Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 105 (The President, *et al.*) (By Request – Administration)
Education, Health, and Environmental Affairs Health and Government Operations

Statewide Advisory Commission on Immunizations - Duties and Sunset Extension

This Administration bill extends the termination date for the Statewide Advisory Commission on Immunizations from May 31, 2008 to May 31, 2010, expands the commission by one member, and specifies additional information the commission must report.

The bill takes effect July 1, 2007. The uncodified provisions of the bill terminate December 31, 2008.

Fiscal Summary

State Effect: General fund expenditures could increase by $225,000 in FY 2008 only to hire a contractor to conduct a study of existing universal vaccine purchasing systems. No effect on revenues.

(in dollars)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Revenues	$0	$0	$0	$0	$0
GF Expenditure	225,000	0	0	0	0
Net Effect	($225,000)	$0	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: A small business impact statement was not provided by the Administration in time for inclusion in this fiscal note. A revised fiscal note will be issued when the Administration's assessment becomes available.

Analysis

Bill Summary: In addition to the commission's existing duties, the commission must consider the development of a universal vaccine purchasing program and must provide an update on the status of the use of thimerosal in vaccines and any other issue related to the use of thimerosal in vaccines identified by the commission. The commission must continue to submit a report on its findings and recommendations annually by December 15 to the Governor and specified legislative committees.

In the commission's evaluation of and report on vaccines that is due on December 15, 2007, the commission must consider whether the State should have a universal vaccine purchasing system, or a similar program, to increase access to necessary vaccines.

In developing its recommendations, the commission must ● consult with stakeholders; ● review the structure, cost, scope, success, and implementation issues of similar programs in other states; ● consider any existing State or federal programs or funds, or other sources of funds, that could be used for any proposed new program; ● provide a range of options to be considered in any proposed new program; ● consider the feasibility and advisability of requiring the Department of Health and Mental Hygiene (DHMH) to reimburse vaccine administration on a per-antigen basis as an alternative to reimbursing on a per-dosage basis; ● consider all options for requiring carriers to reimburse providers adequately for the full cost of immunizations; and ● consider the feasibility of publicizing a list of wholesale vendors and the prices charged by each vendor for vaccines.

Current Law: The Statewide Advisory Commission on Immunization must: determine where vaccine shortages exist and which vaccines are in short supply; develop a recommendation for a plan to equitably distribute vaccines; and study and make recommendations about other related issues, including all available options for purchasing vaccines. Annually, by December 15, the commission must submit a report on its findings and recommendations to the Governor and specified legislative committees. DHMH must staff the commission.

Background: Universal vaccine purchasing systems, which supply all vaccines to all providers, are an approach some states are using to address the challenges of financing and distributing vaccines. According to the Centers for Disease Control and Prevention (CDC), nine states have such programs: Alaska, Idaho, Maine, Massachusetts, New Hampshire, New Mexico, Rhode Island, Vermont, and Washington. CDC advises that six states have universal select purchasing programs that supply vaccines, with the exception of one or more vaccines, to all providers. Those states are Connecticut, Hawaii, Nevada, North Carolina, North Dakota, and South Dakota.

Maryland and eight other states – as well as the District of Columbia, New York City, and San Antonio – have Vaccines for Children (VFC) programs that supply most vaccines for VFC-eligible and uninsured children to all VFC-enrolled providers. The other participating states are: Florida, Georgia, Minnesota, New Jersey, New York, South Carolina, Utah, and Wyoming. Other states have VFC programs that supply most vaccines for VFC-eligible and underinsured children to all VFC-enrolled providers or have VFC only programs that supply VFC vaccines to all VFC enrolled providers, although public health clinics may provide vaccines to all children who come for vaccination.

DHMH's VFC purchases vaccines at discounted prices from manufacturers and gives them to community providers enrolled in the program. The vaccines then are available for free to children 18 and younger who are ● Medicaid eligible; ● uninsured; • insured but whose insurance does not cover immunizations; or • Native Americans or Alaskan Natives. VFC participating physicians may not charge for the VFC supplied vaccine but may charge an administration fee of up to $15.49 per dose for non-Medicaid patients. Medicaid reimburses physicians up to $10 per dose administered for Medicaid patients.

DHMH's fiscal 2008 budget allowance includes $2.7 million for grants to local health departments and other public and private agencies to provide expanded immunization clinics and other services; $650,000 for the Vaccines for Children program; and a $150,000 grant to Maryland Partnership for Prevention to coordinate and promote adult immunization activities related to nursing home requirements for vaccination.

Evaluations of States with Universal Vaccine Purchasing Systems

An examination of eight states with universal vaccine purchasing systems by the Rutgers Center for State Health Policy for the New Jersey Department of Health and Senior Services found several benefits and challenges for states that implemented these systems. **Exhibit 1** provides details on the universal vaccine purchasing systems researchers reviewed in 2005.

Researchers found the following *benefits* to implementing a universal vaccine purchasing system.

- Health care providers would have unexpired vaccine supplies.
- HMOs would not have to negotiate the price of vaccines with vaccine manufacturers.
- Health care providers may be more likely to offer immunizations because they would no longer bear the financial risk of unused vaccines.

- An immunization registry could provide improved state and local data on immunization coverage.

The report also identified several *challenges* in establishing a universal vaccine purchasing system.

- The cost of establishing the system may be prohibitive. It was estimated that establishing such a system in New Jersey could cost more than $78 million.
- A universal vaccine purchasing system's expenses will increase over time as vaccine costs and the number of recommended vaccines increase.
- Funding has decreased for the Federal Public Service Act Section 317 grant program that funds program operations and vaccine purchases for children and adults.
- The need to find alternative funding sources to finance the system, such as private funds from insurance companies and HMOs to pay for children currently covered by private insurance.
- Limiting the choice of vaccine manufacturers to contain program costs would limit providers' choices.
- Using an existing immunization registry to facilitate a more complex ordering and distribution system would need to be mandated.
- Stakeholders representing vaccine manufacturers and distributors strongly opposed a New Jersey universal vaccine purchasing system.

An analysis of North Carolina's universal vaccine purchase program found that after the first year of the program's implementation, the percentage of children ages 12 months and 24 months who were up-to-date on their immunizations increased for children regardless of whether they were covered by private insurance or Medicaid. Researchers also found that children who had periods of being underinsured or uninsured were less likely to be up-to-date on their immunizations than children who had continuous private insurance coverage.

Thimerosal in Vaccines

Thimerosal, a preservative used in some vaccines and other products, contains approximately 49% ethylmercury. CDC states that there is no direct causal evidence that thimerosal in vaccines harms individuals, other than causing reactions such as redness and swelling where the injection occurs. CDC states that vaccines with trace amounts of thimerosal contain one microgram or less of mercury per dose.

State Expenditures: General fund expenditures could increase by an estimated $225,000 in fiscal 2008 only. This estimate reflects the one-time cost of hiring a contractor to review universal vaccine purchasing systems in other states, review funding alternatives for such systems, and present options to the advisory commission.

DHMH advises that general fund expenditures could increase by $301,342 in fiscal 2008 to implement the bill. This reflects: (1) $225,000 for a contract to review universal vaccine purchasing systems in other states; (2) hiring a contractual administrator ($44,053) to support the commission, develop a contract for the study, and be the liaison between the commission and the contractor; (3) $27,414 in travel costs for three commissioners to visit six states that have universal vaccine purchasing systems to review those systems' structure, cost, scope, success, and implementation issues; and (4) $4,875 in operational expenses. DHMH estimates fiscal 2009 expenditures at $23,274 to reflect the salary and related operational expenditures for the contractual administrator whose position would terminate December 31, 2008.

The Department of Legislative Services (DLS) disagrees with this estimate. DHMH is currently required to staff the commission. Existing DHMH staff could write and monitor the contract for the universal vaccine purchasing system study. DLS also disagrees with the travel expenses for commissioners. DLS assumes that the contractor conducting the study will visit a number of states with universal vaccine purchasing systems (as determined by the contract) and will evaluate those systems' performance. DLS does not believe it is necessary for commissioners to duplicate the contractors' efforts.

Additional Information

Prior Introductions: None.

Cross File: HB 140 (The Speaker, *et al.*) (By Request – Administration) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene; "Childhood Vaccine Supply Policy – 2005," Centers for Disease Control and Prevention; *Examination of Universal Vaccine Purchasing States and New Jersey*, Rutgers Center for State Health Policy, November 2005; "Impact of North Carolina's Universal Vaccine Purchase Program by Children's Insurance Status," *Archives of Pediatrics & Adolescent Medicine*, Volume 153, July 1999; Department of Legislative Services

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Exhibit 1 Summary of Universal Vaccine Purchasing Systems by State in 2005								
	Alaska	**Idaho**	**Maine**	**Massachusetts**	**New Hampshire**	**New Mexico**	**Rhode Island**	**Washington**
Coverage	All children 0-18. Adults: tetanus, pneumoccocal and influenza	All children 0-18	All children 0-18	All children 0-18 Adults: influenza only	All children 0-18	All children 0-18	All children 0-18	All children 0-19
Total Vaccine Budget	$12 million	$15 million	Unable to report the total budget. State's portion $1.5 million	$54 million for children; $3 million for adult influenza vaccines	$10 million	$13 million	$12 million	$42 million
Cohort of Children	10,000	20,000-22,000	13,000-14,000	80,000-81,000	14,000	28,000	13,000	80,000
Total Program Costs/Cohort of Children*	Unable to be calculated	$714.29	Unable to be calculated	$670.81	$714.29	$464.29	$923.08	$525.00
UVPS Funding	VFC, 317**, and state funds for children. State funds only for adults.	VFC, 317, and state funds (16%-20%).	VFC, 317, state funds, and HMO reimburse-ment.	VFC (40%-45%), 317 (15%-20%), and state funds (35%-45%).	VFC, 317, private industry pays the remaining costs (33%).	VFC (69%), 317 (15%), state funds (8%), HMO reimbursement (8%).	VFC (47%), 317 (12%). Private insurance pays remaining costs (41%).	VFC (60%), 317 (10%), and state funds (30%).
Immunization per person costs	$513 through age 18	Not reported	Not reported	$519.06 through age 18	$300 for a child under age 1	$500 through age 18	Not reported	Not reported
Administration Fees	$27 and up for the first vaccine and then fees are pro-rated. Additional fees on average, $5-$20.	$14.34 per shot. Reimbursed by insurance or Medicaid. Most physicians charge for a well-visit.	Providers charge $5.	Not reported	Providers charge an administration fee. Range of fees was $70-$250, including a well-visit.	Not reported	Not reported	Providers charge $15.65 for administration for non-Medicaid children and $5 for Medicaid children.

*This figure was calculated by dividing the total program costs by the number of children in the birth cohort. Calculated cost does not account for wastage and only provides an estimate of the cost per child in the cohort. This does not include Alaska because their program covers a number of adult immunizations, nor Maine because that state did not provide a total budget.

**Federal Public Service Act Section 317 grant program for program operations and vaccine purchases for children and adults.

Source: Rutgers Center for State Health Policy, November 2005