House Bill 1502
Human Services Committee
January 23rd, 2023

Good afternoon, Chairman Weisz and members of the House Human Services Committee. My name is Kylie Hall. I currently reside in north Fargo in District 45. I feel uniquely qualified to testify on this bill because I have a Master's Degree in Public Health, with an emphasis in the management of infectious diseases. I have spent the last 7.5 years working on vaccine-related projects at North Dakota State University in the Center for Immunization Research and Education, where I am the currently the Operations Director. I would like to make clear that my comments today are not on behalf of North Dakota State University.

I have many concerns about this bill. First, it is important to point out that this bill would remove the ability of a hospital or healthcare facility to require vaccines for their employees, and this is because of the bill's definition of an experimental vaccine.

The definition of experimental vaccine classifies nearly all vaccines as experimental for one or more (subsections a, b, c, or d) reasons. While at first these requirements may seem reasonable, those who understand vaccine clinical trials and history of vaccine safety systems recognize these points as misleading.

We know from decades of vaccine clinical trials and vaccine safety monitoring that if a vaccine is going to cause a side effect, it usually occurs within the first 6-8 weeks after vaccination. Why is that? Because this is when the vaccine is at the highest levels in your body, but also when your immune system is working the hardest to build protection. Vaccine ingredients are quickly eliminated from your body, and all that remains is your immune response. While it is certainly possible to study vaccines for significant periods of time following the clinical trial, it is unnecessary, and we have other safety monitoring systems in place that can watch for any unforeseen side effects, either short term or long term. It would also be incredibly expensive for pharmaceutical companies to conduct longer trials, as conducting clinical trials already costs billions of dollars. Lastly, requiring a one-year follow-up period could delay the timeline for a life-saving vaccine to be approved.

Liability is also mentioned in this section. Questions about vaccine manufacturer liability come up regularly, and similar language is weaved into other bills being brought before the legislature this session. I understand how hearing that vaccine manufacturers are not liable for injury caused by their products would seem concerning, but I would like to offer some perspective that I hope will help alleviate your concerns.

This true story starts in the 1970s. At the time, there were vaccines against smallpox, measles, mumps, rubella, polio, diphtheria, tetanus and pertussis. The DPT (diphtheria, pertussis, and tetanus) vaccine was known to be very reactogenic, which means it caused a lot of side effects. It wasn't uncommon for vaccine recipients to have injection site reactions, high fevers, and some even had febrile seizures and whole-limb swelling. These short-term side effects did not cause any long-term problems, but public concerns about the vaccine were growing. Some thought the

vaccine caused brain injuries (further studies showed no association), and a TV documentary blamed the vaccine on intellectual and physical disabilities.

Through the 1970s and 1980s, many lawsuits were filed against vaccine manufacturers. Manufacturers made large payouts to those claiming vaccine injury, many of them tied to the DPT vaccine. More and more lawsuits were filed, and they became more expensive. In 1985, vaccine manufacturers knew that a successful vaccine could prevent hundreds of thousands of cases of a deadly disease, but it could also lead to multi-million dollar lawsuits for any bad thing that happened to a child, even if a causal link could not be established. The vaccine manufacturers struggled to obtain liability insurance. Vaccines had low profit margins, so manufacturers began to withdraw their DPT vaccines from the market. In the end, only one vaccine manufacturer was still making DPT. Vaccine prices soared, so providers limited their purchases. Experts saw the writing on the wall – if this continued, there would be a limited supply of vaccines to prevent infectious diseases and vaccine-preventable diseases would return. Additionally, the development of new vaccines would be halted by pharmaceutical companies because the risk was too high.

The United States government stepped in. Congress passed, and President Ronald Reagan signed, the National Childhood Vaccine Injury Act – it was meant to 1) eliminate the potential financial liability of vaccine manufacturers due to vaccine injury claims, 2) help ensure a stable supply of vaccines, 3) stabilize vaccine costs, and 4) provide cost-effective arbitration for vaccine injury claims.

This act created the National Vaccine Injury Compensation Program – often referred to as NVICP or VICP. This is the program that will compensate individuals that experience rare, serious side effects from vaccination. It's also worth mentioning that while vaccine manufacturers are not liable for unforeseen events, they are liable for negligence.

We see the liability language pop up in bills from time to time, and I really can understand how someone who doesn't understand the history and the program would be alarmed and think that vaccines are not safe. But the truth is, if you look closely at the data from the compensation program, it shows that vaccines are extremely safe. Approximately one compensation happens for every million doses of vaccine received.

But let's talk about why a healthcare facility or hospital may require vaccines for their employees.

Let's start with hepatitis B vaccine. Hepatitis B virus is transmitted via blood (or sexual contact). If you have a chronic infection with this virus, you are at increased risk for cirrhosis and liver cancer. Yes, this vaccine prevents cancer. So why is this vaccine often required for certain healthcare workers? Well, healthcare workers may be exposed to hepatitis B virus on the job. Before universal vaccination was widely implemented, this infection was recognized as a common occupational risk among healthcare providers. Routine vaccination and the use of standard precautions resulted in a 98% decline in HBC infections from 1983-2010. OSHA mandates that employers offer HepB vaccination to all employees at risk, and many healthcare

facilities require HepB vaccination or proof of immunity as a means of protecting their workforce.

The next vaccine I want to talk about is the vaccine against meningococcal bacteria – which cause meningitis. While this is not often a vaccine we think about as a requirement for healthcare workers, there are laboratory technicians who may come in contact with meningococcal bacteria. It is important that these employees are vaccinated to protect them from this deadly bacteria.

Influenza vaccination has been determined to be an important protection for healthcare workers because they have a greater risk of exposure. In addition, healthcare workers can pass the virus to vulnerable patients and take the infection home to their families. Multiple studies show that the greater the vaccination rate among your healthcare worker workforce, the less likely you are to spread influenza to your sick, weak, elderly and vulnerable patients. You are also less likely to have influenza outbreaks in places like hospitals and nursing homes. In fact, the rate of influenza vaccination in your nursing home workforce is far more important than the rate of vaccination in your residents at preventing facility-wide outbreaks and reducing resident deaths.

We know that influenza vaccination can lessen disease severity and prevent serious illness and death. When you consider the amount of influenza that spreads in a community in a given year, the number of employees at risk, the potential impact of influenza on the workforce and not to mention the impact on patient safety, it is easy to understand why healthcare facilities require influenza vaccine for their employees. It is the best way to protect the most vulnerable in our community against this virus.

We also know that influenza requirements increase influenza vaccination rates among employees. At a large healthcare system in Fargo, prior to 2015, when influenza vaccination was strongly encouraged but not mandatory, employee vaccination rates stalled between 60% and 70%, despite multiple attempts to raise those rates. After mandatory influenza vaccination was required, vaccination rates went up to 98%.

It's also worth noting that passage of this bill may put our state law in direct conflict with federal vaccine requirements for healthcare workers.

Finally – I want you to think about the patients that our healthcare systems care for. It's healthy people, but it's also a grandparent, an immunocompromised cancer patient, someone's parent residing in a long-term care facility, a pregnant woman, a young child too young to be vaccinated – and everyone in between. You shouldn't have to worry about getting sick when you are seeking healthcare, but the reality is, our frontline healthcare workers are routinely exposed to infectious diseases, and our best bets for protecting them, preserving our workforce, and for preventing spread to patient populations is through vaccinations.

At the end of the day, I think North Dakota residents deserve to know that their healthcare institutions are free to determine, and require if they so choose, policies that assure the safest environment for patients under their care. They should not be limited by state law.

Please vote "do not pass" on House Bill 1502.

Respectfully submitted,

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