

Vaccine Financing, Post-ACA

**National Vaccine Advisory Committee
Washington, DC**

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Lance E. Rodewald, MD

Director, Immunization Services Division
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

Topics

- Vaccine tools, challenges, and NVAC recommendations
- New immunization tools from ACA and NVAC recommendations
- Transition to ACA-advantaged programs

Pre-ACA Tools

- VFC and Section 317 immunization programs
 - Vaccine purchase
 - Infrastructure funding, for states and CDC
- Pediatric vaccine contracts for states' use
- Health insurance coverage for vaccination
- Vaccine administration fee for providers
- Medicare covers vaccines and their administration

Pre-ACA Challenges

- VFC has structural gap of underinsured
- Health insurance coverage for vaccines voluntary, incomplete, variable timeliness, and states without authority to regulate ERISA health plans
- Medicare only includes influenza, PPS, and hepatitis B in Medicare Part B; rest in Medicare Part D
- Medicaid/VFC vaccine administration fee at state discretion with no minimum payment
- Few health department clinics are paid to immunize insured individuals
- States have no authority to use CDC vaccine contracts for adult vaccines

Selected NVAC Recommendations for CDC or Vaccine Financing

- VFC should be extended to cover underinsured in health department clinics (1)
- Health insurance should voluntarily cover ACIP-recommended vaccines and their administration (12)
- CDC and CMS should publish Medicaid/VFC vaccine administration fees (3) and costs to vaccinate (15)
- CDC should promote billing for immunization services in public health clinics (22)
- Cost-benefit studies for child and adolescent vaccination should be funded (20)

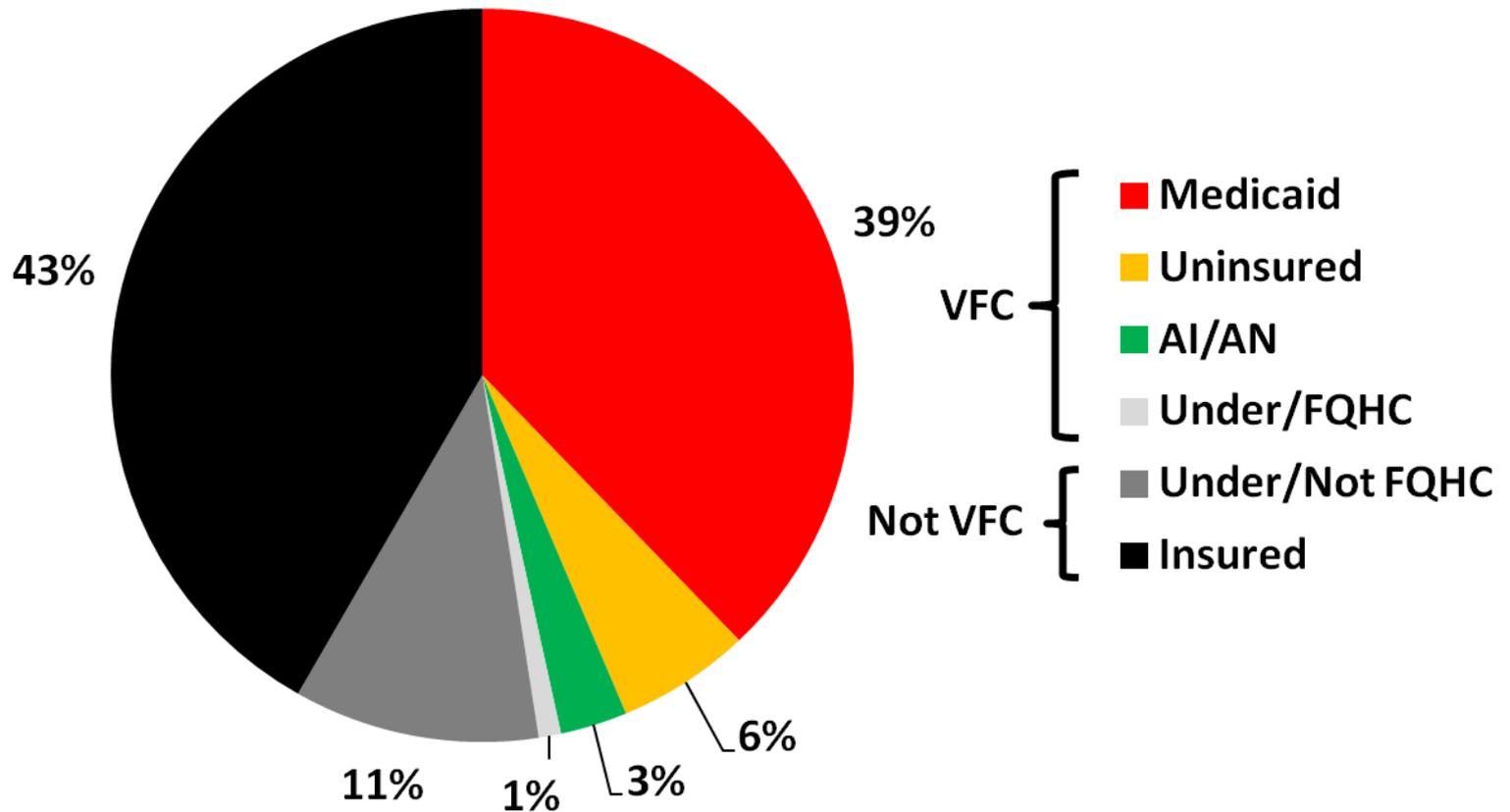
ACA-Provided Tools

- “Immunization” or “vaccine” mentioned 44 times in statute!
- Health insurance mandate for people of all ages
 - ACIP sets coverage standard
 - No cost sharing or co-pays
 - ERISA plans included in the mandate
- States’ optional use of CDC adult vaccine contracts
- Medicaid/VFC vaccine administration fee federalized in 2013 and 2014
- ACA has Prevention and Public Health Funding opportunities
- GAO to study moving all ACIP-recommended vaccines to Medicare Part B
- VFC authorities not changed by ACA

How will the system change under ACA?

ACCESS TO VACCINE

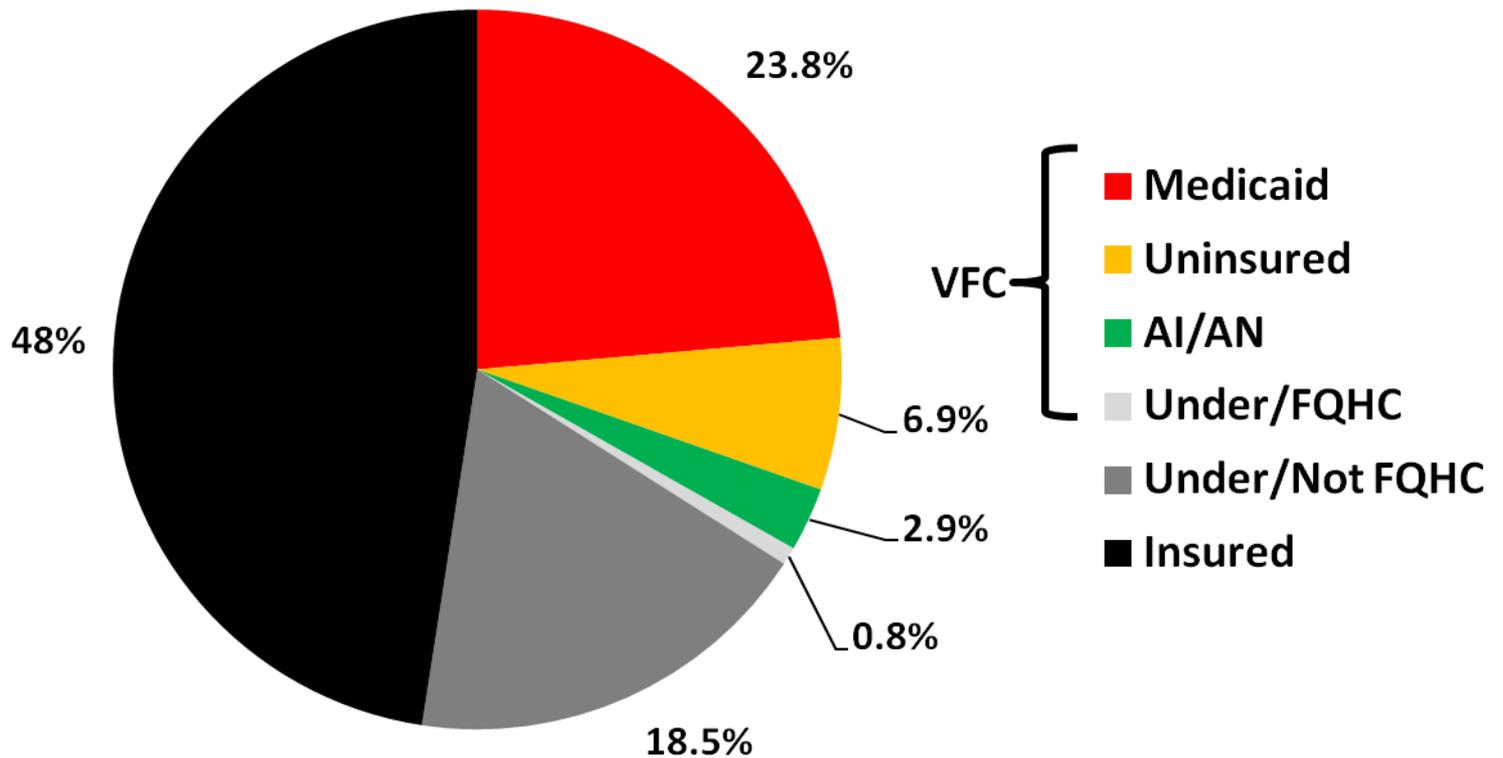
Insurance/VFC Status 19-35 Month Old Children; 2009 NIS Insurance Module



Totals add to > 100% because some AI/AN children are enrolled in Medicaid

Phil Smith et al. Public Health Reports, in press

Insurance/VFC Status 13-17 Year Olds; 2008 NIS-Teen Insurance Module



Totals add to > 100% because some AI/AN children are enrolled in Medicaid

Megan Lindley et al. Public Health Reports, in press

Number of Vaccines in the Routine Childhood and Adolescent Immunization Schedule

1985

Measles
Rubella
Mumps
Diphtheria
Tetanus
Pertussis
Polio

7

1994

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

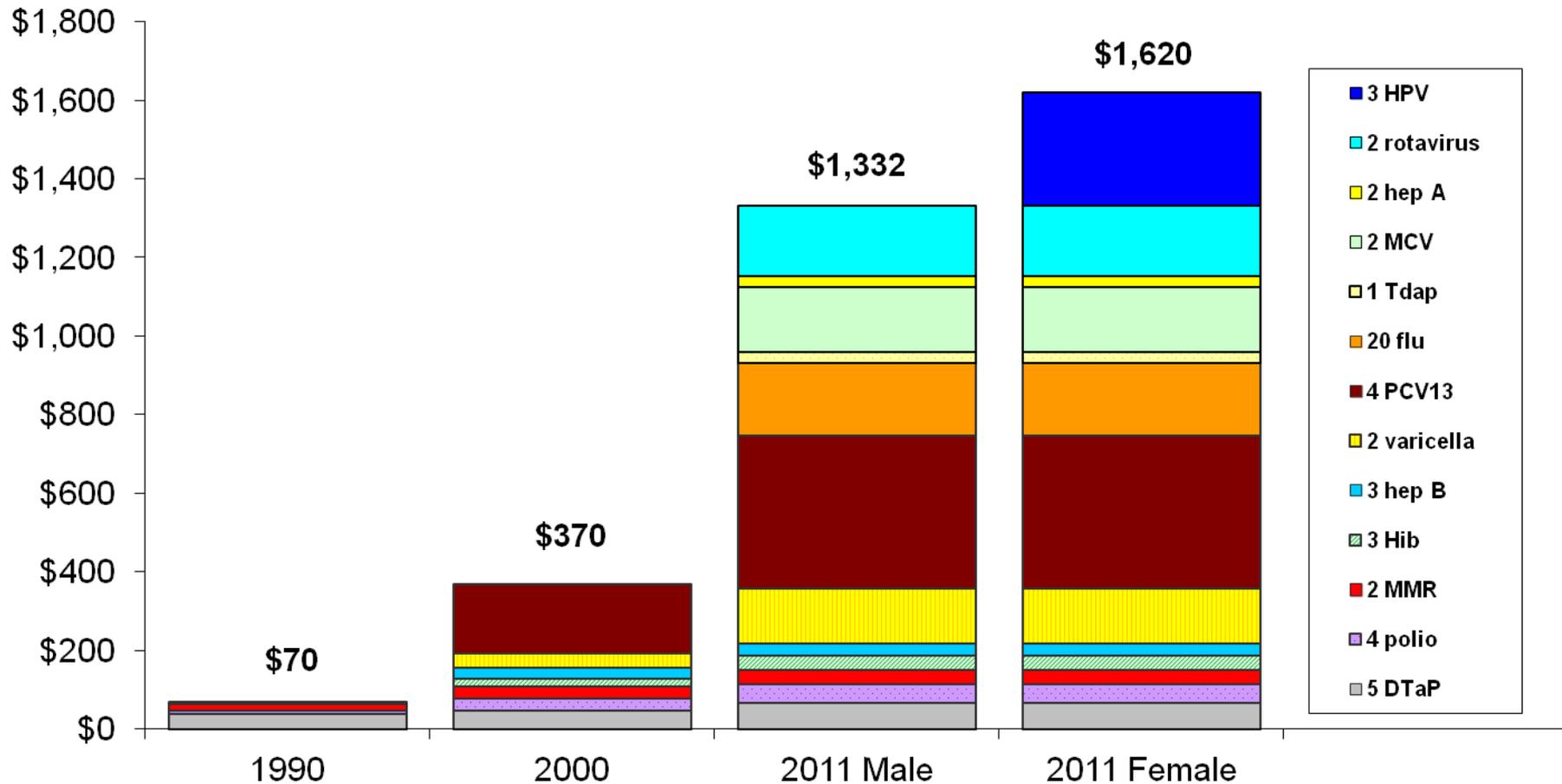
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2011

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

16

Cost to Vaccinate One Child with Vaccines Universally Recommended from Birth Through 18 Years of Age: 1990, 2000, and 2011

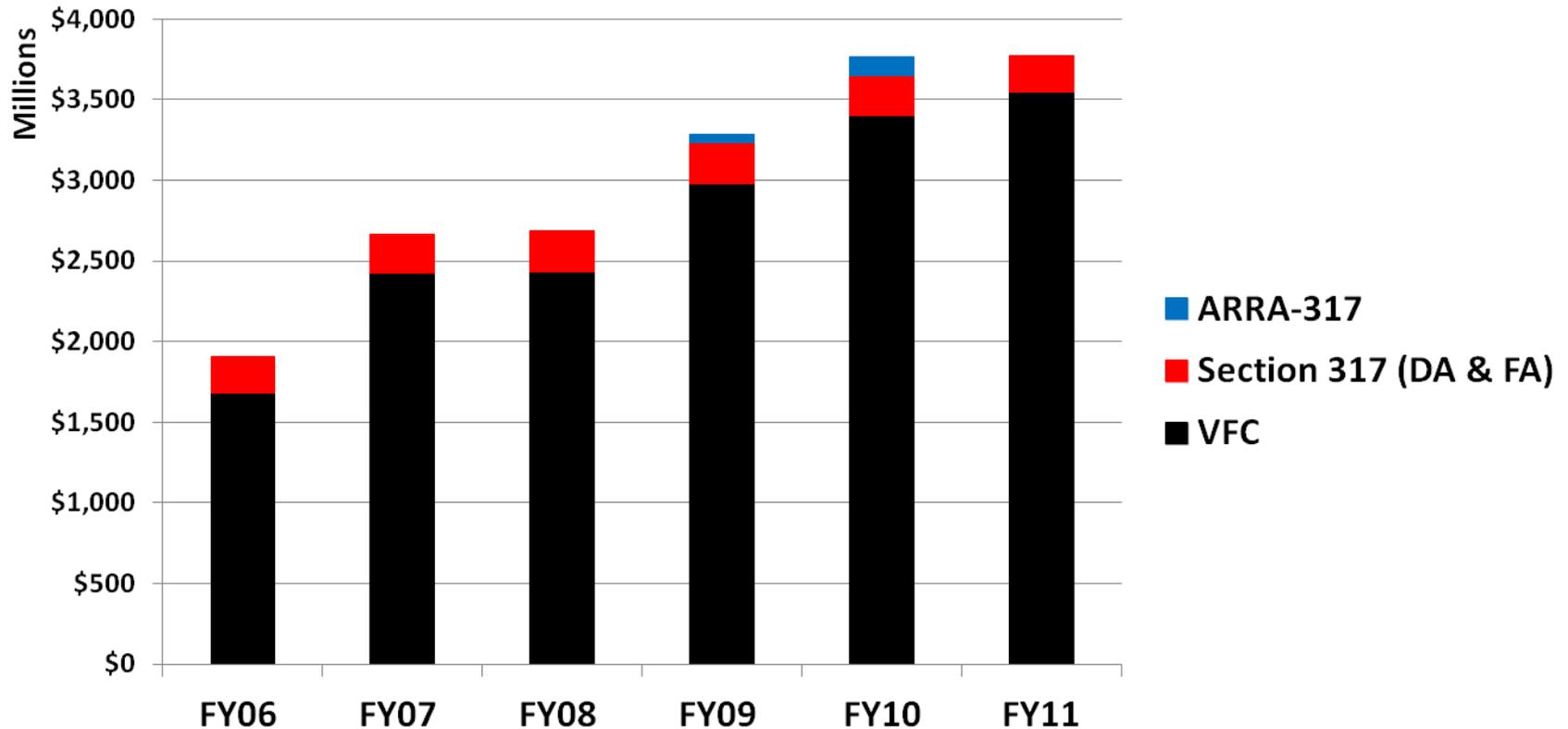


2011 represents minimum cost to vaccinate a child (birth through 18); exception is no preservative influenza vaccine, which is included for children 6-47 months of age.

HPV excluded for boys because it is not routinely recommended by the ACIP.

Federal contract prices as of February 1, 1990, September 27, 2000, and April 1, 2011.

VFC and Section 317 Vaccine Funding, FY2006 – FY2011*



* Section 317 funding for FY2011 estimated as of May 2011

Gaps in Vaccine Financing for Underinsured Children in the United States

Grace M. Lee, MD, MPH

Jeanne M. Santoli, MD

Claire Hannan, MPH

Mark L. Messonnier, PhD

James E. Sabin, MD

Donna Rusinak

Charlene Gay

Susan M. Lett, MD, MPH

Tracy A. Lieu, MD, MPH

THE NUMBER AND COST OF NEW vaccines routinely recommended for children and adolescents has increased considerably since 2003. New or expanded

Context The number of new vaccines recommended for children and adolescents has nearly doubled during the past 5 years, and the cost of fully vaccinating a child has increased dramatically in the past decade. Anecdotal reports from state policy makers and clinicians suggest that new gaps have arisen in financial coverage of vaccines for children who are underinsured (ie, have private insurance that does not cover all recommended vaccines). In 2000, approximately 14% of children were underinsured for vaccines in the United States.

Objectives To describe variation among states in the provision of new vaccines to underinsured children and to identify barriers to state purchase and distribution of new vaccines.

Design, Setting, and Participants A 2-phase mixed-methods study of state immunization program managers in the United States. The first phase included 1-hour qualitative telephone interviews conducted from November to December 2005 with 9 program managers chosen to represent different state vaccine financing policies. The second phase incorporated findings from phase 1 to develop a national telephone and paper-based survey of state immunization program managers that was conducted from January to June 2006.

Current and Future Insurance/VFC Status Comparison

2009



Full ACA Implementation



Health Department Billing Practices

- One systematic study from 2001 on health department billing
 - 94% bill Medicaid for their assigned pts
 - 64% bill Medicaid for referred pts
 - 31% bill private insurance

Although budget constraints may make it difficult, the clinics (in collaboration with local and state health departments) may be able to improve their financial standing by billing third-party payers for services rendered and by participating as providers in managed care.

Number, cost of vaccines spur budget dilemma

Several states are asking insurers to pay for children they cover and investigating alternate financing strategies.

By [Victoria Stagg Elliott](#), *AMNews* staff. Nov. 5, 2007.

As of Jan. 1, 2008, the North Dakota Dept. of Health will stop struggling to pay for many of the vaccinations for all the state's children and adolescents. The recommended list has gotten too long and too expensive, so officials are now asking insurance companies to pay to immunize the children on their rolls. If it is a covered service, they will be billed.

"When we gathered information on who was receiving vaccines, we discovered that nearly all '317 funds' (a Centers for Disease Control and Prevention immunization grant) were subsidizing insurance companies. That didn't seem to be right," said State Health Officer Terry Dwelle, MD, MPH.

Oregon's Results: Increased Revenue and Sparing of Section 317 Funding

TABLE 1 ● Funds collected by the Oregon Immunization Program for billable vaccines, 2003–2007

Year	Doses billed	Total amount billed	Total collected	% of 317 saved
2003	16 124	\$357 831	\$328 353	13
2004	15 548	\$392 472	\$346 631	23
2005	19 711	\$588 156	\$580 945	34
2006	25 416	\$854 839	\$814 681	45
2007	28 954	\$1 231 670	\$1 156 826	52
Total	105 753	\$3 424 968	\$3 227 436	33

Billing Third Party Payers for Vaccines: State and Local Health Department Perspectives

Carlos Quintanilla, Lorraine Duncan, and Lydia Luther

J Public Health Management Practice, 2009, 15(5), E1–E5

Public Health Impact

The savings from these well-insured persons enabled the OIP to offer vaccines to the following groups:

- Adults at high risk (hepatitis A and B);
- Adolescents and adults (Tdap);
- Public clinic employees and volunteers (influenza, Tdap, hepatitis A and B, MMR, and varicella);
- All children born in Oregon birthing hospitals (hepatitis B vaccine);
- 317-eligible children and adults (influenza vaccine);
- All 317-eligible girls age 9 through 18 (HPV vaccine);
- 317-eligible infants (rotavirus vaccine); and
- 317-eligible children and adolescents (MCV4 vaccine).

Billing Third Party Payers for Vaccines: State and Local Health Department Perspectives. J Public Health Management Practice, 2009, 15(5), E1-E5.

It takes more than vaccine to vaccinate

PROGRAM SUPPORT

Private Insurance Vaccine Administration Payments

TABLE 5 Vaccine Administration Fee Reimbursement From Most Common Payer

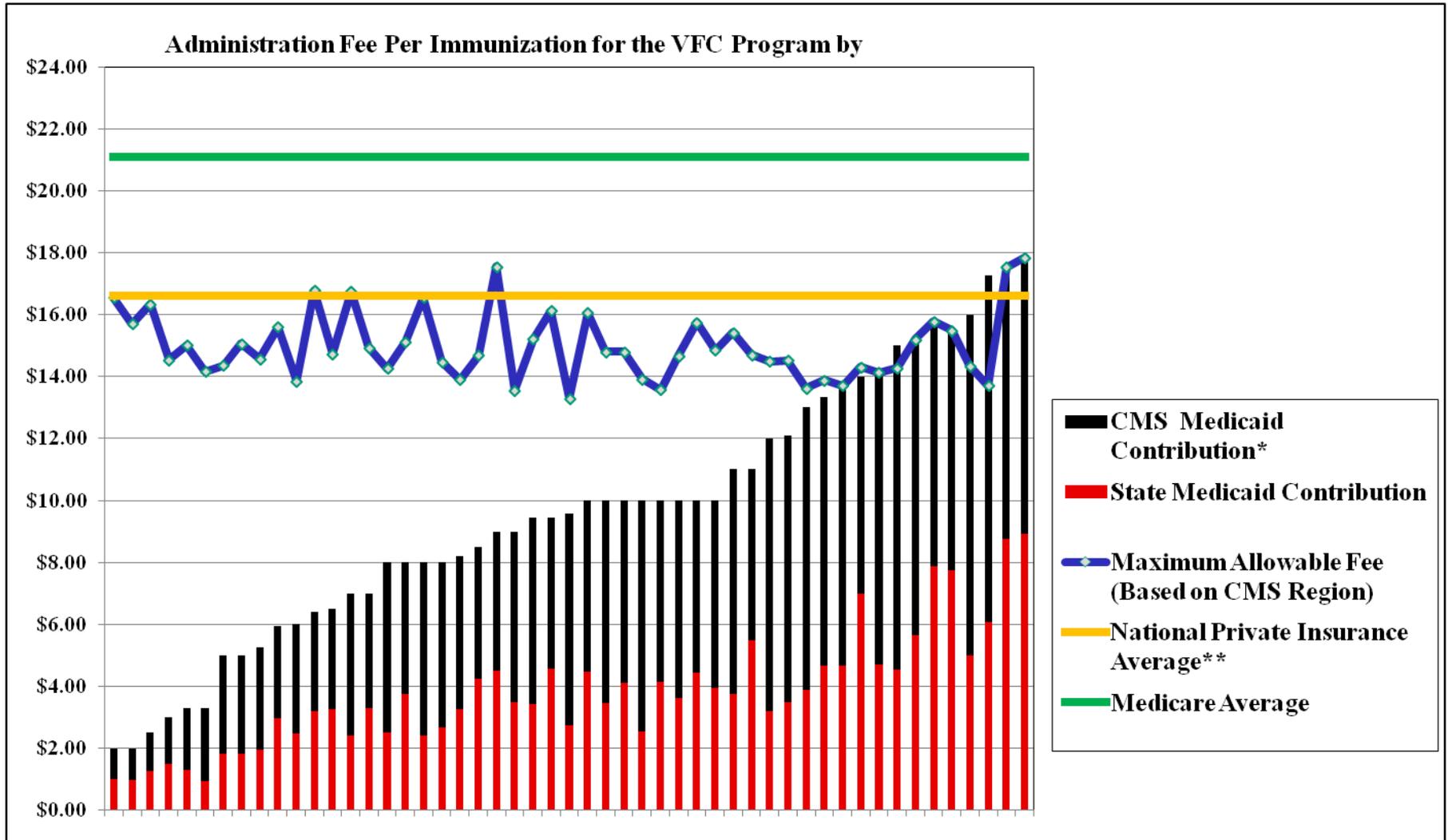
	Administration Fee Reimbursement	
	First Dose (CPT 90471) ^a	Subsequent Doses (CPT 90472) ^b
Mean, \$	16.62	11.63
Maximum, \$	26.55	37.20
Minimum, \$	3.87	3.36

CPT indicates Current Procedural Terminology.

^a Calculations exclude one instance where the most common payer did not reimburse for first dose administration.

^b Calculations exclude three instances where the most common payer did not reimburse for administration of subsequent doses.

VFC, average private insurance, and average Medicare vaccine administration rates



*2011 FMAP rates used to identify the maximum CMS contribution

**National private insurance average from: Freed G, et al. Pediatrics 2008; 122:1325-1331

Rates available on: http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/VFC_RMR.pdf

SEC. 1202. PAYMENTS TO PRIMARY CARE PHYSICIANS.

...

“(C) payment for primary care services (as defined in subsection (jj)) **furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate** that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009);”; and

.....

“(2) **services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.**”.

.....

“(dd) **INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.**—...the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.”

Source: Affordable Care Act

Public Health Workforce and Infrastructure

- Striving to maintain operations funding levels in declining discretionary budget
 - Preparedness and public health funding
 - Balance between Section 317 vaccine and operations
- Section 317 operations funding supports VFC
 - 70% of federal operations funding from Section 317
 - Loss of Section 317 support for VFC would damage programs' ability to fulfill VFC entitlement

TRANSITION

Transition Challenges

- Grandfathered health plans
 - May have slow transition
 - Enforcement critically important
 - In meant time, underinsurance will exist
- ACA does not address private insurance payment amounts for vaccines
- Billing in health departments requires investment and planning
- Very difficult government funding environment

How to Get From Here to There: Transition Principles

- Try to provide vaccine for underinsured children in public sector settings while grandfathered plans exist
- Provide disincentive to grandfathered plans to continue unchanged
- Strengthen health department clinics – important for preparedness
- Maintain Section 317 operations funding to support immunization program efforts
- Articulate expectations of increased Medicaid/VFC administration fee and evaluate impact

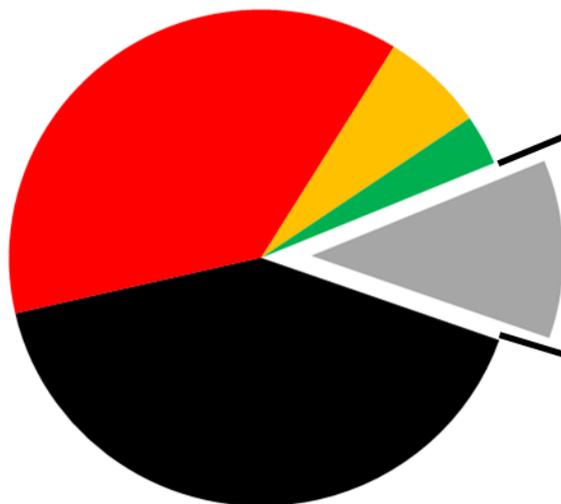
Transition Actions

- ACA's Prevention and Public Health funding opportunity announcement
 - Available only to Section 317 programs
 - Multifaceted opportunity
 - IT solutions for accountability
 - Billing revenue stream for local health departments
 - Strategic use of Section 317 vaccine when no longer needed for underinsured children

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

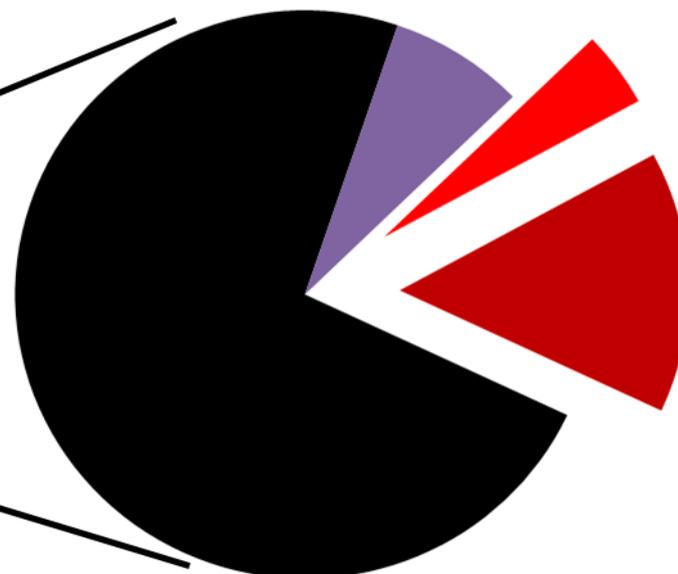
Insurance / VFC Category

■ Medicaid ■ None ■ AI / AN
■ Under ■ Full



Underinsured's Venues

■ FQHC ■ HDC ■ Private ■ Other



Section 317 Immunization Program Vaccine Funding

- Primary use for Section 317 vaccine since 1994 has been to fill VFC underinsured gap
- In ACA environment, Section 317 will not be needed routinely for childhood vaccine
- Repurposed Section 317 possibilities
 - Uninsured adults, e.g., hep B vaccine in STD clinics
 - Outbreak control

Adult Immunization in the Era of Health Reform

- Partnerships to help make ACIP-recommended vaccines available to more adults
 - Retail pharmacies
 - Workplaces
 - Medicaid
 - Hospitals
 - Federally Qualified Health Centers
- Use financial incentives and measurement to improve health care worker vaccination against influenza
- Provide vaccines to uninsured adults through public health venues
 - For example, hepatitis B vaccine in STD clinics
 - Depends on availability of Section 317 and state funding

Conclusions

- Federal government tools to control and prevent VPDs have been defined by Congress
- NVAC recommendations improved the most critical challenges
- ACIP will be in a very powerful position to set a universal standard of care that must be covered
- Transition into ACA environment will require program and insurance industry change
- A successful transition will consistently increase access to vaccines, support the immunizing programs and clinicians appropriately, and repurpose Section 317 vaccine

NVAC recommendation 20 – The Bottom Line

COST-BENEFIT VACCINE STUDIES

The Immunization Schedule Saves Dollars as Well as Lives and Suffering

- Model-based analysis of vaccines recommended through varicella updated to include PCV7, rotavirus, hepatitis A (all vaccines in the 0 to 6 year schedule except influenza vaccine)
- Health impact for each birth cohort
 - Prevent 42,000 VPD deaths
 - Prevent 20 million VPD cases
- Economic impact for each birth cohort
 - \$13 billion saving in direct medical costs
 - \$68 billion in saving to society

THANK YOU!