HPV Vaccine Cost, Funding Challenges Surface

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KANSAS CITY, MO. — In the rush to mandate the human papillomavirus vaccine, several implementation issues, not the least of which is cost, remain unresolved, Dr. Howard Backer said at the National Immunization Conference sponsored by the Centers for Disease Control and Prevention.

Private providers can expect to pay between $10,000 and $15,000 in vaccine inventory per month when adding in the human papillomavirus (HPV) vaccine approved for use in girls and women aged 9-26 years. For a multiprovider practice with five to six physicians who provide childhood vaccines, inventory costs could add up to about $100,000 a month.

"A lot of them aren't willing to put out that much money up front when it may take months before they're reimbursed," said Dr. Backer, immunization branch chief, California Department of Health Services in Sacramento, and chair of the Association of Immunization Managers.

The American Medical Association and American Academy of Pediatrics are working on ways of addressing this. But for now, it means a lot of providers aren't jumping into HPV vaccinations. "They thought it was a good idea until they looked at what it really meant to buy that much vaccine for their practice[s]," he said.

In addition, reimbursement for vaccine administration costs, which include staff time, storage equipment, injection supplies, and possibly even insurance against vaccine loss, is woefully inadequate. It is often about $5-$10 per administered dose, and probably should be at least 20%-25% above vaccine cost, which is approximately $120 per dose, with three doses required over 6 months.

Private providers can sign up with the federal Vaccines for Children (VFC) program, which allows clinicians to receive free vaccines for qualified individuals up to age 18. But this leaves two problem populations—women aged 19-26 years, and the underinsured, whose insurance may not cover vaccinations.

Dr. Backer presented a recent Association for Immunization Managers survey of 50 program managers that shows 72% of states provide HPV vaccine to VFC-eligible children. About half (53%) of the program managers use Medicaid funds to cover vaccinations for women aged 19-26 years,

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whereas very few cover the underinsured in the private (22%) or public (30%) settings.

"It's a challenge to fund this vaccine across the spectrum of girls and women for whom it is recommended," he said in an interview. "The numbers are increasing as the states add funding or pass insurance mandates, but I doubt it will reach 100% coverage for 9- to 26-year-old females."

Many private insurance companies have not yet decided if they will cover the vaccine, and some states have been hesitant to commit beyond the 11- to 12-year-old age group until they receive the necessary state appropriations and are reassured they will have enough vaccine for the VFC population. Still, a number of new nontraditional vaccine providers such as STD clinics, family planning offices, and pharmacies are expressing interest in the vaccine. Although enthusiastic, many have a poor understanding of vaccine implementation issues and lack the necessary office infrastructure, Dr. Backer said.

Moreover, some of the new partners, such as ob.gyns., want to provide only the HPV vaccine. Under VFC rules, providers are supposed to offer all vaccines for which the patient is eligible.

It is unclear whether an exemption will be made for these new partners. Currently, permission is granted on an individual basis by the CDC to states that want to obtain exemptions or add new rules to the VFC program requirements.

Finally, Dr. Backer questioned whether the emergence of nontraditional HPV vaccine providers would jeopardize the medical home model, upon which the VFC program was based, if patients opt to bypass their physician's office in favor of their local pharmacy. ■