MINUTES

(Subject to approval by the subcommittee)

IMMUNIZATION SUBCOMMITTEE
of the
HEALTH CARE TASK FORCE

November 4, 2009
Boise, Idaho

Immunization Subcommittee members present were Senators Dean Cameron, Patti Anne Lodge and John McGee and Representatives Gary Collins, Carlos Bilbao and John Rusche. Panel participants were: Matthew Brown, M.D., St. Alphonsus Medical Group Pediatrics; Richard Rainey, M.D., Idaho Medical Director, Regence BlueShield of Idaho; Susie Pouliot, Idaho Medical Association; Corey Surber, Advocacy & Community Health Coordinator, Saint Alphonsus; Jane Smith, Administrator, Division of Public Health, Department of Health and Welfare; Kurt G. Stembridge, Government Affairs Manager, State Government Affairs, GlaxoSmithKline; Stephen Ryter, M.D., Medical Director, Blue Cross of Idaho; Richard M. Armstrong, Director, Department of Health and Welfare; Christine Hahn, M.D., Office of Epidemiology and Food Protection, Department of Health and Welfare; Russell Duke, Director, Public Health District No. 4; Jeremy Pisca, Risch Pisca, PLLC, & Pharmaceutical Research & Manufacturers Association and St. Alphonsus Regional Medical Center; Tom Patterson, M.D., Chairman of the Immunization Coalition; Ted Epperly, M.D., Program Director and CEO Family Medicine Residency of Idaho; and Sara Stover, Division of Financial Management. Legislative Services Office staff were Paige Alan Parker, Amy Johnson and Charmi Arregui.

Other attendees were: Bruce Krosch, Director, Public Health District No. 3; Rebecca Coyle and Traci Berreth, Department of Health and Welfare; Kathie Garrett, Family Medicine Residency Program; Benjamin Davenport, Risch Pisca, PLLC; Martin Bilbao, Connolly & Smyser; Julie Taylor, Woody Richards and Steve Tobiason, Blue Cross of Idaho; Don Stecher, Novartis; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Paul Nielsen, MedImmune; Julie Robinson, Family Medicine Residency; Sarah Michael, Sanofi Pasteur; McKinsey Miller, Gallatin; Angela Torres, Health Management Systems (HMS); Elizabeth Criner, Veritas Advisors; Dan Heincy, Merck Sharp & Dohme Corp; Joie McGarvin, America's Health Insurance Plans; Torrie Lang, Idaho Freedom Foundation; Denise Chuckovich and Celinda Snyder, Idaho Primary Care Association (IPCA); and Tammy Perkins, Office of the Governor.

Representative Gary Collins called the meeting to order at 8:33 a.m.

Jane Smith, Administrator, Division of Public Health, Department of Health and Welfare was the first presenter, and spoke about the process for selection of vaccines. **Ms. Smith** gave a brief

history of the immunization program prior to 2003. A copy of **Ms. Smith's** "Vaccine Selection Policy History and Major Events" is available in the Legislative Services Office (LSO). Under the prior program, the Department of Health and Welfare still evaluated vaccines annually on criteria including efficacy and packaging. This prior program was challenged by a pharmaceutical company in 2003. A more formal vaccine selection policy was developed in mid-late 2004. In 2005 a draft plan was put together and approved on how vaccines would be selected. Letters were sent to the Idaho Medical Association, the Idaho Chapter of the American Academy of Pediatrics, and the Idaho Association of Family Practitioners requesting recommendations for physicians to participate on the Vaccine Advisory Committee (VAC). A Vaccine Evaluation Committee (VEC), made up of Health and Welfare staff, looks at price, availability, packaging and vaccine management criteria. The VEC puts this information together, looking at clinical aspects of vaccine and compiled scores, and makes recommendations to the VAC, which selects the vaccines.

Senator Cameron asked whether cost is not the highest priority in the selection process. **Ms. Smith** answered that many different factors are considered, but cost is one component. She added that items such as packaging affect cost, since packaging may affect waste.

Representative Rusche asked if different manufacturer's products are interchangeable. **Ms. Smith** deferred to **Dr. Christine Hahn**, Office of Epidemiology and Food Protection, Department of Health and Welfare, who said that some of the newer formulations are interchangeable, adding that the VEC considers interchangeability. **Ms. Smith** noted that the VEC sometimes recommends products from different manufacturers.

Senator Cameron asked who makes up the committees. **Ms. Smith** said that VEC staff does the background information and compilation and VAC is made up of three different pediatricians from across the state. **Senator Cameron** addressed the issue of cost, asking if it would be possible to do a graphical representation on how all the total vaccine dollars are spent for the entire year, rather than the $2.1 million General Fund dollars that the Governor allocated. **Ms. Smith** answered that she could, but cautioned that it would be that on a broader scale than shown on her "Summary of Vaccine Emergency Funds" handout, available in LSO. **Senator Cameron** referred to **Ms. Smith**'s "Summary of Vaccine Emergency Funds" handout and noted that the largest number of doses given under the emergency General Funds used was for Hepatitis B at 7,500 doses, at a cost of $365,625, and asked if it would be appropriate to extrapolate those figures for an entire fiscal year. **Ms. Smith** said that it probably would be, but agreed to compile that data for the subcommittee based on distribution history. **Senator Cameron** said that three pediatricians are determining the vaccines to be purchased and asked if there was a price difference between the low price and the vaccine those physicians actually choose, and if going to a system that put more emphasis on cost would produce savings that would provide more vaccine to more children. **Ms. Smith** said that the overriding reason for the current selection process is getting the biggest bang for the dollar and that factors such as efficacy and packaging impact cost. However, **Ms. Smith** didn't think one could put an exact dollar amount on what is being saved, after all factors are considered. **Senator Cameron** asked how other states

implement vaccine selection policy and what the VAC physicians use to determine the efficacy of one vaccine over another. **Ms. Smith** said there is scientific literature available. She added that some states allow a physician to choose the vaccine that is then ordered off the federal contract from any pharmaceutical company that participates in the program. **Senator Cameron** asked if purchasing power would be lost if Idaho went to that type of system. **Ms. Smith's** response was that in Idaho, General Funds are involved to achieve universal status. States that are VFC-only have no state dollars in their programs and don't have as much investment in saving federal government money. She said some VFC-only states don't put restrictions on vaccine selection.

Representative Rusche asked **Ms. Smith** to estimate the cost savings of having a formulary approach as opposed to allowing practitioners to choose. **Ms. Smith** answered that a cost analysis had not been done recently but agreed to look at that, although it would be difficult, since it was unknown what would be ordered if the committee system was not in place. **Representative Rusche** thought that would be helpful.

Dr. Ted Epperly, Program Director and CEO, Family Medicine Residency of Idaho, spoke next on other state vaccine program models and alternatives. **Dr. Epperly** handed out a "Comparison of Immunization Programs" (available in LSO) showing immunization rates, funding sources, and what works well in Oregon, Colorado, Louisiana, New Mexico, Wisconsin, Utah and Tennessee. **Dr. Epperly** highlighted that each state's vaccination program is unique, calling attention to the national immunization rate of 76.1% with Idaho at 60.4%, Idaho ranking 50th out of 50 states. Emphasis was put upon what was being measured, which was immunization rates for all children between the ages of 19 months and 35 months as published by the Centers for Disease Control (CDC) in the year 2008. Five of the seven states did not use state money, two of the seven did use state money. He focused on Colorado, Oregon and Utah, neighboring states with demographics similar to Idaho.

Dr. Epperly pointed out that Colorado ranked 50th five years ago and has since raised the immunization rates to 79.4% by taking several steps. Colorado uses 317 and VFC funds for vaccine purchase, no state or local funds, and the underinsured are served at public health and Federal Qualified Health Clinics (FQHCs). Colorado held elections with immunization platforms; the Governor and Lt. Governor are both strong advocates of child health; there is a statewide Vaccine Advisory Committee; and Colorado receives additional funds from state and tobacco settlement to support the immunization program for purposes other than the purchase of vaccine.

Dr. Epperly next addressed Oregon which has a 71% immunization rate, still less than the national average, using no state funds. Oregon used Section 317, Vaccine For Children (VFC) and private insurance funds to provide universal access at public clinics. VFC children are seen in both public and private clinics. Oregon partners with communities, having an immunization policy advisory team, with the state supporting immunization coalitions with personnel. Oregon has published an article, "Billing Third Party Payers for Vaccines: State and Local Health Department Perspectives," describing its immunization program, which is available in LSO.

Dr. Epperly last focused on Utah, having a 76.6% immunization rate that is above the national average, using 317, VFC and state funds. VFC children are seen in both public and private clinics and stimulus money has been used to supplement the program. Privately insured children are vaccinated by health insurance plan contract providers or pay out-of-pocket for the service. Utah has strong immunization rules; the state has focused on an opt-out registry, meaning that all infants are registered unless parents opt out. Underinsured vaccine is available through public health, private clinics and FQHCs.

Dr. Epperly and **Mr. Russell Duke**, Director, Public Health District No. 4, compiled a list of recommendations for the subcommittee, which are as follows:

1. Support Universal Access Vaccine Program (vaccine provided free)
    a. VFC
    b. 317
    c. State General Fund (as stimulus starter, not generally long-term)
        i. Insurance (added into the pool)
        ii. Premium Tax
2. Education Program
    a. Idaho involved with statewide vaccination coalition
    b. State works actively with location coalitions
3. Advisory Board for Vaccination Policies
    a. Composed of physicians, nurses, hospitals, public health departments, CHC's, State Department of Health, Legislators, children's advocacy groups
    b. Reports to Senate and House Health and Welfare Committees
4. Governor/First Lady involvement
5. Idaho Registry at Birth (IRIS) / as an opt-out registry (is currently an opt-in registry)
6. Medicaid Medical Home
    a. Vaccines given in Patient Centered Medical Homes (PCMH)

Senator McGee commented that Colorado moved up from being the lowest ranked to now 79.4%, and Louisiana is currently at 81.9% after being ranked very low. He believes that Idaho can also move up from the 50th position rather quickly if prudent ideas of other states were followed.

Representative Rusche asked for an explanation of 317 funds. **Dr. Epperly** answered that 317 funds come from the Public Health Service Act that channels federal dollars to the state. **Representative Rusche** inquired if Idaho is using 317 funds to augment its immunization

program. **Ms. Smith** answered that Idaho does use 317 funds to augment and offset the use of more General Fund money. She said we have the ability from the federal government to utilize 317 funds in many different ways and Idaho has added that to the pool of funds. **Representative Collins** asked how much money was being talked about. **Ms. Smith** answered that she would check on that.

Senator Cameron asked who compiled the recommendations given to the subcommittee and **Dr. Epperly** said that he had collaborated with **Mr. Russell Duke**, adding they had worked together to compile the state comparison data for the subcommittee. **Senator Cameron** thanked them for their contributions and their attention to detail, as well as suggestions. **Senator Cameron** asked **Dr. Epperly** to clarify whether Oregon is using 317 and VFC funds in addition to insurance funds. **Dr. Epperly** explained that in Oregon there are so many rural counties, as in Idaho; Oregon designated certain private clinics in rural areas as delegated public clinics. A combination of VFC, 317 and insurance moneys were used to cover children. The state swept all those three funding sources together into one large pot to purchase vaccine. The redistribution model is administered through the public health departments, FQHCs, and delegated private clinics. **Senator Cameron** asked if Oregon was billing the insurance companies simply for the cost of the vaccine. **Mr. Duke** answered that the clinic bills insurance for the cost to purchase the vaccine; that money is collected by clinics and remitted to the state of Oregon. He said it is a published best-practice model, collecting the money and turning it over to the state; an electronic system does the accounting. The money is placed in a pool for universal access vaccine purchase. Clinics are not required to keep two separate inventories. **Senator Cameron** asked if there had been situations where Oregon has attempted to collect from the insurance companies that don't cover immunizations or have deductibles. **Mr. Duke** said his guess would be that Oregon was probably using 317 funds to cover some shortfall created by deductibles and co-pays. **Senator Cameron** asked about Oregon's parental cost for child immunizations, asking if vaccines are administered free of charge to all children and if there is any age distinction, regardless of whether they have insurance. **Mr. Duke** answered that Oregon's immunization program covers through age 18; parents going to public clinics are not paying for the vaccine itself.

Dr. Patterson, Chairman of the Idaho Immunization Coalition and Vice President of the American Academy of Pediatrics, shared that another model, Hawaii in 2007, was at 80.1% immunization rate and in 2008 was very highly ranked at 87.8%, He commented that Hawaii has a very aggressive program and a model that includes a mandate for all health insurance policies covering immunizations for insured children ages 0 through 5 years; ages 6-18 are covered by a more restrictive universal select program, similar to ours. He believes that a proposal that would work well for Idaho would be a change in the insurance statute to mandate health insurance coverage so if a policy is sold, immunizations would be covered ages 0 through 18 with no gaps, including that at-risk adolescent population. If Idaho mandated coverage for ages 0 through end of 5th year and then looked at VFC universal select for ages 6-18, the estimated cost to General Fund would be $413,000 based on 2008 dollars, which would be a significant savings on what the universal select was previously. That would allow universal coverage, the option to decrease

or eliminate the General Fund contribution, continued use of VFC and 317 dollars and the opportunity to increase immunization rates. **Dr. Patterson** said he fully supports the recommendations made earlier by **Dr. Epperly** and **Mr. Duke**, as do the American Academy of Pediatrics and the Idaho Immunization Coalition. He didn't know if going back to the way things were before is a realistic option.

Senator Cameron stated that there is a problem with the insurance mandate; the mandate only affects those fully insured companies and does not affect those plans that are excluded from state regulation by ERISA. **Dr. Patterson** responded that the policy, as he understands it, is that all

health insurance policies must cover routine immunizations; that is the way the mandate reads, so he would need to address self-funded insurance plans. **Senator Cameron** asked **Dr. Patterson** to look into that for the subcommittee. **Dr. Patterson** said he suspected there was a way to address that since Hawaii has 87.8% coverage and he agreed to get more information on that.

Representative Rusche said that states with strong immunization rates also have a tendency to have strong child care laws. Idaho does not have a requirement to immunize, except through schools, and asked if **Dr. Epperly** would suggest the immunizations required also be applied to child care. **Dr. Epperly** said that was an excellent point and probably should have been added to the recommendations for a law for Idaho in terms of ensuring immunizations. He thought that recommendations 1-6 would be the major thrust to push things forward without mandating insurance coverage; if those recommendations fail, then perhaps a mandate might be a next step. **Mr. Duke** said that it would be good to have the advisory board make those types of recommendations.

Dr. Richard Rainey, Idaho Medical Director, Regence BlueShield of Idaho, asked **Mr. Duke** about the Oregon plan and state reimbursement. This summer when trying to come up with options, they were told emphatically that physician providers could not bill insurance companies for state-provided vaccines, but the model **Dr. Epperly** described for Oregon seems to provide billing insurance companies for state-provided vaccines. **Mr. Duke** said that when this research was being done, the outbreak of H1N1 occurred, so it was difficult to gather data, but he did say that New Mexico uses something very similar. Insurance companies are paying into a purchasing pool, then the state of New Mexico manages that money and buys vaccine off a purchasing pool, not off the CDC contract. New Mexico was able to negotiate lower purchasing prices for vaccine. Oregon, he said, bills the insurance companies for vaccine and the money is collected and is transferred to the State Department of Health in Oregon. So rather than insurance companies paying to buy vaccine off the CDC contract, in Oregon and New Mexico, the money becomes unrecognizable as private insurance money purchasing vaccines. **Dr. Rainey** said that insurance companies would be happy to provide contract benefits if the state was supplying the vaccine; that would enable the existing payment mechanism to obtain vaccine under the CDC contract. We should look into that.

Ms. Smith said that it is against the law to charge for CDC-supplied vaccine. **Mr. Kurt Stembridge,** Government Affairs Manager, State Government, GlaxoSmithKline, provided clarification on Oregon saying that they do not bill for federally-supplied vaccine. What Oregon

is doing, according to his knowledge, is if an insured child comes in, the insurance company is billed for the vaccine and the administration fee, and those dollars are passed on to the state. With regard to uninsured children and Medicaid children, the state cannot, under federal law, bill for that vaccine. Insurance companies are billed for children covered by insurance.

Ms. Sara Michael, Deputy Director, State Government Afffairs, Public Policy, Sanofi Pasteur, commented that in many states the health departments don't have mechanisms to bill, so it ends up more costly for them. **Ms. Michael** asked whether Oregon purchased vaccine for insured children through CDC contract. **Dr. Epperly** acknowledged that it is illegal to buy from CDC on the front-end, but it is okay to do it on the back-end in terms of what the office charges and bills. He said Oregon has an understanding or agreement with the CDC that allows moneys collected from insurance companies to be swept into the public coffer. In terms of how Idaho would purchase, he said that was beyond his knowledge, adding that there are working mechanisms that exist in other states that can be effective. Idaho needs to explore lawful measures to move immunization rates forward.

Representative Collins asked **Mr. Stembridge** about the purchasing pool in New Mexico and how it works. **Mr. Stembridge** answered that New Mexico uses federal VFC and 317 funds for uninsured children. New Mexico also has a voluntary tax on insurance companies and uses the Minnesota multi-state contract, and not from the CDC. This is how New Mexico got away from the problem of using private dollars. He added that New Mexico has opened the whole system up, and does have a selection policy; manufacturers are allowed to compete at the physician level to determine which vaccines are used. **Representative Collins** asked how long New Mexico has been doing this, and **Mr. Stembridge** answered 8 to 10 years.

Dr. Epperly said that the publication from Oregon indicated that, amazingly, the project was supported by a grant from the CDC, and suggested that perhaps Idaho could also apply for a grant from the CDC to jump-start a program. **Representative Collins** requested a copy of this Oregon publication.

Dr. Stephen Ryter, Medical Director, Blue Cross of Idaho, said he was in New Mexico when the purchasing agreement was reached with insurance companies and the health department; the health department initially billed the insurance companies for VFC vaccine given at VFC cost levels. However, New Mexico did transition to a purchasing pool cooperative because what was being done was not in agreement with federal law. **Dr. Ryter** said actuaries have looked at the cost of not having VFC, and the estimate is that without VFC, going back to a private market for insurance companies, would cost about $1.20 per member per month for all lines of business; with a purchasing cooperative, the cost is reduced to eighty cents per member per month, which is significant. **Dr. Ryter** said that he and his colleagues are concerned if Idaho goes to a two-stock requirement for practitioners, physicians in large clinics will get decent prices, discounts and terms. The concern is with the family physician in smaller communities who doesn't do many immunizations monthly and who has to maintain two stocks. With waste due to non-use, this will become extremely expensive. He believes those physicians will get discouraged and want to withdraw, which could create a disaster.

Dr. Patterson said that the Immunization Coalition has communicated with CDC regarding grants and the operatives of those grants are very interested in Idaho due to Idaho's current low immunization rate. **Dr. Epperly** said that **Dr. Ryter** made valid points and expressed concern about how Idaho reaches out to children in rural communities. What Oregon did was to contract with private offices in rural areas to serve as distribution points. Oregon took an active role in reaching out. Idaho is a very rural state and could contract with private practitioners in rural areas if there are not community health centers or public health departments in those locations.

Mrs. Amy Johnson, Principal Budget & Policy Analyst, addressed the subcommittee and handed out "Department of Insurance Agency Profile on Premium Tax Distribution" and "Insurance Premium Tax Fund Projection - Fund 0173 for state fiscal years 2005-2012." These documents are available in LSO. She alerted the subcommittee that premium tax revenues have declined over the last five years and, even though tax rate reductions were expected, what was unexpected was the reduction in number of premiums sold in the state. The Division of Financial Management's forecast for 2010 shows zero percent growth in premiums sold in Idaho and one-half percent forecast for 2011. **Mrs. Johnson** emphasized that in 2011, while there is CHIP B and Children's Access card cash fund balances available, there is no distribution in 2011 since the $55 million cap requirement won't be reached. The state General Fund has seen about an $8 million to $10 million decline since the premium tax rate was reduced, and other areas have gone down as well. **Mrs. Johnson** said that the premium tax dollar forecast does not cover the current distribution in statute for the next fiscal year. The CHIP B and Children's Access Program has not collected enough revenue from premium tax to cover the number of children in CHIP B, and for several years money has been transferred between the two, using fund balances to cover cash expenditures. Starting in 2010, the Department of Health and Welfare will need to transfer money from the adult access card program into the children's program in order to make the children's program whole for this fiscal year. Even then, the children and adult programs are forecasted to be short by $3.8 million in FY 2011. If there isn't any revenue enhancement, then the number of children on CHIP B and Access card programs, and the number of adults on the Access card program, will have to be reduced to meet revenue forecast.

Representative Rusche observed that the premium tax being cut is not currently enough revenue coming in to meet existing draws on that funding source. Without either a huge increase in premiums, which is unlikely, he said there is not going to be even enough money for the existing program, and certainly not enough for additional vaccine. **Mrs. Johnson** responded that there is a tax decline as well as an unanticipated sales decline on premiums statewide.

Dr. Epperly said that as Idaho's immunization rate dropped, the amount of 317 funds from federal government decreased; due to that, undue pressure was put on the state fund to make up the loss in 317 funds. Until Idaho gets numbers back up, the federal government money will not be maximized, so it becomes critical to drive this forward since federal money is being left on the table.

Senator Cameron inquired about the Oregon model, asking if specified physicians in communities were required to keep two stocks of vaccines. **Dr. Epperly** answered "they are not;

because of this contracting, Oregon has one combined stock." **Mr. Duke** said that was his understanding as well. Under the Oregon public clinic plan, the vaccine is being purchased by the state and redistributed to specific clinics.

Senator Cameron referred to the recommendation sheet and suggestion to use state General Fund dollars for insurance, adding that he wasn't sure if the state could even afford to do what is currently being done. He asked for distinction between the recommendation of state General Fund dollars supporting insurance and premium tax (since premium tax comes from insurance). **Senator Cameron** thought that put all the weight on the insurance industry; he said he knew the Governor's thoughts about this, and the Governor expects the insurance industry to step up to the plate to cover immunizations for those individuals who are insured. **Senator Cameron** said the trick is to work this out with the least amount of harm to the industry and the Department of Health and Welfare. **Dr. Epperly** said that in the capitalization of this Idaho faces a very tough economy. He realized this was not a long-term solution, but could be a short-term investment to get the comprehensive list of recommendations moving forward. In terms of nuance between insurance and premium tax, **Mr. Duke** said the group being talked about is uninsured or under-insured children who are covered by VFC and 317 funds, which would bleed into the insured population. The goal is to figure out an easy way for providers to get vaccine from the state. From the insurance industry side, the goal is to save money overall in Idaho. **Mr. Duke** said private providers who buy vaccine from the free market may pay double the state price. Insurance reimburses in most instances at that much higher rate plus a profit margin. **Dr. Ryter** said his concern is to avoid the chaos that existed in the summer of 2009 with no true definition of what was to happen with General Fund moneys; he said the process of what will occur in Idaho will be somewhat lengthy and expressed hope there would be some stop-gap funding for a number of months until some solution can be reached. **Dr. Ryter**'s greatest fear is that December will come and practitioners will become anxious about whether they should purchase vaccine privately or if some will be available from the state. This waiting game could prove disastrous to Idaho physicians, affecting everyone.

Dr. Hahn stated that the Oregon model would leave most private practitioners with dual inventories. She thought that the answer most likely would be yes, Idaho is moving to a VFC world. **Mr. Duke** stated that in his conversations Oregon is looking to expand delegated status to private practices in urban settings, allowing universal access in those clinics.

Dr. Epperly commented that this discussion today was about a long-term plan for Idaho, not short-term; Idaho needs a plan in place for winter. Recommendations he presented are focused on what Idaho could do to stabilize, sustain and grow a program for Idaho. Short-term, Idaho must have a distribution program functioning this year. He believes the universal access program must be put back into place short-term or chaos will be repeated during this vaccination year.

Senator Cameron said that he didn't believe **Dr. Epperly's** recommendations 2-6 to be difficult. He suggested that a plan be brought forth at the subcommittee's November 30, 2009 meeting. **Senator Cameron** said that the state is going to have to deal with the lack of available dollars, but that some of the recommendations could be implemented rather quickly. **Senator**

Cameron doesn't envision the same summer chaos reoccurring. **Dr. Epperly** responded that he didn't fully comprehend how things get paid for in the state, adding that physicians want the immediate ability to immunize children on time. He said that whatever it takes, VFC, 317, or state funds to accomplish that, must be done, while a long-term plan is being formulated so that vaccine is available and being used. **Dr. Epperly** asked how to restore what Idaho had before it got unplugged; a total restoration of the $4.3 million. He believed that, in the short term, to prevent chaos, non-immunizations and further decline in Idaho's present immunization percentage of 60% would require that money being plugged back in immediately. He said that Utah used Millennium Fund money.

Dr. Rainey believes that with existing funding being discontinued on January 31, 2010, chaos will occur as it did on July 1, 2009, the only difference being that physicians and the public have learned what options were available. **Dr. Rainey** added that the providers will have some experience in what to do.

Dr. Patterson said that even after researching thoroughly, his group practice still had $105,000 worth of vaccine purchased for July alone, adding this was no small expenditure for physicians. He said that a rural physician or a private practice could not afford to do that. If there is constant flux, he believes that physicians will simply opt-out of the vaccine business. **Dr. Patterson** has been shocked at the number of his patients who do not know they can get vaccinations at his office, so aggressive involvement and education with patients is important and the culture must remain constant. Immunizations need to become a top agenda item in Idaho or rates will slip further. **Dr. Patterson** emphasized that Idaho must initiate a short-term plan as a bridge to a long-term solution.

Representative Collins said there is much work ahead in preparation for the November 30, 2009 meeting, inviting input from the subcommittee and participants.

Ms. Smith said that the $2.1million received for immunizations in the interim was fabulous to get through until January 31, 2010, cautioning that there is no money after that.

Ms. Sara Michael commented that she believed the state should focus on raising immunization rates, adding that her concern was that continuing the universal program might not be the best way to accomplish that. **Ms. Michael** said studies have been done showing that universal purchase may not raise immunization rates. **Ms. Michael** said she wanted to work with the state and, in the future, if the state moves toward universal purchase and universal distribution, something to think about is offering choice of vaccines to physicians, which will allow for free market competition. **Ms. Michael** said that there are programs available working with physicians, such as 90-day dating, since purchasing vaccines is so expensive. She expressed opposition to assessing insurance companies in order to convert private dollars to public dollars.

Senator McGee moved that the minutes from September 28, 2009 be approved, seconded by Representative Rusche, and the minutes were approved unanimously by voice vote.

The next meeting of the Immunization Subcommittee will be on November 30, 2009.

Representative Collins adjourned the meeting at 9:55 a.m.