



HEALTH & SCIENCE

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.

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Public health officials appreciate the opportunity to prevent more disease, but paying the tab for an ever-expanding childhood and adolescent vaccination schedule has become a significant challenge. It was also a focus of the first National Immunization Congress organized by the American Medical Association and the American Academy of Pediatrics earlier this

year.

AMA policies support increased federal funding for vaccine purchase, the establishment of a national immunization strategy and encouraging health insurers to pay for this preventive service.

Uninsured children can get their shots through the federal Vaccines for Children Program, but more than half of states use other federal funds to attempt to do more. They use this money to broaden access to immunizations to those who do not fully qualify for this program, such as those whose insurance doesn't cover vaccines. A handful of states also attempt to give vaccines to all children to simplify administration, but this bill has become extremely hefty for many of these jurisdictions.

Consider North Dakota. Until 2002, it provided all recommended vaccines to all children. In the past few years, though, its policies have been shifting toward supplying the full schedule

to uninsured and underinsured kids and only an abbreviated list to those with insurance. The most recent, soon-to-take-effect change has advanced with the support of BlueCross BlueShield of North Dakota, the state's largest insurer, because the number of vaccines recommended for children has nearly doubled in the past five years, while federal funding has not kept up.

The number of vaccinations recommended for children has nearly doubled in the past five years.

"There's any number of states looking at alternative ways to pay for vaccine, and there's a number of ideas floating around," said Claire Hannan, MPH, executive director of the Assn. of Immunization Managers.

And some of these examinations may evolve into official recommendations. The vaccine finance working group of the National Vaccine Advisory Committee will publish a draft white paper on this topic by the end of the year. Their suggestions are expected to call for increases in the maximum allowable payment for this service from Medicaid and the collection of data on the expenses associated with vaccination in private physician practices beyond just the cost of the shot itself to ensure that reimbursement reflects the true expense. Manufacturers and distributors most likely will be asked to reduce financial liability

for the initial stocks of newly approved vaccines.

"It's great that we have new vaccines on the market. We have a tremendous opportunity, but the challenge is to get all children access to all recommended vaccines without any financial barriers," said Guthrie Birkhead, MD, MPH, chair of the working group and director of the Center for Community Health at the New York State Dept. of Health.

Cautious and optimistic

While both North Dakota's efforts and the ongoing, broad consideration of vaccine-financing issues have garnered much praise and attention, a great deal of concern haunts any such discourse for fear that resulting steps might negatively affect vaccination rates.

For example, it's unknown what kind of impact, if any, having an insurance co-pay will have on a parent's decision to have a child vaccinated. Physicians also are hesitant to support anything that may make vaccine administration more complicated. Already, physicians working in states that provide shots only to those eligible for the Vaccines for Children Program have to keep those supplies separate from those for kids who don't qualify for the program.

But evidence is demonstrating that increased private-sector involvement can work. A paper presented at the 2006 National Immunization Conference documented the experience of the Oregon Dept. of Human Services. Several years ago, the department started billing insurance companies covering children who received immunizations in public clinics. The approximately \$1 million so far resulting from this initiative has allowed the state to increase the number of hepatitis vaccinations it provides.

"Some people still think we're crazy, but billing worked really well for us," said Lorraine Duncan, lead author on that paper and the immunization program manager for the department.

And many in the public health system strongly support greater private-sector involvement.

"These are very creative and very important responses to the vaccine-financing issue," said Lance Rodewald, MD, director of the CDC's Immunization Services Division. "The best way to provide vaccinations is a private-public collaboration."

The goal of these efforts is not just to increase childhood vaccinations. North Dakota officials are expecting to generate enough money from insurance payments to be able to start providing publicly funded vaccines for adults, and some states already have expanded their programs to serve this age group.

In September, the Vermont Dept. of Health announced that it would start providing pneumococcal and the combined tetanus, diphtheria, pertussis vaccines at no charge for administration to those older than 18. A select list of clinics in Bennington, Vt., has started receiving supplies, and the intention is to eventually expand this program to the entire state.

[Back to top.](#)

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ADDITIONAL INFORMATION:

The price of shots

The vaccination schedule for those younger than 18 has become more expensive because it has been expanded so much. The actual cost to immunize a child fully can vary widely depending on the situation, but here is how the estimated public-sector expense has changed in the past quarter century as expressed in 2007 dollars. The HPV and rotavirus vaccines are not included because the shots are too new.

Public sector immunization cost per child:

1975	\$11.68
1976	\$10.95
1977	\$10.50
1978	\$10.06
1979	\$11.62
1980	\$10.66
1981	\$10.87
1982	\$10.61

1983	\$14.45
1984	\$16.39
1985	\$39.96
1986	\$54.16
1987	\$97.74
1988	\$110.11
1989	\$120.93
1990	\$108.44
1991	\$168.45
1992	\$163.21
1993	\$156.76
1994	\$171.92
1995	\$152.79
1996	\$196.95
1997	\$247.18
1998	\$253.89
1999	\$249.93
2000	\$241.52
2001	\$443.97
2002	\$453.97
2003	\$463.79
2004	\$524.67
2005	\$510.56
2006	\$668.81

Source: Centers for Disease Control and Prevention; analysis by Matthew M. Davis, MD, MAPP, Child Health Evaluation and Research Unit, University of Michigan, Ann Arbor

[Back to top.](#)

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Childhood vaccine supply policy by state, 2006, Centers for Disease Control and Prevention

(www.cdc.gov/vaccines/programs/vfc/projects/data/vacc-supply-public-2006.htm)

"Financing Vaccines in the 21st Century: Assuring Access and Availability," Institute of Medicine, Aug. 4, 2003 (www.iom.edu/?id=14451)

American Academy of Pediatrics/American Medical Association Immunization Congress, Feb. 27-March 1 (www.cispimmunize.org/immunizationcongress.htm)

[Back to top.](#)

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