

Vaccine Finance

Overview of stakeholder input and NVAC working group
draft white paper

Walt Orenstein, MD

Consultant to the National Vaccine Program Office

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Number of Vaccines in the Routine Childhood and Adolescent Immunization Schedule

1984

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio

7

1994

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio
Hib (infant)
HepB

9

2008

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio
Hib (infant)
HepB
Varicella
Pneumococcal disease
Influenza
Meningococcal disease
HepA
Rotavirus
HPV

16

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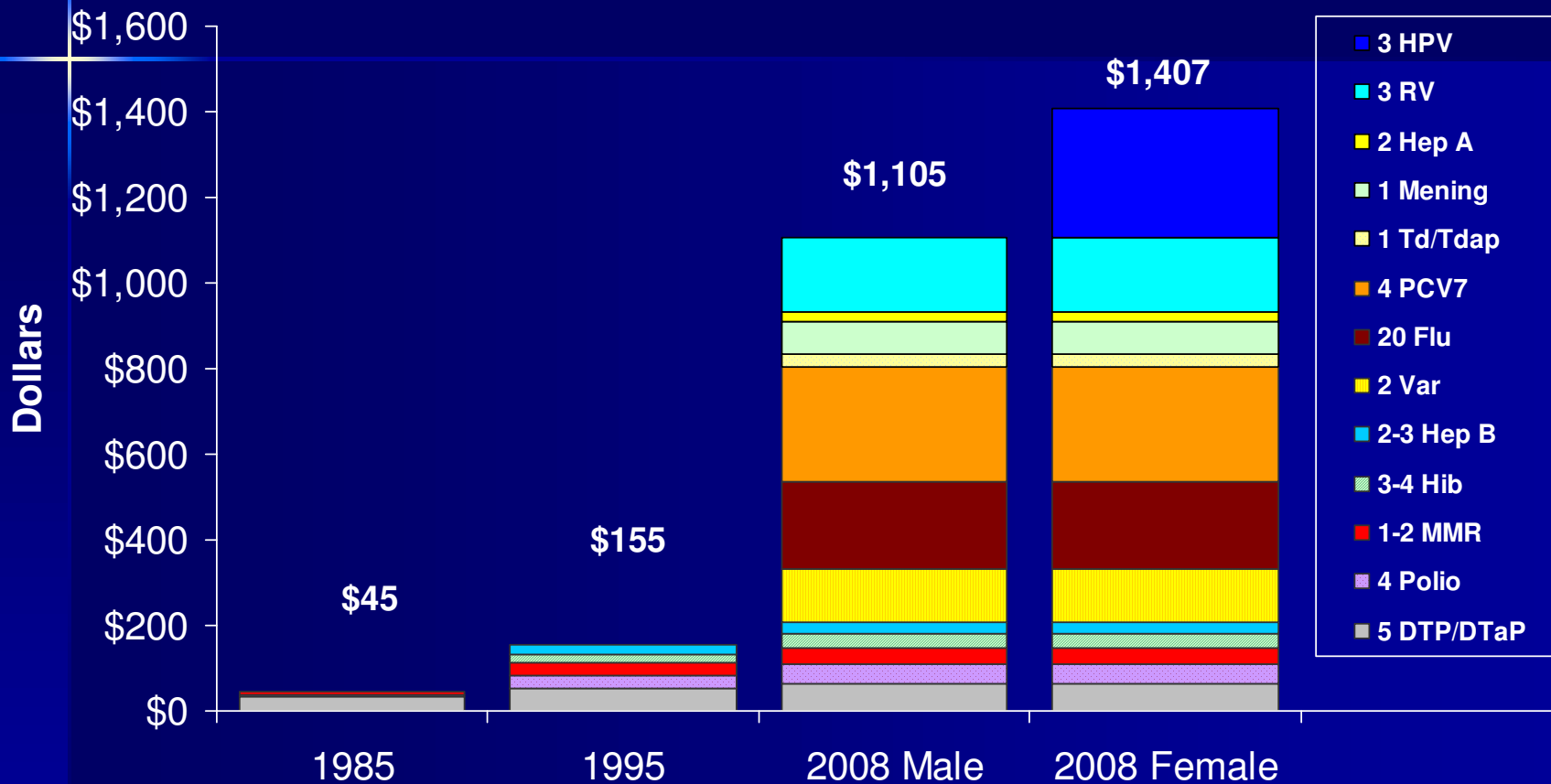
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Vaccines in yellow recommended for routine use since 2004

U.S. Federal Contract Prices for Vaccines Recommended Universally for Children and Adolescents: 1985, 1995, 2008



1985 and 1995 represent the average federal contract price to account for price changes within the respective year.

2008 represents the minimum cost to vaccinate children and adolescents and is based on the federal contract price as of April 2, 2008. The 2008 cost to vaccinate includes the new ACIP expanded recommendation for influenza vaccine for all children 0-18 years of age.

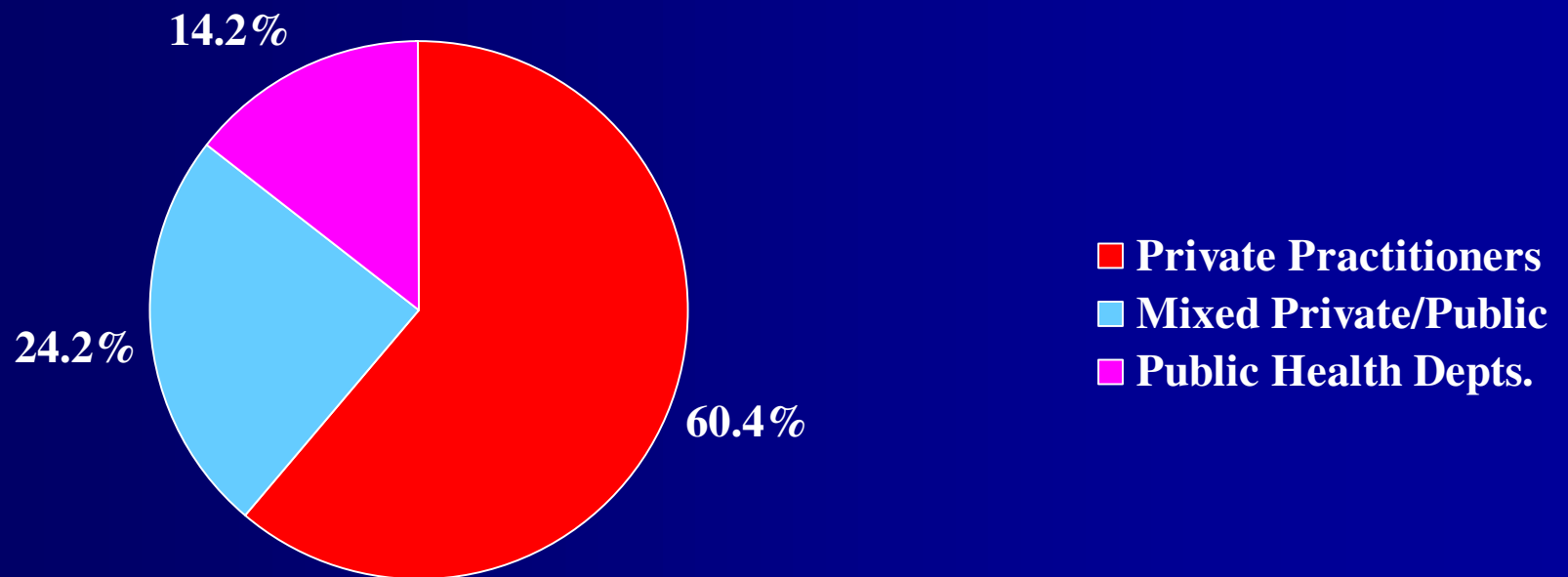
Burden of Vaccine Delivery on Providers

ⁿ Recent surveys of family practitioners and pediatricians indicate significant financial concerns related to the purchase and delivery of vaccines, particularly newer and more expensive vaccines.

– University of Michigan CHEAR unit (Freed et al, under review)

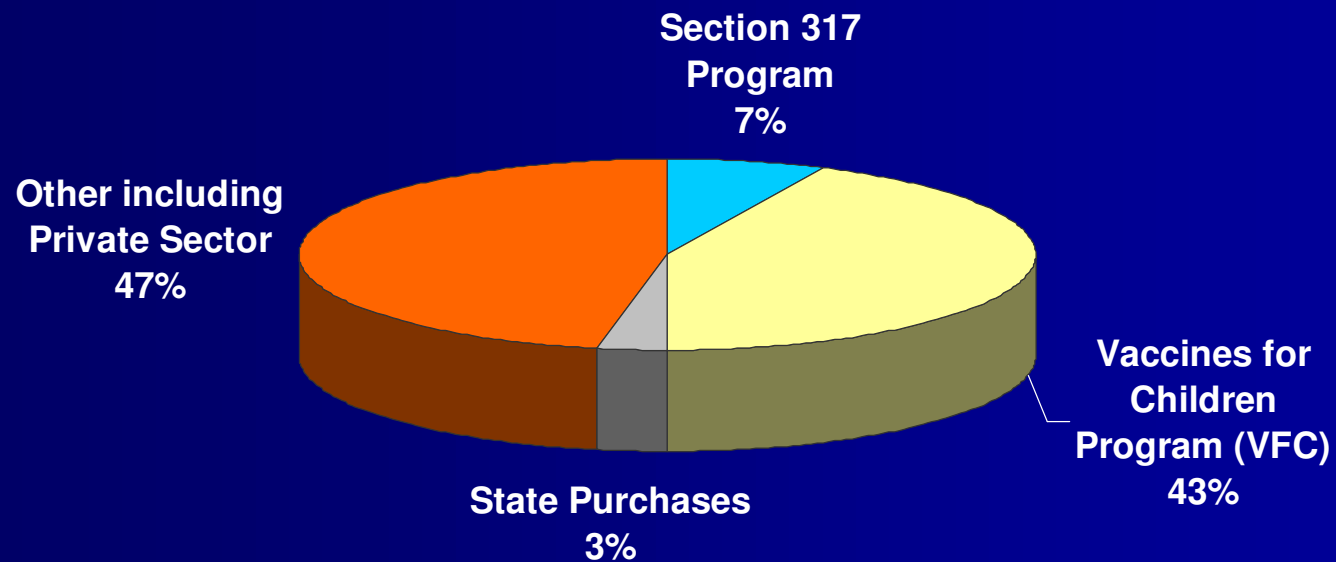
Pediatric Immunization Delivery System

n Private providers vaccinate most US children



Source: National Immunization Survey, 2004
www.cdc.gov/vaccines/stats-surv/default

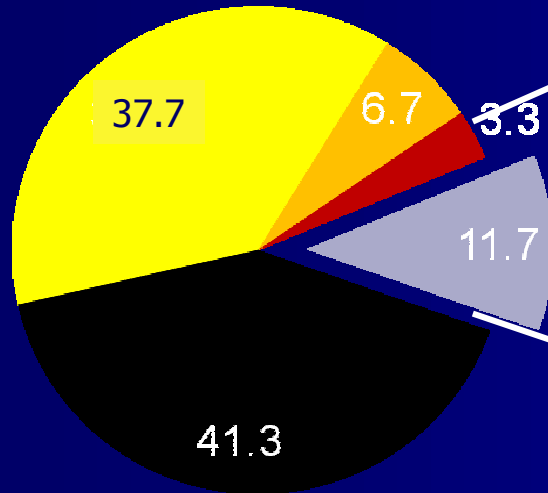
Vaccine Doses by Funding Source, 2007 (Children 0-6)



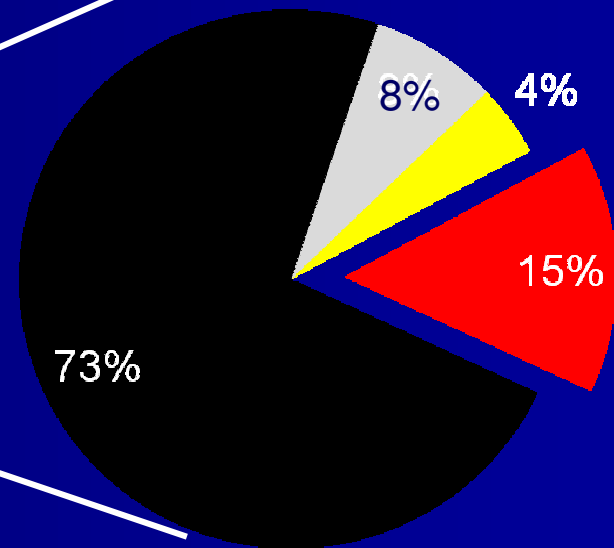
Source: Biologics Surveillance Data 2007. Does not include influenza vaccine.

Insurance / VFC Status and Vaccination Venue, 19-35 Months of Age: 2006 NIS

Insurance / VFC Category



Underinsured's Venues



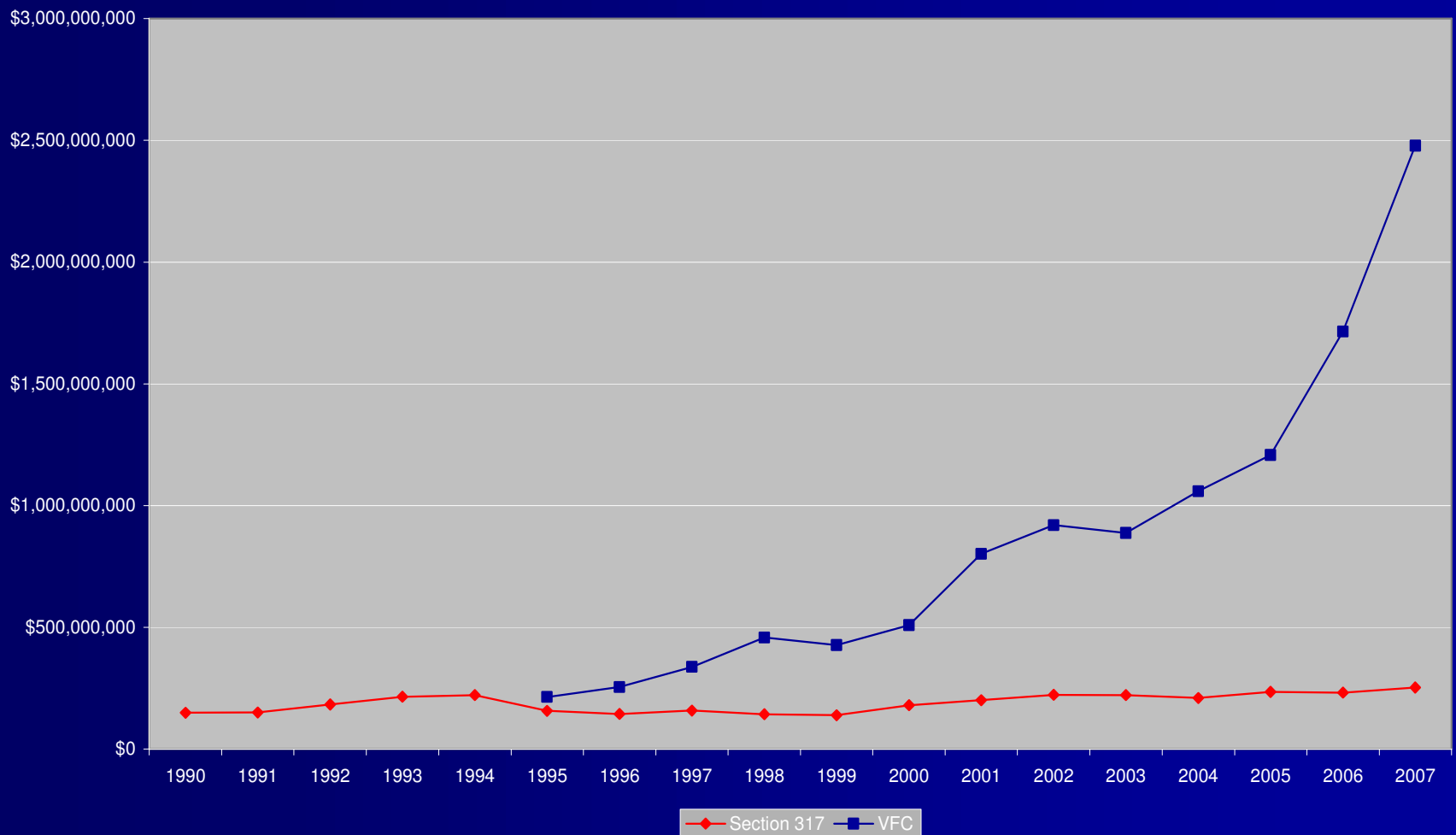
Vaccines For Children (VFC) Program

- n Federal entitlement program to purchase and provide vaccines to enrolled healthcare providers
- n Covers children 0 through 18 years: Medicaid, American Indian/Alaska Native, uninsured, or underinsured (only at federally qualified/rural health centers)
- n Federal purchase of vaccines at federal contract price
- n The ACIP votes to include vaccines in VFC, which are automatically financed after conclusion of a federal contract

Section 317 Grant Program

- n Federal discretionary grants to support activities of state immunization programs
- n Not age-restricted but approximately 87% of funds go to childhood immunization
- n States can use to purchase vaccines at federal contract price
- n Significant source of safety-net vaccine for those not adequately covered by public or private insurance
- n Annual appropriations have not been keeping pace with the cost of the vaccination schedule

VFC and 317 funding levels from 1990-2007



Private Sector Vaccine Provision

- n Medical providers purchase and store vaccines for administration to patients
- n Seek reimbursement from health insurance plans or other payers, or directly from patients (self-pay)
 - Vaccine purchase
 - Administration fee

The Problem Is Not Readily Visible

- n Current vaccination coverage is high and disease incidence is low, however:
 - Data on coverage levels are not necessarily timely
 - There is limited measurement of coverage with newer (more expensive) vaccines, which appear to be the source of the problem
 - n Morbidity not yet prevented by newer vaccines may not be recognized as a significant problem
 - Future vaccines will further increase immunization schedule cost and size
 - n Critical to address problem before a crisis occurs

Solutions Require Increased Funds

- n Potential sources of increased funds
 - Government (i.e., taxpayers)
 - n Distributes burden of funding across society for a societal benefit
 - n Could be federal, state, and/or local governments
 - Purchasers (i.e., employers)
 - Consumers (i.e., out of pocket)

- n Actual required increase in funds depends on:
 - Manufacturer and distributor charges
 - Non-vaccine costs of vaccination

NVAC Vaccine Finance Workgroup Focus

n Public Sector:

- Vaccines for the underinsured
- Administration fees:
 - n Medicaid admin fee not adequate in many states
 - n No admin fee for other VFC-eligible children

n Private Sector:

- Easing the burden of vaccine purchase and administration for providers
- Insurance issues: adequacy of coverage for vaccines and administration fees

Purpose of Presentation

- n Update IOM on the status of the NVAC Vaccine Finance Workgroup's proposed recommendations to ensure that all children and adolescents have access to all routinely recommended vaccinations without financial barriers

PLEASE NOTE:

The proposed recommendations represent a work in progress of the Vaccine Finance Workgroup, and have not yet been reviewed and approved by NVAC

Structure of Recommendations

Public Sector

- I. Providing vaccines for the underinsured
 - A. VFC vs. 317
- II. Covering the cost of vaccine administration
 - A. Covering for all VFC-eligible children and adolescents
 - B. Improving current Medicaid reimbursement
- III. Activities of federal agencies and offices
- IV. Activities of state/local agencies and offices
- V. Other recommendations of the Adolescent WG

Private Sector

- I. Improving business practices in provider offices
- II. Reducing underinsurance and financial barriers to vaccination
 - A. Voluntary standards

Public Sector Recommendations

Providing Vaccines for the Underinsured

- n 1. Extend VFC access to underinsured children and adolescents in public health clinics (VFWG Rec. 5)

OR

- n 2. Expand Section 317 program funding to support vaccine purchase for all children and adolescents who traditionally have relied on 317 for vaccines (VFWG Rec. 1)

Covering the Costs of Vaccine Administration for All VFC-Eligible Children

- n 3. Expand VFC to cover vaccine administration reimbursement for all VFC-eligible children and adolescents, (single system including Medicaid) (VFWG Rec. 7)

Covering the Costs of Vaccine Administration: Improving Medicaid Reimbursement

- n 4. CDC and CMS annually update, publish, and disseminate actual Medicaid vaccine administration reimbursement rates by state (VFWG Rec. 10)
- n 5. CMS update maximum allowable Medicaid administration reimbursement amounts for each state (VFWG Rec. 11)
- n 6. Increase federal match for Medicaid vaccine administration reimbursement to levels for other services of public health importance (VFWG Rec. 12)

Activities of Federal Agencies and Offices (1)

- n 7. Congress request annual 317 report from CDC and ensure funding at specified levels (VFWG Rec. 3)
- n 8. CDC and CMS continue to collect and publish information on costs associated with public and private vaccine administration (VFWG Rec. 17)
- n 9. NVPO calculate marginal increase to insurance premiums to insurance plans of including all ACIP recommended vaccines (VFWG Rec. 26)
- n 10. NVAC convene expert stakeholder panels to determine if acceptable policy options could be developed for tax credits for insurance coverage of vaccination benefits (VFWG Rec. 27a)

Activities of Federal Agencies and Offices (2)

- n *11. Substantially decrease the time from creation to official publication of ACIP recommendations (AWG Rec. 4)*
- n *12. Expand 317 funding to support additional national, state and local public health infrastructure needed for adolescent immunizations (AWG Rec. 5)*
- n *13. Continue federal funding for cost-benefit studies of vaccinations targeted for adolescents (AWG Rec. 9)*

Activities of State and Local Agencies and Offices

- n 14. State, local, federal governments and professional organizations outreach to providers currently serving VFC-eligible children to encourage them to participate in VFC (VFWG Rec. 14)
- n 15. States and localities develop mechanisms for billing insured children and adolescents served in the public sector, with technical support and possibly funding from CDC (VFWG Rec. 16)

Other Recommendations of the Adolescent Workgroup

- n *16. Ensure adequate funding to cover all costs (including to schools) associated with child and adolescent school immunization mandates (AWG Rec. 7)*
- n *17. Promote shared public and private sector approaches to funding school-based and other complementary-venue child and adolescent immunization efforts (AWG Rec. 8)*

Private Sector Recommendations

Improving Business Practices in Provider Offices

- n 18. AMA's RUC should review Relative Value Unit coding to ensure it accurately reflects non-vaccine costs of vaccination (including combination vaccines) (VFWG Rec. 18)
- n 19. Vaccine manufacturers and distributors work with individual providers to reduce financial burden for initial and ongoing vaccine inventories (VFWG Rec. 19)
- n 20. Professional medical organizations provide members with technical assistance on efficient business practices associated with immunization such contracting and billing (VFWG Rec. 20)
- n 21. Medical providers, particularly in smaller practices, should participate in pools of vaccine purchasers to obtain volume ordering discounts (VFWG Rec. 21)

Reducing Underinsurance and Financial Barriers: Voluntary Standards

- n 22. CDC and other relevant stakeholders develop and support additional employer health education efforts (VFWG Rec. 22)
- n 23. Insurers and health care purchasers adopt contract benefit language flexible enough to permit coverage and reimbursement for new or altered ACIP recommendations and vaccine price changes that occur mid-contract period (VFWG Rec. 23)
- n 24. All public and private health insurance plans should voluntarily offer first-dollar coverage of all costs associated with the acquisition, handling, storage and administration of routine and catch-up childhood and adolescent vaccines (VFWG Rec. 24)
- n 25. Insurers and health care purchasers assure vaccination reimbursement is based on methodologically sound cost studies of efficient practices (VFWG Rec. 25)

Reducing Underinsurance and Financial Barriers: Mandatory Coverage

n *26. National legislation to mandate first-dollar insurance coverage of ACIP recommended adolescent vaccines (and associated costs) in all health plans exempted from state mandates by ERISA and all health plans serving federal employees (AWG Rec. 3)*

– **It was felt by the Finance Workgroup that this approach was not viable.**

Dropped Recommendations

- ⁿ Based on feedback received from stakeholders and NVAC members, certain proposed recommendations were dropped:
- Recommendations advocating state-by-state solutions
 - Recommendations to expand VFC to underinsured children served in any public or private setting
 - Recommendations relying on significant expansion of 317 appropriations to track increases in the VFC entitlement, or to cover vaccine administration for all children who receive publicly purchased vaccines
 - Recommendation to set a minimal level of reimbursement for Medicaid vaccine administration
 - Recommendation to convene expert panels to explore the use of insurance mandates and universal vaccine purchase/reimbursement

Key Themes of Finance Workgroup Discussions

- n Strong support for national-level solutions vs. state-by-state approaches
- n Strong opposition from multiple stakeholders on use of universal purchase systems or insurance mandates to address financing problems
- n Broad support for long-term solutions, i.e. modifying VFC program to include underinsured children served at public health clinics

Next Steps

- n The NVAC will vote on the proposed recommendations at its September meeting
- n A final report of the Finance Workgroup will be prepared and disseminated
- n Adult vaccine financing will be addressed