and are only 10-15% of the market, so savings would only be $100,000-$150,000. It also would not be a universal program, losing the benefits of

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administrative savings and simplification of processes. Also, limiting the program to PHUs will drive clients to PHUs, instead of kids receiving vaccinations at their medical home, if that is what they prefer. Equal access to all providers increases vaccination rates.

Objections have been raised by pharmaceutical manufacturers that this will cut into profits of their industry that could be used to develop new vaccines. Childhood vaccines are a minute piece of the entire pharmaceutical industry. They provide huge discounts in other situations, such as selling **pneumococcal vaccine in other countries** at between **$1 and $5/dose**, compared to **$91.75 on the federal contract and $108.75 on the private market in the US.** It is also important to remember that the rates at which vaccines are sold is negotiated; manufacturers are not required to sell them at a loss. In fact, when the current plan was being implemented, the Department of Health asked the manufacturers of they would negotiate a rate for vaccines in ND, and the manufacturers declined to participate.

The Senate recognized the importance and the expertise of the growing vaccine development research and technology businesses in ND and thinks that their participation is critical in the success of this program. Added to the purchasing board is a member of the ND business community involved in biotechnology with an emphasis on immunization vaccine research.

Our responsibilities as legislators are to support the health and safety of our citizens and to be good stewards of the state's resources, including taxpayer dollars. SB 2276 will return the state to the universal system which provides vaccines for all children at the federal rate which should assist the state in its goal of continuing to **increase the number of children who are properly immunized**, and it can **save over $2 million in costs**, compared to the federal rate.

I appreciate the opportunity to share the details of SB 2276 with the House Human Services Committee, and I will be happy to attempt to answer your questions.

Immunization P[redacted]n

Cost to Vaccinate One Child Through 18 Years of Age

Rates as of January 1, 2011

Age		Number	Federal Rate	Total	Private Rate	Total
<1	Vaccine Type	of Doses*	Per Dose	Federal Rate	Per Dose	Private Rate
	Hepatitis B	3	$10.25	$30.75	$21.37	$64.11
	Pentacel (DTaP-IPV/Hib)	3	$50.70	$152.10	$77.48	$232.44
	Prevnar13 (pneumococcal)	3	$91.75	$275.25	$114.75	$344.25
	Rotavirus	3	$59.17	$177.51	$69.59	$208.77
	Influenza	2	$10.64	$21.28	$13.16	$26.32
	Total	**14**		**$656.89**		**$875.89**
1-2						
	Pentacel (DTaP-IPV/Hib)	1	$50.70	$50.70	$77.48	$77.48
	Prevnar13 (pneumococcal)	1	$91.75	$91.75	$114.75	$114.75
	MMR (measles, mumps, rubella)	1	$18.64	$18.64	$50.16	$50.16
	Varicella (chickenpox)	1	$67.08	$67.08	$83.77	$83.77
	Hepatitis A	2	$13.25	$26.50	$28.74	$57.48
	Influenza	2	$10.64	$21.28	$13.16	$26.32
	Total	**8**		**$275.95**		**$409.96**
3-6						
	Kinrix (DTaP-IPV)	1	$32.75	$32.75	$48.00	$48.00
	MMRV (MMR-Varicella)	1	$85.72	$85.72	$133.93	$133.93
	Influenza***	4	$11.99	$47.94	$15.44	$61.74
	Total	**6**		**$166.41**		**$243.67**
7-18						
	Tdap (tetanus, diphtheria, pertussis)	1	$28.54	$28.54	$37.55	$37.55
	HPV (human papillomavirus)**	3	$108.72	$326.16	$130.27	$390.81
	Menactra (meningococcal)	2	$79.75	$159.50	$106.49	$212.98
	Influenza***	12	$11.99	$143.82	$15.44	$185.22
	Total	**18**		**$658.02**		**$826.56**
			Total Overall Cost	**$1,757.27**		**$2,356.08**

* Number of doses based on 100% immunization rate.

** Includes females and males

***Cost/dose is average of injectable and nasal cost

This schedule doesn't include catch-up doses.

Prepared by Molly Sander 2/18/2011

	2010 NDIIS Doses Administered to Insu						Using Federal Pricing (January 1, 2011)				
	Cost/Dose	<1 Year	Cost <1	1-2 Year	Cost 1-2		Cost 3-6	7-18 Years	Cost 7-18	Total	Total Cost
Chickenpox (varicella)	$67.08	9	$603.72	4764	$319,569.12		$212,241.12	3611	$242,225.88	11548	$774,639.84
DTaP (diphtheria, tetanus, pertussis)	$14.25	144	$2,052.00	1452	$20,691.00	640	$9,120.00	64	$912.00	2300	$32,775.00
DTaP-HBV-IPV (Pediarix)	$49.75	496	$24,676.00	473	$23,531.75	17	$845.75	5	$248.75	991	$49,302.25
DTaP-Hib-IPV (Pentacel)	$50.70	9361	$474,602.70	8908	$451,635.60	250	$12,675.00	11	$557.70	18530	$939,471.00
Hepatitis A	$13.25	7	$92.75	9295	$123,158.75	2309	$30,594.25	7963	$105,509.75	19574	$259,355.50
Hepatitis B	$10.25	12607	$129,221.75	3831	$39,267.75	173	$1,773.25	313	$3,208.25	16924	$173,471.00
Hib (Haemophilus influenzae type B)	$11.51	601	$6,917.51	2126	$24,470.26	1804	$20,764.04	9	$103.59	4540	$52,255.40
HPV4 (human papillomavirus)	$108.72	2	$217.44	3	$326.16	2	$217.44	6847	$744,405.84	6854	$745,166.88
Influenza (TIV)	varies	2787	$23,048.49	7991	$66,085.57	4634	$49,305.76	11664	$124,104.96	27076	$262,544.78
Influenza (Live virus)	$15.70	13	$204.10	1191	$18,698.70	6738	$105,786.60	10387	$163,075.90	18329	$287,765.30
IPV (polio)	$11.74	89	$1,044.86	188	$2,207.12	492	$5,776.08	159	$1,866.66	928	$10,894.72
MCV (meningococcal)	$79.75	3	$239.25	14	$1,116.50	9	$717.75	12000	$957,000.00	12026	$959,073.50
MMR (measles, mumps, rubella)	$18.64	5	$93.20	4754	$88,614.56	3281	$61,157.84	229	$4,268.56	8269	$154,134.16
MMRV (MMR-Varicella)	$85.72	2	$171.44	271	$23,230.12	1898	$162,696.56	40	$3,428.80	2211	$189,526.92
PCV13 (Pneumococcal)	$91.75	9930	$911,077.50	13835	$1,269,361.25	3434	$315,069.50	19	$1,743.25	27218	$2,497,251.50
PPV23 (Pneumococcal)	$30.03	4	$120.12	8	$240.24	11	$330.33	64	$1,921.92	87	$2,612.61
Rotavirus (3 dose)	$59.17	8612	$509,572.04	4559	$269,756.03	4	$236.68	10	$591.70	13185	$780,156.45
Rotavirus (2 dose)	$83.75	819	$68,591.25	362	$30,317.50	0	$0.00	0	$0.00	1181	$98,908.75
TD (tetanus, diphtheria)	$16.50	10	$165.00	0	$0.00	0	$0.00	100	$1,650.00	110	$1,815.00
Tdap (tetanus, diphtheria, pertussis)	$28.54	7	$199.78	4	$114.16	2	$57.08	7086	$202,234.44	7099	$202,605.46
Total											$8,473,726.02
	2010 NDIIS Doses Admistered to Insured Children Using Private Pricing (January 1, 2011)										
Vaccines	Cost/Dose	<1 Year	Cost <1	1-2 Year	Cost 1-2	3-6 Year	Cost 3-6	7-18 Years	Cost 7-18	Total	Total Cost
Chickenpox (varicella)	$83.77	9	$753.93	4764	$399,080.28	3164	$265,048.28	3611	$302,493.47	11548	$967,375.96
DTaP (diphtheria, tetanus, pertussis)	$20.96	144	$3,018.24	1452	$30,433.92	640	$13,414.40	64	$1,341.44	2300	$48,208.00
DTaP-HBV-IPV (Pediarix)	$70.72	496	$35,077.12	473	$33,450.56	17	$1,202.24	5	$353.60	991	$70,083.52
DTaP-Hib-IPV (Pentacel)	$77.48	9361	$725,290.28	8908	$690,191.84	250	$19,370.00	11	$852.28	18530	$1,435,704.40
Hepatitis A	$28.74	7	$201.18	9295	$267,138.30	2309	$66,360.66	7963	$228,856.62	19574	$562,556.76
Hepatitis B	$21.37	12607	$269,411.59	3831	$81,868.47	173	$3,697.01	313	$6,688.81	16924	$361,665.88
Hib (Haemophilus influenzae type B)	$22.77	601	$13,684.77	2126	$48,409.02	1804	$41,077.08	9	$204.93	4540	$103,375.80
HPV4 (human papillomavirus)	$130.27	2	$260.54	3	$390.81	2	$260.54	6847	$891,958.69	6854	$892,870.58
Influenza (TIV)	varies	2787	$31,130.79	7991	$89,259.47	4634	$60,983.44	11664	$153,498.24	27076	$334,871.94
Influenza (Live virus)	$19.70	13	$256.10	1191	$23,462.70	6738	$132,738.60	10387	$204,623.90	18329	$361,081.30
IPV (polio)	$25.43	89	$2,263.27	188	$4,780.84	492	$12,511.56	159	$4,043.37	928	$23,599.04
MCV (meningococcal)	$106.49	3	$319.47	14	$1,490.86	9	$958.41	12000	$1,277,880.00	12026	$1,280,648.74
MMR (measles, mumps, rubella)	$50.16	5	$250.80	4754	$238,460.64	3281	$164,574.96	229	$11,486.64	8269	$414,773.04
MMRV (MMR-Varicella)	$133.93	2	$267.86	271	$36,295.03	1898	$254,199.14	40	$5,357.20	2211	$296,119.23
PCV13 (Pneumococcal)	$114.75	9930	$1,139,467.50	13835	$1,587,566.25	3434	$394,051.50	19	$2,180.25	27218	$3,123,265.50
PPV23 (Pneumococcal)	$42.58	4	$170.32	8	$340.64	11	$468.38	64	$2,725.12	87	$3,704.46
Rotavirus (3 dose)	$69.59	8612	$599,309.08	4559	$317,260.81	4	$278.36	10	$695.90	13185	$917,544.15
Rotavirus (2 dose)	$102.50	819	$83,947.50	362	$37,105.00	0	$0.00	0	$0.00	1181	$121,052.50
TD (tetanus, diphtheria)	$20.39	10	$203.90	0	$0.00	0	$0.00	100	$2,039.00	110	$2,242.90
Tdap (tetanus, diphtheria, pertussis)	$37.55	7	$262.85	4	$150.20	2	$75.10	7086	$266,079.30	7099	$266,567.45
Total											$11,587,311.15
Cost Savings	$3,113,585.13										
BCBSND Share (Federal Rate)*	78.40%		$6,643,401.20								
Other Share (Federal Rate)	21.60%		$1,830,324.82								
317 Vaccine Allocation			$1,283,451.00								
Insurance Need (Federal Rate)			$7,190,275.02								
Non BCBS Need (Federal Rate)			$546,873.82								
317 Vaccine Allocation			$1,283,451.00								
Adult Program Cost			$477,518.00								
Insurance Need (Federal Rate)			$7,667,793.02								
Non BCBS Need (Federal Rate)			$1,024,391.82								
Notes:											
2 doses of MCV recommended in October 2010. 7441 administered in 2010. Estimated need for booster dose.	Supplemental dose of PCV13 in 2010. Will continue in 2011										
*NDIIS LPHU Billing Data											
					Prepared by	Molly Sander	2/18/2011				

Rep. Kaldor

BismarckTribune.com

Vaccinate one child and many benefit

By EDWARD LOTTERMAN | Posted: Sunday, March 20, 2011 2:00 am

In many states the proportion of children who are vaccinated against infectious diseases is declining. Is this a problem? What, if anything, should we want government to do about it?

The problem is that this is an issue where considerations of individual liberty clash particularly strongly with the health of society as a whole.

We live in an era in which there is greater emphasis on human liberty and personal responsibility than was true for many years. Many people oppose intrusive government. Few things are more intrusive than government telling people that they must have their children injected with various vaccines.

Moreover, there always have been members of some religious groups that find vaccination against their faith. So we don't have a federal law per se that requires vaccinations. There are, however, laws in some states that do require vaccinations and a federal law that requires them before attending educational institutions.

Those suspicious of government coercion ask why government should be involved at all. Why are vaccinations any different than getting a tumor removed, a hernia fixed or a pill prescribed to reduce blood pressure?

If people think childhood vaccinations have greater benefits than costs, let them go ahead and get their kids vaccinated. If they don't think so, let them do without and run the risks of getting sick.

The problem is that vaccinations against infectious diseases are different from medical care for noninfectious maladies. Vaccinations have what economists call "spillover benefits." That is, they do good things for society that go beyond the protection afforded to the person getting the shots.

This is because of a phenomenon called "population immunity." Higher rates of vaccination reduce the risks of epidemics. They also reduce the risk of even nonvaccinated people getting the disease, epidemic or not. The reason is that as the fraction of the population that could get the disease shrinks, the harder it is for the pathogen to spread from one person to another.

The risks of an unvaccinated person getting a disease fall extremely low well before vaccination rates approach 100 percent.

This introduces perverse incentives. It benefits society as a whole for people to get vaccinated. But if most people are getting vaccinated, any single individual can avoid the discomfort, risk and expense of being vaccinated and still benefit from the reduced risk of getting sick that spills over from others taking the precaution.

This leads to what logic professors call a fallacy of composition, of assuming that what is true for an individual is necessarily true for a group. Any one individual may be better off by "free-riding" and not getting vaccinated. But if everyone avoids vaccination, society as a whole will be much worse off because dangerous diseases will spread throughout the population.

Economists agree that when all the costs and benefits of some product or service are borne by the person deciding to consume it or not, there is no need for government to act.

If no one else is affected by my eating a muffin or reading a magazine, there is no reason for government to either promote or retard muffin eating or magazine reading.

But when others are affected, society is worse off if government does not act.

Both history and economic theory demonstrate that there are some goods or services, such as national defense or fire protection, that have large spillover benefits and that will not be produced in optimal quantities in free, private markets. Society gets fewer of its needs and wants met than if government "intervenes" to use resources to provide such "public goods."

A muffin or a magazine is a purely private good. A police cruiser is largely a public good. But many other things, including education and vaccinations, fall somewhere in between, with some benefits accruing solely to the individual getting educated or vaccinated and other benefits spilling over to the rest of society.

Educating everyone in basic literacy and numeracy has enormous spillover benefits for society in the form of economic productivity. Getting a Ph.D. in economics or archeology may benefit the student, but it does little extra for society. So we subsidize and mandate education through age 16 but let public support taper off after high school, with government paying nearly all of the cost of education through the secondary level, but proportionally less for college and graduate school.

We indirectly coerce people to get vaccinated against the most dangerous infectious diseases. We also provide some subsidies, but we expect households or their insurers to pick up much of the cost. Some of the decline in vaccination rates is attributed to declining levels of reimbursement by private insurers and Medicaid. I think this is a mistake.

Private demand for vaccinations and public support for government subsidies of vaccination are driven by perceived risk. I was one of more than 60 kids home with the measles out of a school of 110 students when I was in the third grade. My cousin lived with a hand withered by polio. I knew people scarred by smallpox when I worked in Brazil and Peru. That is why I think government should both subsidize vaccination and "encourage" it, subject to exemptions for legitimate religious beliefs.

But I am getting to be an old geezer. Younger generations that have never seen the scourge of such diseases evidently don't feel the same urgency.

(Economist Edward Lotterman teaches and writes in St. Paul, Minn. Write him at ed@edlotterman.com)

Testimony
Senate Bill 2276
House Human Services Committee
March 23, 2011; 9 a.m.
North Dakota Department of Health

Good morning, Chairman Weisz and members of the House Human Services Committee. My name is Arvy Smith, and I am the deputy state health officer for the North Dakota Department of Health. I am here today to provide background information on immunizations in North Dakota, describe the features of Senate Bill 2276 and provide testimony in support of the bill.

Immunizations in North Dakota

- Immunizations are recommended by the federal ACIP (Advisory Committee on Immunization Practices).
    - Children are currently recommended to be vaccinated against 16 diseases.
- State law requires all ACIP recommended vaccines for school and child-care attendance, except influenza and human papillomavirus (HPV) vaccine.
    - Exemptions:
        - Medical
        - Religious
        - Philosophical
        - Moral
        - History of disease
- The most recent National Immunization Survey (NIS) data for North Dakota is for 2009. The NIS rate shows the percentage of children who are up-to-date with a series of vaccinations at ages 19 to 35 months. North Dakota's most current NIS up-to-date percentage for the series is 77.0 percent (3rd in the nation). This is higher than the U.S. rate for the same series at 70.5 percent.
    - Increased rates are most likely attributed to new school and childcare immunization requirements, increased uptake of new vaccines, and North Dakota private providers and local public health units doing a good job of vaccinating.
- The following table shows the cost to vaccinate a child through the age of 18. The increases are due to the number of vaccines recommended, combination vaccines and vaccine price increases.

Year	Cost/Child (Federal Rate)	Cost/Child (Private Rate)	Comments
1999	$186		
2004	$476		
2005	$618		
2006	$1,156		4 new vaccines recommended, includes HPV vaccine for females
2009	$1,519	$1,991	New combination vaccines, influenza vaccine recommended for all children
2011	$1,757	$2,356	New combination vaccines, new pneumococcal vaccine, additional dose of meningococcal vaccine

Vaccine Funding

- The North Dakota Department of Health (NDDoH) does not receive federal funding to purchase vaccines; we receive an allocation or allotment of vaccines.
- The Vaccines For Children Program (VFC) is a federal entitlement program that provides all ACIP recommended vaccines for children who are Medicaid-eligible, American Indian, uninsured or underinsured (have insurance, but it does not cover a particular vaccine).
    - 33.33 percent of children ages 18 and younger in North Dakota are VFC-eligible.
    - Providers may not charge patients for the cost of VFC vaccine, but may charge a maximum administration fee of $13.90.
- Insured children receive privately purchased vaccine. Local public health units and private providers bill insurance companies for the cost of the vaccine plus an administration fee. The federal Section 317 Program is a discretionary program available to children and adults. The state can decide which vaccines to offer through this program.
    - The North Dakota Immunization Advisory Committee decides which vaccines to offer through this program.
    - Current vaccines offered include hepatitis B birth dose for all newborns, hepatitis A and B vaccine for high-risk adults and various vaccines for uninsured and underinsured adults.
    - Providers may not charge patients for the cost of 317 vaccine, but may charge a maximum administration fee of $13.90.

- Section 317 vaccine allocations have decreased each year, due to North Dakota being historically overfunded. In 2004, North Dakota received a Section 317 allocation of $2.1 million per year. We were informed by the federal government that our Section 317 allocation could be reduced to $300,000 by 2008. Although this significant of a cut did not happen, our 2011 Section 317 vaccine allocation is more than $800,000 less at $1,283,451.

History

In 2004, North Dakota was considered a universal state, which means the Department of Health provided all vaccines for all children, including those with insurance. The federal allotment of VFC and Section 317 vaccines was sufficient to immunize all the children in North Dakota. As new vaccines were recommended by the ACIP, vaccine prices increased and North Dakota's Section 317 vaccine allotment declined, it was becoming difficult to maintain our universal vaccine status.

Part way through 2005, BlueCross BlueShield of North Dakota agreed to provide funding to the NDDoH to purchase vaccines to fill the growing gap. They agreed to do this only for a limited time feeling they, alone, should not bear this cost; it should be shared with other insurers in the state. Other insurers were asked to voluntarily provide funding as well and they did not elect to participate.

North Dakota had to discontinue universal vaccine status starting in 2008 because funding was not available to fill the gap between the federal allotment of vaccines and the need for vaccines. The Department of Health attempted to establish contracts with vaccine manufacturers for bulk purchasing, but the manufacturers were not receptive, so private health-care providers and local public health units started purchasing private supplies of vaccine to immunize insured children and then billing insurance for the cost of vaccines and administration. The Department of Health continued to supply VFC and Section 317 vaccines.

This change in vaccine supply has been complicated and time consuming for all parties involved. Significant education to providers and the public was conducted. Providers had to learn how to screen for VFC eligibility, order vaccine, store separate supplies of vaccine, and bill insurance. The public had to be educated about checking insurance coverage for vaccines. Contracts for private vaccine purchases had to be created for private providers and local

public health units. A billing system had to be created for local public health units to bill for immunizations. BlueCross BlueShield of North Dakota established first dollar coverage for recommended childhood immunizations. First dollar coverage means that vaccines are not subject to any deductible or co-pay, that coverage begins with the first dollar billed for vaccines.

In 2009, there was a legislative proposal that the state general fund pay for vaccinations for insured children. The cost to cover this was estimated at $16 million per biennium. This cost would have increased each biennium as vaccine prices increased and new vaccines were recommended by the ACIP. Due to the high cost and concerns about the sustainability of funding for future increased costs, the bill did not pass.

Independent Quality Improvement Study on Immunization

During the 2009-2010 interim, a study to review the state immunization program was completed as required by Senate Bill 2004. A main focus of the study was to improve administrative performance, including the procurement and management of vaccines. The study, which was conducted by a consultant, concluded that the current methods of vaccine procurement and management are time consuming and inefficient mainly due to the federal rules which require separate accounting and storage of vaccine inventories for each source of vaccine (such as VFC). The recommendation stated, "Based on the savings to be realized in terms of cost of vaccine and procurement/management of vaccines for local public health units, we believe a universal vaccine supply policy is best for local public health units and should be pursued if further investigation determines that universal yields a similar impact on private providers and payers."

Senate Bill 2276

Senate Bill 2276 establishes a vaccine group purchasing board, which would be responsible for assessing insurers and third-party administrators for an estimate of the cost of vaccines administered to their covered children. This funding would then be used by the Department of Health to purchase vaccines for insured North Dakota children through the federal contract. These vaccines, along with VFC vaccine, would be supplied to North Dakota providers to be administered to children. Providers would not bill insurers for the cost of the vaccine, but could still bill for the administration fee.

The Department of Health did not attempt this program in the past because previously the federal government would only allow a small number of

"grandfathered" states to purchase vacoines from the federal contract with private funds. The federal government has now determined that they cannot prohibit states from doing this. Maine, Idaho, Washington, New Hampshire and Rhode Island all use funds from insurance companies to purchase vaccines from the federal contract.

Benefits

There are three significant benefits of implementing the vaccine group purchasing program included in Senate Bill 2276. The most important benefit is the possibility of increasing vaccination rates by removing barriers and increasing access to vaccination. It is much easier to conduct school and other mass vaccination clinics when separate inventories of each vaccine pool do not have to be kept. School and other mass vaccination clinics provide an opportunity to efficiently vaccinate many children, improving vaccination rates in the state. Also, if some of the complexities of vaccinating children are removed, several providers may return to vaccinating all children rather than only VFC eligible children, increasing access to vaccinations.

Another benefit is the ability to reduce health-care costs. Using actual data of vaccines and doses provided to insured children in 2010, we compared the cost at the federal rates to the cost at private rates. The difference was $3,113,585 or 26.9 percent (private $11,587,311 and federal $8,473,726). The actual savings may not reach this amount, however, because local public health units, which administer between 10 and 15 percent of the vaccines, are already purchasing vaccines at a rate below the private rate and many private providers are receiving discounts below the private rate for volume purchasing. On the other hand, some providers are marking up the vaccine, above their cost, and billing insurance for the marked-up amount. This would not be possible if vaccine were provided free. Because of these nuances, we are estimating savings to be from around $2.5 million to $3 million each year. Reducing costs to insurers will reduce the costs they have to pass on to payers of insurance premiums.

Thirdly, as we learned from the legislative study and through visits with providers, returning to universal vaccine status will provide administrative efficiencies that could reduce costs to providers. If the NDDoH supplied all vaccines for all children, including those with insurance, providers would no longer have to manage separate inventories of private and public vaccines. This would significantly reduce staff time at provider offices. In addition, providers would no longer have to purchase vaccines privately. All vaccines could be ordered from one source, which also would reduce staff time. Providers would

simply administer the vaccines and bill insurance only for the cost to administer the vaccines. We are unable to estimate the total savings related to administrative efficiencies, but one private provider reported being able to reduce one position in purchasing alone. In addition, the study indicated that eliminating the local public health unit administrative burden associated with maintaining separate inventories and the loss from expired vaccines would result in significant savings.

Fiscal Impact

Since the stakeholders have been considering this type of method for some time, the Department of Health's budget originally contained sufficient authority of $19.4 million to purchase the vaccines and provide the administrative support needed. The House removed this authority from HB 1004, the Department of Health's budget, since SB 2276 had not yet been passed by the House. If SB 2276 is passed, this authority will need to be added back in to HB 1004. Aside from the program start-up period, minimal staff time will be needed to operate this effectively so there is no additional appropriation needed to implement this bill.

Conclusion

Senate Bill 2276 provides a sustainable mechanism for vaccinating children in North Dakota in the most efficient and cost effective manner. If more vaccines are recommended by the ACIP, the assessment to insurers will increase to cover these vaccines. Under this mechanism, the increases to insurers for the new vaccines will be at the federal contract rate as opposed to the private rate.

There has only been a private market for vaccines in North Dakota for two years. Prior to that, all childhood vaccines in North Dakota were purchased off of the federal contract. SB 2276 would move North Dakota back to a vaccine supply policy that was successful in the past.

Although North Dakota's immunization rates are above the national average, there is room for improvement. And the many complexities for providers are increasing the costs associated with the current system and possibly affecting immunization rates. These complexities and costs can be lowered substantially through this bill to provide a more efficient, cost effective approach to immunizing the greatest number of children possible in North Dakota. This concludes my testimony. I am happy to answer any questions you may have.

#4

Testimony
To the
House Human Services Committee
On
SB 2276

Good morning Chairman Weisz 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. In 2010 First District Health Unit administered 1,923 doses to children under age 3, 5,702 doses age 3 – 18, and 11,318 doses to ages 19 and over.

First District Health Unit participated in the study conducted on the immunization system. Three independent contractors spent two days at First District with all of my staff involved in the immunization process (nurses, billing staff, inventory managers, receptionists etc). The contractors also spent several hours after their initial visit gathering information and data. The study was a very comprehensive review of our delivery system and identified several inefficiencies. For example, First District paid $11,614 to UND to process 5,807 claims which produced $33,120 in gross charges. That results in a 35% cost of billing per claim. First District Health Unit is in the process of transitioning to our own billing system to try to reduce the 35% loss.

A universal vaccination delivery system not only addresses billing but most importantly it would reduce the costs associated with managing separate inventories of vaccine. Some clients qualify for VFC vaccine, some for 317 vaccine, some for vaccine purchased privately by First District Health Unit, and others a combination of any of the three. This is not only inefficient and costly to both private and public healthcare providers but very confusing for the client. We are allowed to transfer vaccine supplies from one inventory to the other but the process to do so is very complicated and time consuming. I have attached First District's process to borrow and return vaccine. Every borrow and return that is done includes the billing staff, nursing staff and front desk staff.

An example of the complexities caused by having vaccine from 3 different funding sources is that a child may be able to receive private vaccine and be eligible for VFC vaccine in the same visit. For instance, a child entering middle school may need Tdap, Menactra and Hepatitis A vaccine. With Section 317 supplying Tdap and Menactra for middle school children those vaccines are VFC, a fee of $13.90. However the Hepatitis A vaccine would be private vaccine. That administration fee is $23.38 and vaccine cost is $14.00. This is confusing to parents and difficult for staff. It means that we must take from 2 different vaccine supplies, enter the data differently and bill differently.

The study provides several recommendations that will improve our current system of delivering vaccines. The transition to a universal immunization system is the resolution that would address billing problems, vaccine management costs, and vaccine wastage. In one year the VFC wastage at First District was $7,153.73 and private vaccine wastage was $8,812.20.

SB2276 also states that all providers of vaccinations are required to enter the immunization record into the ND immunization data system or state supplied vaccine will not be provided. When this data is not entered, children's complete immunization records cannot be obtained by other providers. It is important to have this information entered within four weeks of the

administration of vaccine so that second doses can be administered appropriately and children do not receive duplicate vaccinations.

In summary, 2276 takes North Dakota back to a universal immunization delivery system. This is not a new way of doing things. It is what we did prior to 2006 and it worked. 2276 provides the funding mechanism to support universal vaccinations without any cost to the taxpayer. The past two legislative sessions have appropriated $1.2 million dollars to local public health units to cover the financial loses incurred with our present system of vaccine delivery. 2276 would eliminate the need for those funds and save taxpayers $1.2 million dollars.

Thank you for your consideration and I would be happy to answer any questions.

Borrow or Return Vaccine
PRIVATE/VFC

This is the process to change private vaccine to VFC or vice versa. Do it whenever the wrong category of vaccine is inadvertently given.
To make this easier to understand, the process is written separately.

VFC dose used, should have been a private dose.

1. The VFC dose you used must be "borrowed" in NDIIS. To see how, go to www.ndhealth.gov/Immunize/Providers/Forms/ . Scroll down to "How to borrow and return vaccines in NDIIS." This needs to be done before entering the VAR data in NDIIS.

2. Fill this borrowed dose information on the **Borrow / Return Vaccine** form in the Desktop Reference.

3. Take a dose of Private vaccine in your fridge and move it to VFC section in the fridge. Change the dot from blue to yellow.

4. This private dose must be "returned" in NDIIS. Follow format as in # 1.

5. This private, returned dose information needs to be documented on the **Borrow / Return Vaccine** form also.

6. Once both the borrowed and returned vaccines with their lot # 's have been filled in on the **Borrow / Return Vaccine Form,** email it as an attachment to Linda H for her to change it in PH Clinic.

Private dose used, should have been a VFC dose.

1. The Private dose you used must be "borrowed" in NDIIS. To see how go to www.ndhealth.gov/Immunize/Providers/Forms/. Scroll down to "How to borrow and return vaccines in NDIIS." This needs to be done before entering the VAR data in NDIIS.

2. Fill this Private, borrowed dose information on the **Borrow / Return Vaccine** form in the Desktop Reference.

3. Take a dose of VFC vaccine in your fridge and move it to Private section in the fridge. Change the dot from yellow to blue.

4. This VFC dose must be "returned" in NDIIS.

5. This VFC, returned dose information needs to be documented on the **Borrow / Return Vaccine** form also.

6. Once both the borrowed and returned vaccines with their lot # 's have been filled in on the **Borrow / Return Vaccine Form,** email it as an attachment to Linda H for her to change it in PH Clinic.

NDDoH will not let us transfer from one category to another due to no availability. This is part of the Prevention Partnership agreement. Call Melissa, Danell or Penny if you are unsure.

Created August 29, 2008 Revised May 15, 2009

Testimony on SB 2276
House Human Services Committee
March 23, 2011

Chairman Weisz and members of the House Human Services Committee, for the record I am Dan Ulmer, representing Blue Cross Blue Shield of North Dakota (BCBSND).

With changes made to Engrossed SB 2276, BCBSND supports this bill. SB 2276 is one of the most important public policy statements that this legislative body will make during this legislative session. Childhood immunizations are so important for the entire health of our State. While our state has successfully maintained a high level of childhood immunizations, this bill will not only create an environment where children's immunizations will be more accessible, but it will save millions of dollars for our citizens. It is expected that our company could save up to $2 million dollars a year for our members if this bill is approved and works as intended.

BCBSND has been an active participant in ND's immunization program and when the Universal Immunization Program was threatened a few years ago, our company "stepped up to the plate" and contributed funding to ensure the continued distribution of state funded vaccines. We have also been an active participant in the Health Department's transition to the current provider choice program. While there have been many "bumps in the road" through this journey, local public health units and BCBSND worked tirelessly to ensure that this program continued the state's high rate of childhood immunizations.

When the State Health Department came to us about this proposal to change to the Universal Vaccine Program, we evaluated all of the pros and cons of different options. We had an internal work group that explored all aspects if this program were to be adopted. While we have some concerns with some language in the bill, we considered this a "work in progress" and continued to work with the Health Department in shaping this bill. Our internal work group had conference calls with other states that have adopted programs (Washington and Idaho) similar to this. The differences between these states identified the advantages and disadvantages of each program. Personally, our company would rather the state adopt an actual "claims" process similar to what Washington adopted versus the "assessment" process that Idaho utilizes. However, we were concerned about the added administrative costs associated with the "claims" process which basically ate up much of the anticipated savings. One of our concerns with the assessment process was the effect that this could have on new PPACA requirements for Medical Loss Ratio (MLR) on health insurers. PPACA requires a minimum MLR to limit administrative expenses for health insurers. Our worry was these assessments would have to count as an administrative expense and thus possibly put our company out of compliance with the new Federal law. However, after legal research it is expected that this immunization assessment would not be treated as an administrative expense.

Our internal work group had identified several issues that were addressed and amended in the bill in the Senate.

As I indicated, this bill was truly a "work in progress". We are pleased with the amendments adopted and though there may be some obstacles to face in future and probably many more that no one has

contemplated yet, we urge that you give the bill a Do Pass. It will ensure that children's vaccinations are a priority in our state and at the same time save money for the citizens of our state. Our residents deserve the same benefits allowed in several other states.

I would be willing to answer any questions that the committee may have.

Testimony To The
HOUSE HUMAN SERVICES COMMITTEE
Prepared March 23, 2011, by
Terry Traynor, Assistant Director
North Dakota Association of Counties

REGARDING ENGROSSED SENATE BILL No. 2276

Chairman Weisz and members of the House Human Services Committee, this past fall the delegates from all 53 counties that make up the policy body of the North Dakota Association of Counties unanimously passed a resolution supporting this legislation. Additionally, at the annual meeting of the North Dakota County Commissioners Association – representing the 225 county commissioners statewide – the identical resolution (below) was adopted.

The straightforward, accessible and affordable immunization of children is a critical issue to communities across the State, and we believe that SB2276 will simplify the administration, reduce taxpayer costs, and ultimately improve coverage.

Discontinuing immunization by several county health units four years ago when we moved away from the universal model was unfortunate. The administrative structure that was created to maintain immunization in the rest of the counties was complex and costly.

Counties and county commissioners across the State urge a "do pass" recommendation on engrossed Senate Bill 2276 for the benefit of children and the property taxpayers.

* * * * *

2010-08. Immunization Costs. 2007 Legislative changes to the delivery system for immunizations have increased local health district financial responsibilities and administrative costs. Four county health units no longer participate in the current immunization program due to the administrative burden of billing insurance providers. The 2009 Legislature allowed one-time funding to assure that local public health units do not lose money on the immunization program, but this did not address the long-term administrative costs of the current structure and procedures. This Association supports implementation of the interim study recommendations that would reduce both State and county administrative costs for the delivery of this critical service.

BIO
BIOTECHNOLOGY
INDUSTRY ORGANIZATION

Statement Opposing S.B. 2276

The Biotechnology Industry Organization (BIO) respectfully submits the following statement in opposition to the universal vaccine purchase program set forth in Senate Bill 2276. While we recognize that the state is seeking options to increase the administrative ease of vaccine administration, we believe that the proposed program would have exactly the opposite effect: creating a large state-run bureaucracy established for the sole purpose of purchasing and distributing vaccines. Further, the program stands to jeopardize the nation-leading vaccination rates North Dakota already enjoys, decrease the State's attractiveness for biotechnology investment, and potentially places the State's existing contract for vaccines with the U.S. Centers for Disease Control (CDC) in jeopardy. It is for all these reasons that we believe the Committee should reject S.B. 2276.

BIO is a national trade organization, based in Washington, D.C., representing more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in research and development of healthcare, agricultural, industrial and environmental biotechnology products.

Initially, we want to point out that while we recognize that administrative process issues exist with local public health administration and follow-up under the current vaccine program in North Dakota, it is also true that these local public health units account for only about 10% of immunizations given in North Dakota. This bill places in jeopardy a currently-existing immunization program with the third highest immunization rate in the United States in order to deal with billing and administration issues for a very small proportion of the vaccine landscape in the State. Surely there are more narrowly tailored options the state can explore short of a wholesale reorganization of an already very successful program. BIO would be happy to participate in a discussion of these alternative options.

What is more is that a universal purchase program, as envisioned in S.B. 2276, is legally suspect. More specifically, because the Vaccines for Children (VFC) contract that the State has with the CDC to purchase vaccines for certain underinsured individuals has strict prohibitions on the resale of vaccines purchased through the program, the proposed universal purchase option in this bill, with the corresponding insurance company assessment, risks running afoul of North

Legal and Public Health Policy Concerns Regarding

State Use of Private Funds to Buy through the VFC Program

OVERVIEW

Under the Vaccines for Children (VFC) program, created by Section 13631 of Omnibus Budget Reconciliation Act of 1993 (OBRA 93),[1] the Centers for Disease Control and Prevention (CDC) is authorized to contract with vaccine manufacturers to ensure that every state has a sufficient quantity of vaccines to vaccinate specified classes of disadvantaged children—namely: uninsured, Medicaid-eligible or underinsured children,[2] and children of Indian tribes.[3] This program sets forth a laudable goal that the Biotechnology Industry Organization (BIO) fully supports.

Recently, however, several states have attempted to fund the purchase of additional vaccines for already insured children through the federal VFC contract by using funds provided by insurance companies or other private entities. While this may initially seem to be attractive to states for various reasons, these programs violate the stated purpose and intent of the VFC program; ultimately are likely to cost the programs and the states more money; and may also constitute a violation of federal contracting law. More specifically, using private funds in this manner could:

- Lead to an increase in a state's administrative costs for its immunization programs;
- Serve as a de-facto subsidy to private insurers and health plans;
- Represent a misinterpretation of the standard VFC contract by inappropriately using the optional purchase contract clause;
- Distort both the state and national vaccine marketplace significantly enough over the long-term to cause an adverse economic impact on the states' ability to effectively maximize their immunization funds; and
- Would be unnecessary as these programs will become obsolete in light of the health insurance expansion and vaccine coverage provisions included as part of the Affordable Care Act of 2010 (ACA).

Initially, one of the more relevant upcoming health system changes under the ACA will render these programs unnecessary. Specifically, pursuant to the terms of the ACA, by 2014 most, if not all, private insurers will be required to cover all vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP) at first-dollar for individuals of all ages. Given that immunizations will be available free of charge to nearly every citizen, there is no reason to believe that a state setting up a program to buy vaccines from the federal contract will make any difference whatsoever in state immunization rates.

Over the next few years children and adolescents who are uninsured or *under*insured are expected to shift into health plans providing first-dollar coverage for vaccines or into new state exchanges when they become available. In the interim, programs buying off of the VFC contract by using insurance pools should be discontinued, or at least strongly discouraged, as they represent an unnecessary subsidy to private insurers and a shift in the national vaccine marketplace that may negatively impact future vaccine supply and private investment. Additionally, and as importantly, these programs may conflict with several federal contracting standards.

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[1] Pub. L. No. 103-66, § 13631, 107 Stat. 312, 636-45 (codified at 42 U.S.C. § 1396s).

[2] This category includes children immunized with qualified vaccine in Federally-qualified health centers or rural health centers who are not insured with respect to the vaccine. 42 U.S.C. § 1396s(b)(2)(A)(iii).

[3] 42 U.S.C. § 1396s(b)(2) (collectively "VFC-eligible children").

distribution of such vaccine is also prohibited, except where such vaccine is administered in the context of Grantee immunization program activities.[12]

The term "sale" has been defined in a simple sense as "[t]he transfer of property or title for a price."[13] This term includes situations where product is paid for or "covered" by a third party such as the private vaccine pooling arrangements contemplated by some of the states.[14] It is the essence of these state insurance funding proposals: an insurance company pays the state to purchase vaccine at a discounted price for the beneficiaries of the state or insurance company immunization program that the company (or the state) otherwise would have had to negotiate directly with the manufacturer.[15]

3) Private Funding Subsidizes Health Plans and May Impact Future Vaccine Supply

Over the years, Federal agencies that procure these products have witnessed many—often creative—attempts by third parties to improperly access Federal contracts for drugs and biologics. Responses to these attempts have been swift and severe[16] because such attempts undermine the government's basic goals when contracting for supplies.

First, these attempts have been viewed in the past by the government and policymakers as potentially undermining the government's ability to obtain favorable terms and conditions for its procurements. Second, these attempts to improperly access a Federal contract have been viewed as eroding the government's ability to maintain sources of supply that are willing to contract with the government. As a result, they ultimately threaten the availability of necessary products for the government's beneficiaries and programs.

As such, contract language prohibiting resale is a standard term in the government's multiple award contracts such as the CDC's VFC contracts. One stark example of this type of language can be found in Federal Supply Schedule (FSS) contracts administered by the General Services Administration and the Department of Veterans Affairs, which place a clear resale limitation on FSS contract users.[17] Just as clearly, CDC states that products obtained from VFC contracts cannot be sold or given away. Simply put, we believe the sale of vaccine bought under the VFC contract is unauthorized and undermines the CDC's ability to administer the VFC program, which inhibits its goal to provide necessary vaccine to VFC-eligible children.

These strict limits also are of critical importance in terms of maintaining adequate supply of vaccine for children in the specified classes set forth in the VFC statute. By the terms of the VFC contract, vaccine manufacturers must honor orders from state purchasers: "[State optional] orders shall not be subject to refusal by the manufacturers."[18] To permit a dramatic increase in inappropriate or unauthorized

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[12] CDC VFC Solicitation No. 2010-N-11873 (Non-Flu), § C.17, Restrictions on Use of Vaccines (emphasis added).

[13] Black's Law Dictionary (9th ed. 2009).

[14] *See, e.g.*, Dep't of Veterans Affairs, Office of Gen. Counsel, "Dear Manufacturer of Covered Drugs Letter" (Oct. 14, 2004) (TRICARE Retail Pharmacy rebates); 10 U.S.C. § 1074g(f) (same); 32 C.F.R. § 199.21(q) (same).

[15] The VFC statute was never intended to replace the existing ability of states to negotiate contracts directly with manufacturers to obtain vaccine for non-VFC children: OBRA 93 was "not intend[ed] to limit [a] State's current ability to negotiate independently for vaccine purchasers, if they do not elect this option."). H.R. Rep. No. 103-111, at 230 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 557.

[16] *See, e.g.*, Dep't of Veterans Affairs, Nat'l Acquisition Ctr., "Dear Contractor Letter" (Oct. 1, 1999) (discussing improper access of Federal Supply Schedule prices by certain Indian tribes).

[17] *See, e.g.*, GSA Order 4800.2F ¶ 7(d)(5) (2009) ("Authorization to use GSA sources of supply under the authority cited in this paragraph does not include purchases for resale unless the contract, grant, cooperative agreement, or funding agreement authorizes such activity.").

[18] CDC VFC Solicitation No. 2010-N-11860, § B; CDC VFC Solicitation No. 2010-N-11873, § B.1.

"assessment" programs violate the intent and spirit of the law and represent flawed public health policy. Taking into account the planned changes to the health system over the next few years, these programs are unnecessary and will serve principally to create another state-run bureaucracy while adding significantly to a state's administrative cost burden without immunizing more children.

* * * *

Mr. Chairman and members of the House Human Services Committee:

I am writing to you concerning Senate Bill 2276. I am the CEO of one of North Dakota's leading biotechnology companies, NovaDigm Therapeutics, based in Grand Forks. Our company is developing vaccines against Staph aureus (including antibiotic-resistant MRSA types) and Candida, two leading hospital-acquired infections. We are currently conducting our first clinical trial at Cetero (formerly known as PRACS), a clinical research organization based in Fargo. This trial is the first vaccine clinical trial conducted by a North Dakota-based company. We have raised $18 million in venture capital funding and have a further $17 million in grants from the Department of Defense and the National Institutes of Health. I have also been active in the vaccine industry for 20 years and was at Merck Vaccines from 1991-2000 when I was quite involved in several policy issues including vaccine funding.

North Dakota has a growing number of small biotechnology firms that are developing vaccines. In addition to NovaDigm, there is Aldevron and Altravax in Fargo and Avianax in Grand Forks. These companies depend on a strong and profitable vaccine industry in order to attract early-stage funding from investors. The established vaccine industry's profitability depends largely on "tiered pricing", that is the ability to price vaccines at different prices based on ability to pay. Vaccine companies offer the lowest price to the federal government in the Vaccines for Children program that allows states to purchase vaccines at a reduced price for children who are not covered by private insurance. This amounts to a sharing of costs by the vaccine industry and government to ensure high immunization rates for children. The impact of S.B. 2276 would be to shift more costs of immunization to the vaccine industry (through lower prices and resulting lower profits). Removing profits from vaccine companies in the short-term is not without long-term consequences, since this would negatively impact future R&D spending as well as investments in early-stage vaccine companies like NovaDigm.

The vaccine industry is vital to our nation but also fragile. In 1967, there were 26 vaccine manufacturers in the U.S. market; by 2002 there were 12. Today there are only five companies that provide vaccines for US children. It is important to not let short-term savings further erode the strength of this industry.

Senate Bill 2276 also risks upending a vaccine delivery system in North Dakota that should be the envy of nearly all states. North Dakota has very high childhood immunization rates, especially for the introduction of new vaccines. According to the US Center for Disease Control's National Immunization Survey for 2009, North Dakota ranked #1 (of the 50 states) for hepatitis A vaccine immunization rates and #2 for rotavirus vaccine, two of the more recently recommended routine vaccines for children. The state also ranked #2 for varicella vaccine, #3 for measles-mumps-rubella, #4 for hepatitis B and #4 pneumococcal conjugate vaccines. North Dakota can't do much better than it is at delivering vaccines to kids, so there is no need for a drastic shift to the universal purchase of vaccines as proposed in S.B. 2276.

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#9

NORTH DAKOTA
CHAMBER of COMMERCE

Testimony of Jeb Oehlke
North Dakota Chamber of Commerce
SB 2276
March 23, 2011

Chairman Weisz and members of the House Human Services Committee, my name is Jeb Oehlke. I represent the North Dakota Chamber of Commerce, the principal business advocacy group in North Dakota. Our organization is an economic and geographical cross section of North Dakota's private sector and also includes trade associations, local chambers of commerce, economic development organizations, convention and visitors bureaus, and public sector organizations. I am here today to stand in opposition to SB 2276.

One of our guiding principles as an organization is to support the free market system. When laws, such as the one proposed in SB 2276 are passed it creates an obstacle to the market being able to regulate itself properly and in the long term may result in unwanted outcomes. In the case of this bill, North Dakota is a small state and if just our state were to adopt this policy of removing the private market for vaccines it might not make much of a difference in the grand scheme of things. However, when more and more states adopt this practice the net benefit we hope to realize will be wiped away because there will no longer be an incentive for the vaccine makers to negotiate a lower contract price to benefit programs such as Vaccines for Children.

Additionally, by eliminating the private vaccine market this bill sends a negative message to the biotechnology companies we currently have and are otherwise hoping to attract to our state. Essentially we are telling them that we want them to invest in our state and create jobs here, but after they do that there may not be a private market for their products.

Thank you for the opportunity to testify this morning. I will do my best to answer questions from the committee.

AN ACT

To require the Department of Public Health (the "department") to implement a provider choice system for certain vaccines.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____:

SECTION 1. Section ___, is amended by adding section ___ to read as follows:

PROVIDER CHOICE SYSTEM. (1) The department shall implement a provider choice system for the vaccines for children program operated by the department under authority of 42 U.S.C. Section 1396s.(NOTE: This section may have to be tailored for each state. To include any state statutes as well that give the DoH authority to administer immunization programs).

(2) The department shall ensure that eligible health care providers participating in the vaccines for children program, or

any other immunization program for children, adolescent or adults administered through the state using federal or state funds, have the right to select any licensed vaccine, including combination vaccines and any dosage forms that have in effect a recommendation from the federal Advisory Committee on Immunization Practices

(3) This section does not apply in the event of a disaster or public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

SECTION 2. The Department of Public Health shall implement all or part of the provider choice system as soon as it is determined to be feasible, provided, however, that the department shall complete full implementation of the system not later than DATE.

SECTION 3. Except as provided by this Act, this Act takes effect immediately upon becoming law.

Dept. of Health 4-19-11

#1

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 8, line 8, insert "1." before "There"

Page 8, after line 12, insert:

2. The Department will use the funding to purchase no more than forty percent of the vaccines purchased under this chapter from the Centers for Disease Control and Prevention pediatric vaccine federal purchasing contract.

Renumber accordingly

Insured Children Cost Savings Scenarios

Vaccine Group Purchasing Program

SB 2276

Federal Contract	Private Rate	Annual Cost Savings	Federal Rate Vaccine Cost	Private Rate Vaccine Cost	Total Annual Vaccine Cost
0%	100%	$0.00	$0.00	$ 11,576,326.35	$ 11,576,326.35
10%	90%	279,583.95	878,048.68	10,418,693.72	11,296,742.40
20%	80%	559,167.90	1,756,097.37	9,261,061.08	11,017,158.45
30%	70%	838,751.85	2,634,146.05	8,103,428.45	10,737,574.50
40%	60%	1,118,335.80	3,512,194.74	6,945,795.81	10,457,990.55
50%	50%	1,397,919.76	4,390,243.42	5,788,163.18	10,178,406.60
60%	40%	1,677,503.71	5,268,292.10	4,630,530.54	9,898,822.64
70%	30%	1,957,087.66	6,146,340.79	3,472,897.91	9,619,238.70
80%	20%	2,236,671.61	7,024,389.47	2,315,265.27	9,339,654.74
90%	10%	2,516,255.56	7,902,438.16	1,157,632.64	9,060,070.80
100%	0%	2,795,839.51	8,780,486.84	0.00	8,780,486.84

Note: Based on 2010 NDIIS Doses Administered to Insured Children
Rates Effective: April 1, 2011

April 19, 2011

11-19-11

#2

[redacted]ines	2010 NDIIS Doses Adm[redacted] to Insured Children Using Federal Pricing (April 1, 2011)										[redacted]
	Cost/Dose	<1 Year	Cost <1	1-2 Year	[redacted]1-2	3-6 Year	Cost 3-6	7-18 Years	Cost 7-18	Total	Tota[redacted]t
Chickenpox (varicella)	$69.73	9	$627.57	4764	$332,193.72	3164	$220,625.72	3611	$251,795.03	11548	$805,242.04
DTaP (diphtheria, tetanus, pertussis)	$14.85	144	$2,138.40	1452	$21,562.20	640	$9,504.00	64	$950.40	2300	$34,155.00
DTaP-HBV-IPV (Pediarix)	$51.15	496	$25,370.40	473	$24,193.95	17	$869.55	5	$255.75	991	$50,689.65
DTaP-Hib-IPV (Pentacel)	$52.55	9361	$491,920.55	8908	$468,115.40	250	$13,137.50	11	$578.05	18530	$973,751.50
Hepatitis A	$14.25	7	$99.75	9295	$132,453.75	2309	$32,903.25	7963	$113,472.75	19574	$278,929.50
Hepatitis B	$10.35	12607	$130,482.45	3831	$39,650.85	173	$1,790.55	313	$3,239.55	16924	$175,163.40
Hib (Haemophilus influenzae type B)	$11.64	601	$6,995.64	2126	$24,746.64	1804	$20,998.56	9	$104.76	4540	$52,845.60
HPV4 (human papillomavirus)	$108.72	2	$217.44	3	$326.16	2	$217.44	6847	$744,405.84	6854	$745,166.88
Influenza (TIV)	varies	2787	$32,552.16	7991	$93,334.88	4634	$43,096.20	11664	$108,475.20	27076	$277,458.44
Influenza (Live virus)	$15.70	13	$204.10	1191	$18,698.70	6738	$105,786.60	10387	$163,075.90	18329	$287,765.30
IPV (polio)	$11.97	89	$1,065.33	188	$2,250.36	492	$5,889.24	159	$1,903.23	928	$11,108.16
MCV (meningococcal)	$82.12	3	$246.36	14	$1,149.68	9	$739.08	12000	$985,440.00	12026	$987,575.12
MMR (measles, mumps, rubella)	$18.99	5	$94.95	4754	$90,278.46	3281	$62,306.19	229	$4,348.71	8269	$157,028.31
MMRV (MMR-Varicella)	$85.72	2	$171.44	271	$23,230.12	1898	$162,696.56	40	$3,428.80	2211	$189,526.92
PCV13 (Pneumococcal)	$97.21	9930	$965,295.30	13835	$1,344,900.35	3434	$333,819.14	19	$1,846.99	27218	$2,645,861.78
PPV23 (Pneumococcal)	$34.54	4	$138.16	8	$276.32	11	$379.94	64	$2,210.56	87	$3,004.98
Rotavirus (3 dose)	$59.76	8612	$514,653.12	4559	$272,445.84	4	$239.04	10	$597.60	13185	$787,935.60
Rotavirus (2 dose)	$89.25	819	$73,095.75	362	$32,308.50	0	$0.00	0	$0.00	1181	$105,404.25
TD (tetanus, diphtheria)	$16.50	10	$165.00	0	$0.00	0	$0.00	100	$1,650.00	110	$1,815.00
Tdap (tetanus, diphtheria, pertussis)	$29.59	7	$207.13	4	$118.36	2	$59.18	7086	$209,674.74	7099	$210,059.41
Total											**$8,780,486.84**
	2010 NDIIS Doses Admistered to Insured Children Using Private Pricing (April 1, 2011)										
Vaccines	Cost/Dose	<1 Year	Cost <1	1-2 Year	Cost 1-2	3-6 Year	Cost 3-6	7-18 Years	Cost 7-18	Total	Total Cost
Chickenpox (varicella)	$83.77	9	$753.93	4764	$399,080.28	3164	$265,048.28	3611	$302,493.47	11548	$967,375.96
DTaP (diphtheria, tetanus, pertussis)	$20.96	144	$3,018.24	1452	$30,433.92	640	$13,414.40	64	$1,341.44	2300	$48,208.00
DTaP-HBV-IPV (Pediarix)	$70.72	496	$35,077.12	473	$33,450.56	17	$1,202.24	5	$353.60	991	$70,083.52
DTaP-Hib-IPV (Pentacel)	$77.48	9361	$725,290.28	8908	$690,191.84	250	$19,370.00	11	$852.28	18530	$1,435,704.40
Hepatitis A	$28.74	7	$201.18	9295	$267,138.30	2309	$66,360.66	7963	$228,856.62	19574	$562,556.76
Hepatitis B	$21.37	12607	$269,411.59	3831	$81,868.47	173	$3,697.01	313	$6,688.81	16924	$361,665.88
Hib (Haemophilus influenzae type B)	$22.77	601	$13,684.77	2126	$48,409.02	1804	$41,077.08	9	$204.93	4540	$103,375.80
HPV4 (human papillomavirus)	$130.27	2	$260.54	3	$390.81	2	$260.54	6847	$891,958.69	6854	$892,870.58
Influenza (TIV)	varies	2787	$36,676.92	7991	$105,161.56	4634	$51,761.78	11664	$130,286.88	27076	$323,887.14
Influenza (Live virus)	$19.70	13	$256.10	1191	$23,462.70	6738	$132,738.60	10387	$204,623.90	18329	$361,081.30
IPV (polio)	$25.43	89	$2,263.27	188	$4,780.84	492	$12,511.56	159	$4,043.37	928	$23,599.04
MCV (meningococcal)	$106.49	3	$319.47	14	$1,490.86	9	$958.41	12000	$1,277,880.00	12026	$1,280,648.74
MMR (measles, mumps, rubella)	$50.16	5	$250.80	4754	$238,460.64	3281	$164,574.96	229	$11,486.64	8269	$414,773.04
MMRV (MMR-Varicella)	$133.93	2	$267.86	271	$36,295.03	1898	$254,199.14	40	$5,357.20	2211	$296,119.23
PCV13 (Pneumococcal)	$114.75	9930	$1,139,467.50	13835	$1,587,566.25	3434	$394,051.50	19	$2,180.25	27218	$3,123,265.50
PPV23 (Pneumococcal)	$42.58	4	$170.32	8	$340.64	11	$468.38	64	$2,725.12	87	$3,704.46
Rotavirus (3 dose)	$69.59	8612	$599,309.08	4559	$317,260.81	4	$278.36	10	$695.90	13185	$917,544.15
Rotavirus (2 dose)	$102.50	819	$83,947.50	362	$37,105.00	0	$0.00	0	$0.00	1181	$121,052.50
TD (tetanus, diphtheria)	$20.39	10	$203.90	0	$0.00	0	$0.00	100	$2,039.00	110	$2,242.90
Tdap (tetanus, diphtheria, pertussis)	$37.55	7	$262.85	4	$150.20	2	$75.10	7086	$266,079.30	7099	$266,567.45
Total											**$11,576,326.35**
Cost Savings	**$2,795,839.51**										
BCBSND Share (Federal Rate)*	**78.40%**		**$6,883,901.68**								
Other Share (Federal Rate)	**21.60%**		**$1,896,585.16**								
Notes:											
2 doses of MCV recommended in October 2010. 7441 administered in 2010. Estimated need for booster dose.	Supplemental dose of PCV13 in 2010. Will continue in 2011										
*NDIIS LPHU Billing Data											

[redacted]cines	2010 NDIIS Doses [redacted]ered to Insured Children Using MMCAP Pricing (April 1, 2011)										[redacted]otal Cost
	Cost/Dose	<1 Year	Cost <1	1-2 Year	Cost 1-2	3-6 Year	Cost 3-6	7-18 Years	Cost 7-18	Total	
Chickenpox (varicella)	$83.69	9	$753.21	4764	$398,699.16	3164	$264,795.16	3611	$302,204.59	11548	$966,452.12
DTaP (diphtheria, tetanus, pertussis)	$17.08	144	$2,459.52	1452	$24,800.16	640	$10,931.20	64	$1,093.12	2300	$39,284.00
DTaP-HBV-IPV (Pediarix)	$61.75	496	$30,628.00	473	$29,207.75	17	$1,049.75	5	$308.75	991	$61,194.25
DTaP-Hib-IPV (Pentacel)	$77.48	9361	$725,290.28	8908	$690,191.84	250	$19,370.00	11	$852.28	18530	$1,435,704.40
Hepatitis A	$16.43	7	$115.01	9295	$152,716.85	2309	$37,936.87	7963	$130,832.09	19574	$321,600.82
Hepatitis B	$12.52	12607	$157,839.64	3831	$47,964.12	173	$2,165.96	313	$3,918.76	16924	$211,888.48
Hib (Haemophilus influenzae type B)	$22.75	601	$13,672.75	2126	$48,366.50	1804	$41,041.00	9	$204.75	4540	$103,285.00
HPV4 (human papillomavirus)	$125.09	2	$250.18	3	$375.27	2	$250.18	6847	$856,491.23	6854	$857,366.86
Influenza (TIV)	varies	2787	$34,503.06	7991	$98,928.58	4634	$47,452.16	11664	$119,439.36	27076	$300,323.16
Influenza (Live virus)	$17.70	13	$230.10	1191	$21,080.70	6738	$119,262.60	10387	$183,849.90	18329	$324,423.30
IPV (polio)	$25.43	89	$2,263.27	188	$4,780.84	492	$12,511.56	159	$4,043.37	928	$23,599.04
MCV (meningococcal)	$106.49	3	$319.47	14	$1,490.86	9	$958.41	12000	$1,277,880.00	12026	$1,280,648.74
MMR (measles, mumps, rubella)	$50.11	5	$250.55	4754	$238,222.94	3281	$164,410.91	229	$11,475.19	8269	$414,359.59
MMRV (MMR-Varicella)	$133.80	2	$267.60	271	$36,259.80	1898	$253,952.40	40	$5,352.00	2211	$295,831.80
PCV13 (Pneumococcal)	$114.15	9930	$1,133,509.50	13835	$1,579,265.25	3434	$391,991.10	19	$2,168.85	27218	$3,106,934.70
PPV23 (Pneumococcal)	$54.62	4	$218.48	8	$436.96	11	$600.82	64	$3,495.68	87	$4,751.94
Rotavirus (3 dose)	$69.52	8612	$598,706.24	4559	$316,941.68	4	$278.08	10	$695.20	13185	$916,621.20
Rotavirus (2 dose)	$101.48	819	$83,112.12	362	$36,735.76	0	$0.00	0	$0.00	1181	$119,847.88
TD (tetanus, diphtheria)	$20.39	10	$203.90	0	$0.00	0	$0.00	100	$2,039.00	110	$2,242.90
Tdap (tetanus, diphtheria, pertussis)	$33.97	7	$237.79	4	$135.88	2	$67.94	7086	$240,711.42	7099	$241,153.03
Total											$11,027,513.21
	2010 NDIIS Doses Admistered to Insured Children Using Private Pricing (April 1, 2011)										
Vaccines	Cost/Dose	<1 Year	Cost <1	1-2 Year	Cost 1-2	3-6 Year	Cost 3-6	7-18 Years	Cost 7-18	Total	Total Cost
Chickenpox (varicella)	$83.77	9	$753.93	4764	$399,080.28	3164	$265,048.28	3611	$302,493.47	11548	$967,375.96
DTaP (diphtheria, tetanus, pertussis)	$20.96	144	$3,018.24	1452	$30,433.92	640	$13,414.40	64	$1,341.44	2300	$48,208.00
DTaP-HBV-IPV (Pediarix)	$70.72	496	$35,077.12	473	$33,450.56	17	$1,202.24	5	$353.60	991	$70,083.52
DTaP-Hib-IPV (Pentacel)	$77.48	9361	$725,290.28	8908	$690,191.84	250	$19,370.00	11	$852.28	18530	$1,435,704.40
Hepatitis A	$28.74	7	$201.18	9295	$267,138.30	2309	$66,360.66	7963	$228,856.62	19574	$562,556.76
Hepatitis B	$21.37	12607	$269,411.59	3831	$81,868.47	173	$3,697.01	313	$6,688.81	16924	$361,665.88
Hib (Haemophilus influenzae type B)	$22.77	601	$13,684.77	2126	$48,409.02	1804	$41,077.08	9	$204.93	4540	$103,375.80
HPV4 (human papillomavirus)	$130.27	2	$260.54	3	$390.81	2	$260.54	6847	$891,958.69	6854	$892,870.58
Influenza (TIV)	varies	2787	$36,676.92	7991	$105,161.56	4634	$51,761.78	11664	$130,286.88	27076	$323,887.14
Influenza (Live virus)	$19.70	13	$256.10	1191	$23,462.70	6738	$132,738.60	10387	$204,623.90	18329	$361,081.30
IPV (polio)	$25.43	89	$2,263.27	188	$4,780.84	492	$12,511.56	159	$4,043.37	928	$23,599.04
MCV (meningococcal)	$106.49	3	$319.47	14	$1,490.86	9	$958.41	12000	$1,277,880.00	12026	$1,280,648.74
MMR (measles, mumps, rubella)	$50.16	5	$250.80	4754	$238,460.64	3281	$164,574.96	229	$11,486.64	8269	$414,773.04
MMRV (MMR-Varicella)	$133.93	2	$267.86	271	$36,295.03	1898	$254,199.14	40	$5,357.20	2211	$296,119.23
PCV13 (Pneumococcal)	$114.75	9930	$1,139,467.50	13835	$1,587,566.25	3434	$394,051.50	19	$2,180.25	27218	$3,123,265.50
PPV23 (Pneumococcal)	$42.58	4	$170.32	8	$340.64	11	$468.38	64	$2,725.12	87	$3,704.46
Rotavirus (3 dose)	$69.59	8612	$599,309.08	4559	$317,260.81	4	$278.36	10	$695.90	13185	$917,544.15
Rotavirus (2 dose)	$102.50	819	$83,947.50	362	$37,105.00	0	$0.00	0	$0.00	1181	$121,052.50
TD (tetanus, diphtheria)	$20.39	10	$203.90	0	$0.00	0	$0.00	100	$2,039.00	110	$2,242.90
Tdap (tetanus, diphtheria, pertussis)	$37.55	7	$262.85	4	$150.20	2	$75.10	7086	$266,079.30	7099	$266,567.45
Total											$11,576,326.35
Cost Savings	$548,813.14										
BCBSND Share (Federal Rate)*	78.40%		$8,645,570.36								
Other Share (Federal Rate)	21.60%		$2,381,942.85								
2 doses of MCV recommended in October 2010. 7441 administered in 2010. Estimated need for booster dose.	Supplemental dose of PCV13 in 2010. Will continue in 2011										
*NDIIS LPHU Billing Data											
				Prepared by Molly Sander 4/19/2011							

Immuniza[illegible] Program

Cost to Vaccinate One Child Through 18 Years of Age

Rates as of April 1, 2011

Age		Number	Federal Rate	Total	MMCAP Rate	Total	Private Rate	Total
<1	Vaccine Type	of Doses*	Per Dose	Federal Rate	Per Dose	MMCAP Rate	Per Dose	Private Rate
	Hepatitis B	3	$10.50	$31.50	$12.52	$37.56	$21.37	$64.11
	Pentacel (DTaP-IPV/Hib)	3	$52.55	$157.65	$77.48	$232.44	$77.48	$232.44
	Prevnar13 (pneumococcal)	3	$97.21	$291.63	$114.15	$342.45	$114.75	$344.25
	Rotavirus	3	$59.76	$179.28	$69.52	$208.56	$69.59	$208.77
	Influenza	2	$11.68	$23.36	$12.38	$24.76	$13.16	$26.32
	Total	**14**		**$683.42**		**$845.77**		**$875.89**
1-2								
	Pentacel (DTaP-IPV/Hib)	1	$52.55	$52.55	$77.48	$77.48	$77.48	$77.48
	Prevnar13 (pneumococcal)	1	$97.21	$97.21	$114.15	$114.15	$114.75	$114.75
	MMR (measles, mumps, rubella)	1	$18.99	$18.99	$50.11	$50.11	$50.16	$50.16
	Varicella (chickenpox)	1	$69.73	$69.73	$83.69	$83.69	$83.77	$83.77
	Hepatitis A	2	$14.25	$28.50	$16.43	$32.86	$28.74	$57.48
	Influenza	2	$11.68	$23.36	$12.38	$24.76	$13.16	$26.32
	Total	**8**		**$290.34**		**$383.05**		**$409.96**
3-6								
	Kinrix (DTaP-IPV)	1	$34.25	$34.25	$40.70	$40.70	$48.00	$48.00
	MMR (measles, mumps, rubella)	1	$18.99	$18.99	$50.11	$50.11	$50.16	$50.16
	Varicella (chickenpox)	1	$69.73	$69.73	$83.69	$83.69	$83.77	$83.77
	Influenza***	4	$12.50	$50.00	$13.97	$55.88	$15.44	$61.74
	Total	**7**		**$172.97**		**$230.38**		**$243.67**
7-18								
	Tdap (tetanus, diphtheria, pertussis)	1	$29.59	$29.59	$33.97	$33.97	$37.55	$37.55
	HPV (human papillomavirus)**	3	$108.72	$326.16	$125.09	$375.27	$130.27	$390.81
	Menactra (meningococcal)	2	$82.12	$164.24	$106.49	$212.98	$106.49	$212.98
	Influenza***	12	$12.50	$150.00	$13.97	$167.64	$15.44	$185.22
	Total	**18**		**$669.99**		**$789.86**		**$826.56**
			Total Overall Cost	**$1,816.72**		**$2,249.06**		**$2,356.08**

SAVINGS FROM PRIVATE RATE:	**$539.36**	**$107.02**	**$0.00**

* Number of doses based on 100% immunization rate.

** Includes females and males

***Cost/dose is average of injectable and nasal cost

This schedule doesn't include catch-up doses.

Prepared by Molly Sander 4/19/2011

#3

11.0713.03003
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 21, 2011

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; to provide for a legislative management study; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of

immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new section to chapter 23-01 of the North Dakota Century Code is created and enacted as follows:

Immunization program - Provider choice - Purchasing.

1. As used in this section:

   a. "Department" means the state department of health.

   b. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

   c. "North Dakota immunization advisory committee" means the group of private health care providers, local public health units, department staff, and other applicable individuals which makes immunization and vaccine selection recommendations to the North Dakota immunization program.

   d. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

   e. "Program-eligible child" means any child, who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

   f. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee.

   g. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

   h. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396s].

2. As part of the North Dakota immunization program:

   a. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist

attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

b. The department shall establish a program through which the department orders vaccines through the federal government.

(1) The department shall supply all providers with the ordered vaccines. A provider that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(2) A provider that receives vaccines under this subdivision may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this program first through participation in the vaccines for children program and the federal section 317 immunization grant program and then through assessments collected from insurers and third-party administrators. The department shall assess insurers and third-party administrators based upon the percentage of premium paid in this state.

(4) In addition to the vaccines supplied to providers under the vaccines for children program and the federal section 317 immunization grant program under the federal vaccine purchasing contract, no more than nine and one-half percent of the remaining vaccines the department supplies under this subdivision may be purchased under the federal vaccine purchasing contract.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-12 interim, the legislative management shall consider studying the North Dakota immunization program. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective October 1, 2011."

Renumber accordingly

#4

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 4, delete "and"; after "penalty" insert "; and to provide an effective date"

Page 3, after line 29, insert

"2. The department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered through the state using federal or state funds, may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This subsection does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency."

Page 3, line 30, replace "2." with "3."

Page 4, line 1, replace "3." with "4."

Page 8, line 8, insert "1." before "There"

Page 8, after line 12, insert:

"2. The department will use moneys from the North Dakota vaccine fund to purchase no more than ten percent of the total vaccine doses ordered in North Dakota from the centers for disease control and prevention vaccine federal purchasing contract."

Page 8, replace lines 26 through 28 with:

"2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section."

Page 9, after line 4, insert:

"SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-12 interim, the legislative management shall consider studying the North

Dakota immunization program. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. EFFECTIVE DATE. Section 2 of this Act becomes effective on October 1, 2011."

Renumber accordingly

11.0713.03004
Title.

Prepared by the Legislative Council staff for #5
Senator J. Lee
April 22, 2011

PROPOSED AMENDMENTS TO REENGROSSED SENATE BILL NO. 2276

That the House recede from its amendments as printed on pages 1022-1024 of the Senate Journal and pages 1135-1137 of the House Journal and that Reengrossed Senate Bill No. 2276 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new chapter to title 23 of the North Dakota Century Code, relating to the North Dakota immunization program; to amend and reenact section 23-01-05.3 of the North Dakota Century Code, relating to reporting immunization data; to provide for a legislative management study; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-01-05.3 of the North Dakota Century Code is amended and reenacted as follows:

23-01-05.3. Immunization data.

1. The state department of health may establish an immunization information system and may require the childhood immunizations specified in subsection 1 of section 23-07-17.1 and other information be reported to the department. The state department of health may only require the reporting of childhood immunizations and other data upon completion of the immunization information reporting system. A health care provider who administers a childhood immunization shall report the patient's identifying information, the immunization that is administered, and other required information to the department. The report must be submitted using electronic media, and must contain the data content and use the format and codes specified by the department.

2. If a health care provider fails to submit an immunization report required under this section within four weeks of vaccination:

   a. That health care provider may not order or receive any vaccine from the North Dakota immunization program until that provider submits all reports required under this section.

   b. The state department of health shall make a report to that health care provider's occupational licensing entity outlining that provider's failure to comply with the reporting requirements under this section.

3. Notwithstanding any other provision of law, a health care provider, elementary or secondary school, early childhood facility, public or private postsecondary educational institution, city or county board of health, district health unit, and the state health officer may exchange immunization data in any manner with one another. Immunization data that may be exchanged under this section is limited to the date and type of

immunization administered to a patient and may be exchanged regardless of the date of the immunization.

SECTION 2. A new chapter to title 23 of the North Dakota Century Code is created and enacted as follows:

Definitions.

As used in this chapter:

1. "Department" means the state department of health.

2. "Health insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.

   a. Health insurance coverage does not include any one or more of the following:

      (1) Coverage only for accident or disability income insurance, or any combination of the two;

      (2) Coverage issued as a supplement to liability insurance;

      (3) Liability insurance, including general liability insurance and automobile liability insurance;

      (4) Workers' compensation coverage or insurance;

      (5) Automobile medical payment insurance;

      (6) Credit-only insurance;

      (7) Coverage for onsite medical clinics; and

      (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

   b. Health insurance coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

      (1) Limited scope dental or vision benefits;

      (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

      (3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan.

3. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, and health maintenance organization and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

4. "North Dakota immunization program" means the program administered by the department to provide vaccinations to North Dakota children consistent with state and federal law.

5. "Program-eligible child" means any child who is under nineteen years of age, whose custodial parent or legal guardian resides in this state, who receives vaccinations from a North Dakota provider, and who is not eligible for the vaccines for children program.

6. "Third-party administrator" means a person that administers payments for health care services on behalf of a client health plan in exchange for an administrative fee.

7. "Vaccine" means any vaccine recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

8. "Vaccines for children program" is a federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the Social Security Act [42 U.S.C. 1396S].

Immunization program - Provider choice.

As part of the North Dakota immunization program the department shall implement a provider choice system as part of the state's implementation of the vaccines for children program. This provider choice system must provide a health care provider participating in the state's vaccines for children program or in any other immunization program for children, adolescents, or adults which is administered

through the state using federal or state funds may select any licensed vaccine, including combination vaccines, and any dosage forms that have in effect a recommendation from the federal advisory committee on immunization practices. This section does not apply in the event of a disaster, public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency.

Immunization program - Vaccine ordering program - Funding - Limitations.

1. As part of the North Dakota immunization program the department shall establish a program through which the department orders vaccines through the federal government.

   a. The department shall supply all providers with the ordered vaccines. A provider that receives vaccines under this vaccine ordering program shall administer the vaccines to program-eligible children.

   b. A provider that receives vaccines under this vaccine ordering program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

2. The department shall fund this vaccine ordering program first through participation in the vaccines for children program and the federal section 317 immunization grant program and then through assessments collected from insurers and third-party administrators. The department shall assess insurers and third-party administrators based upon the percentage of premium paid in this state.

3. In addition to the vaccines supplied to providers under the vaccines for children program and the federal section 317 immunization grant program under the federal vaccine purchasing contract, no more than ten percent of the remaining vaccines the department supplies under this section may be purchased under the federal vaccine purchasing contract.

Vaccine ordering program - Assessment.

1. An insurer or third-party administrator shall pay the insurer's or third-party administrator's annual assessment on the dates specified by the department. The department shall establish payment dates that are at least quarterly but which may be more frequent.

2. Within sixty days of the department sending the notice of assessment to the insurer or third-party administrator, that insurer or third-party administrator shall pay the department the assessment.

3. For late or nonpayment of an assessment by an insurer or third-party administrator, the department shall impose interest at the rate of one percent of the unpaid assessment due for each month or fraction of a month during which the assessment remains unpaid, computed from the due date of the assessment to the date paid, excepting the month in which the assessment was required to be paid or the assessment became due. If an insurer's or third-party administrator's assessment remains partly or fully unpaid for more than ninety days from the due date, the department may impose a penalty not to exceed two times the amount of the unpaid assessment. In addition, the department may refer the insurer or

third-party administrator to the insurance commissioner who may use any sanctions available to penalize for nonpayment of the assessment.

4. For good cause, an insurer or third-party administrator may request that the department grant a deferment from all or part of an assessment. The department may defer all or part of the assessment if the department determines the payment of the assessment would place the insurer or third-party administrator in a financially impaired condition, as provided under title 26.1. If all or part of an assessment against an insurer or third-party administrator is deferred, the amount deferred may be assessed against the other insurers and third-party administrators in a manner consistent with the basis for assessment provided under this section. The insurer or third-party administrator receiving the deferment remains liable to the North Dakota vaccine fund for the amount deferred and may be referred to the insurance commissioner who may use any sanctions available.

5. The department shall use all funds received through these assessments for the purposes expressly authorized by this chapter. The department may not use these assessment funds for any purpose that is not expressly authorized under this chapter.

6. If the department provides the health insurers and third-party administrators subject to an assessment under this chapter with notice and the opportunity to comment, for purposes of the assessment under this chapter the department is exempt from the administrative rulemaking requirements of chapter 28-32. An insurer or third-party administrator may appeal an assessment under this chapter in the manner provided under section 28-32-47.

North Dakota vaccine fund.

There is created in the state treasury the North Dakota vaccine fund. Moneys in the North Dakota vaccine fund must be appropriated by the legislative assembly solely for purposes established by this chapter. All interest and earnings of the North Dakota vaccine fund must be retained in the fund. Any entity subject to this assessment is not entitled to a credit for this assessment against tax due under section 26.1-03-17. Administrative costs associated with establishing and operating the North Dakota vaccine fund must be paid out of the fund.

SECTION 3. LEGISLATIVE MANAGEMENT IMMUNIZATION STUDY. During the 2011-12 interim, the legislative management shall consider studying the North Dakota immunization program. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective October 1, 2011."

Renumber accordingly

#6

Lee, Judy E.

From: Olson, Laura J.
Sent: Monday, April 25, 2011 8:51 AM
To: Lee, Judy E.
Cc: Clark, Jennifer S.; Sander, Molly A.
Subject: SB 2276 Amendment Request

Good morning Senator Lee,

After reviewing the amendment to SB 2276 (version 11.0713.03004), we are suggesting an additional change. The added language is from the Senate version 11.0713.03000, with the replacement of "board" with "department" and this provides the department with the ability to use the data which is available for the determination of the assessment.

On Page 4, strike out language as indicated below, and add in the underlined language:

2. The department shall fund this vaccine ordering program first through participation in the vaccines for children program and the federal section 317 immunization grant program and then through assessments collected from insurers and third-party administrators. ~~The department shall assess insurers and third-party administrators based upon the percentage of premium paid in this state.~~ The department will identify methodology and procedures for determining assessments that are fair and equitable for insurers and third-party administrators, including a third-party administrator for a self-insurance plan. The department may assess a subgroup of the insurers and third-party administrators to be assessed based on immunization volume or other factors as approved by the department. The department shall provide for any additional matters necessary for the implementation and administration of the fund.

Thank you for your time and consideration of this change to the amendment. Should you have any questions, please feel free to contact me at 328-4514 or lauraolson@nd.gov.
Laura Olson

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PROtect ND Kids Business Manager
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NORTH DAKOTA
DEPARTMENT of HEALTH

Lee, Judy E.

From: Clark, Jennifer S.
Sent: Wednesday, April 27, 2011 9:58 AM
To: Weisz, Robin L.; Lee, Judy E.; Uglem, Gerald P.
Cc: Sander, Molly A.; Olson, Laura J.
Subject: Proposed language - 2276

#7

All-

Please review and comment on the following language. Language in paragraphs (1) and (3) has been amended and the appropriation clause is new.

I'll sit on this for another 15 minutes, and then have this language put in final form if I have not heard back from you.

b. The department shall establish a program through which the department purchases vaccines through the federal vaccine purchasing contract.

(1) The department shall supply public health units with the purchased vaccines ~~and may assist the public health units with administrative expenses~~. A public health unit that receives vaccines under this subdivision shall administer the vaccines to program-eligible children.

(2) A public health unit that receives vaccines under this purchasing program may not bill an insurer for the cost of the vaccine but may charge an administration fee.

(3) The department shall fund this purchasing program through participation in the vaccines for children program, the federal section 317 immunization grant program, and state funds appropriated for this purpose. If it appears there will be inadequate funds to fund this purchasing program, the department shall petition the emergency commission for a transfer from the state contingency fund. The emergency commission may grant the transfer request, or so much thereof as may be necessary, to fund this purchasing program.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $1,500,000, or so much of the sum as may be necessary, to the state department of health for the purpose of funding the program through which the department purchases vaccines through the federal vaccine purchasing contract, for the biennium beginning July 1, 2011, and ending June 30, 2013.