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## High Cost of HPV Vaccine Limits Access in Surprising Way: The Problem with Private Insurance

By Rebecca Gudeman

On June 8, 2006, the FDA approved the first vaccine against the Human Papillomavirus (HPV). Within the month, it was added to the federal government's list of recommended vaccines for children. HPV is the world's most common sexually transmitted disease and causes nearly 100 percent of cervical cancers in women.<sup>1</sup> Because there is no cure for HPV, the vaccine presents the first opportunity to prevent the thousands of deaths and millions of medical interventions HPV currently causes each year. With its status as a vaccine recommended by the Centers for Disease Control, Immunization Advisory Committee, the HPV vaccine should be easily accessible. However, its high cost is becoming a barrier to care. The HPV vaccine is the most expensive of all recommended<sup>2</sup> children's vaccines.<sup>3</sup> It costs \$360 to vaccinate one child against HPV.<sup>4</sup> By comparison, most other recommended vaccines cost less than \$50.<sup>5</sup> The HPV vaccine's high cost is a barrier to use, although not in the expected way. Because many minors are eligible for free or low cost vaccinations through private insurance or public programs, the

cost is not reducing demand. Rather, only a limited number of clinicians are willing and able to provide the immunization through private insurance because of high up front costs. This summer, multiple state legislatures are considering bills designed to increase the availability of the HPV vaccine. Many of the bills require that private insurance cover the HPV vaccine as a plan benefit. This legislation would increase availability on paper. However, increased insurance coverage will have limited impact on availability in the real world until clinicians are enticed to provide the vaccine as a clinic service in spite of its price tag.

### The HPV Virus and Vaccine

The Human Papillomavirus infects up to 80 percent of all sexually active people at some point in their lives.<sup>6</sup> While most people's immune systems clear the infection, a significant percentage of people remain infected. Most infections will not lead to deadly outcomes. However, four strains of the virus can cause cell abnormalities that ultimately lead to cervical cancer.<sup>7</sup> In addition, HPV can cause penile

cancer, genital warts, and recurrent respiratory papillomatosis (RRP) in babies born to infected women.<sup>8</sup> There is no cure for HPV.

The Food and Drug Administration (FDA) approved Gardasil, the first HPV vaccine, on June 8, 2006, and Merck & Co., Inc. began distributing it in early fall 2006.<sup>9</sup> Gardasil protects against four strains of HPV, including the two strains responsible for 70 percent of cervical cancer cases.<sup>10</sup> An initial five-year study suggests that Gardasil is 100 percent effective for at least five years and is likely to be effective even longer.<sup>11</sup> GlaxoSmithKline asked the FDA to approve its HPV vaccine, Cervarix, in March 2007. The FDA response is pending.<sup>12</sup>

Gardasil does not treat or cure HPV; it simply prevents infection. Therefore, it only works if individuals are inoculated before exposure. Most people become infected within just a few years of first sexual intercourse.<sup>13</sup> For this reason, the Centers for Disease Control's Immunization Advisory Committee (ACIP) recommends vaccinating against HPV prior to sexual onset. Because at least 62 percent of teens have had sexual intercourse by

1 Zimet, Mays, et al., *Acceptability of Human Papillomavirus Immunization*, 9 J. Women's Health & Gender-Based Med. 1 (2000).

2 The federal government recommends certain vaccines for children through the Centers for Disease Control's Immunization Advisory Committee (ACIP). ACIP currently recommends children receive 13 different vaccines before they turn 18 years old. See *2007 Child & Adolescent Immunization Schedules*, available at <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable>.

3 Association of State and Territorial Health Officials (ASTHO), *Cost to Immunize one Child in Public Sector 2007* (citing data from Centers for Disease Control), available at <http://www.astho.org/pubs/2007HillCosttoimmunize1.pdf>.

4 *Id.* (The federal government's contract price is estimated to be \$290.25.)

5 *Id.*

6 Gardiner Harris, *U.S. Approves Use of Vaccine for Cervical Cancer*, N.Y. Times (June 9, 2006), available at <http://www.nytimes.com/2006/06/09/health/09vaccine.html?ex=1154836800&en=874435cc541d7c15&ei=5070>.

7 Koutsky, *Epidemiology of Genital Human Papillomavirus Infection*, 102 Am J Med 5, Sup. 1 (1997).

8 Kahn, *Vaccination as a Prevention Strategy for Human Papillomavirus-related Diseases*, 37 J. Adol. Health, 6, Supp. 1 (2005).

9 Harris, *supra*, fn. 9.

10 Kahn, *supra*, fn. 11.

11 Dempsey, Zimet, et al., *Factors That Are Associated With Parental Acceptance of Human Papillomavirus Vaccines: A Randomized Intervention Study of Written Information About HPV*, 117 Pediatrics 5 (2005).

12 Thomas Ginsburg, *Glaxo asks Cervarix Approval*, Philadelphia Inquirer (May 30, 2007), available at [http://www.philly.com/inquirer/business/20070330\\_Glaxo\\_asks\\_Cervarix\\_approval.html](http://www.philly.com/inquirer/business/20070330_Glaxo_asks_Cervarix_approval.html).

13 Winer et al., *Genital Human Papillomavirus Infection Incidence and Risk Factors in a Cohort of Female University Students*, 157 Am. J. Epidemiol. 218 (2003).

age 18,<sup>14</sup> ACIP recommends routine vaccination of 11- to 12-year-old girls and gives general approval for vaccinating females ages 9 to 26.<sup>15</sup>

Studies suggest that the great majority of parents are interested in vaccinating their children against HPV because they recognize the preventive health and safety benefits of HPV inoculation.<sup>16</sup> According to some doctors, “the public is clamoring for [the vaccine].”<sup>17</sup>

### Private Insurance Traditionally an Important Source of Coverage

Private insurance traditionally has played an important role in vaccine finance and distribution, funding just under half of all recommended vaccines in recent years.<sup>18</sup> Most large health insurance companies include ACIP recommended vaccines as a plan benefit, and most have agreed to cover the HPV vaccine.<sup>19</sup> In some states, state law already obligates private insurance to cover the cost of ACIP recommended vaccines for children under 18 years old.<sup>20</sup> However, not every private insurance plan covers the HPV vaccine, and even when a plan does provide coverage, co-payments and deductibles can make vaccination prohibitively expensive.

14 Slomovitz, Sun et al., *Are Women Ready for the HPV Vaccine?* 103 *Gynecologic Oncology* 1 (Oct. 2006).

15 Centers for Disease Control, *Quadrivalent Human Papillomavirus Vaccine: Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, (Mar. 23, 2007), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5602a1.htm>.

16 Constantine, Jerman, *Acceptance of Human Papillomavirus Vaccination among Californian Parents of Daughters: A Representative Statewide Analysis*, 40 *J. Adol. Health* 2 (Feb. 2007) (In a 2006 study of California parents, 81 percent said they were likely to vaccinate their adolescent daughter against HPV. Of parents interested in vaccinating their teen, almost 40 percent cited health and safety reasons for the decision and 25 percent cited interest in prevention.).

17 *N.H. Hit with Cervical Cancer Vaccine Shortage*, Foxnews.com, (Apr. 23, 2007), available at [www.foxnews.com/story/0,2933,267892,00.html](http://www.foxnews.com/story/0,2933,267892,00.html) (quoting Dr. Elizabeth Sanders of Sanders Family Medicine in Concord, N.H.).

18 Rodewald, *infra*, fn. 37; see Institute of Medicine, *Calling the Shots: Immunization Finance Policies and Practices*, National Academy Press: Washington, D.C., 2000, fig. 3-2.

19 Kaiser Family Foundation, *HPV Vaccine: Implementation and Financing Policy*, Women’s Health Policy Fact Sheet, Jan. 2007, available at <http://www.kff.org/womenshealth/7602.cfm>.

20 See e.g. Cal. Health & Saf. Code §§ 1367.3; 1367.35; Cal. Insur. Code §§ 10123.5; 10123.55.

## New Hampshire Repeals Parental Notification Law<sup>1</sup>

By Linnea Forsythe

On June 29, Gov. John Lynch of New Hampshire signed a bill into law repealing a requirement that health care providers notify parents at least 48 hours before a minor has an abortion.<sup>2</sup>

The Governor’s action marks the final chapter in the controversial teen abortion litigation – *Ayotte v. Planned Parenthood of Northern New England* – that went all the way to the U.S. Supreme Court.

The New Hampshire legislature passed the “Parental Notification Prior to Abortion Act” (the Act) in June 2003. Before its implementation, health care providers challenged the Act in federal district court.<sup>3</sup> Their lawsuit claimed that the Act was unconstitutional because it did not allow a minor to obtain an abortion without parental notification when her health was at risk. The district court agreed, finding the Act unconstitutional because it lacked a health exception. The court invalidated the Act in its entirety. The First Circuit affirmed the district court’s decision, and the U.S. Supreme Court decided to hear the case.<sup>4</sup>

The Supreme Court’s opinion in *Ayotte* surprised both sides. Rather than review the constitutional questions presented, the Court addressed the appropriateness of relief granted. Although in a prior case the Supreme Court invalidated an entire statute

because it did not include a health exception,<sup>5</sup> the Court in *Ayotte* questioned whether it was necessary to strike the entire law. The Supreme Court held that a court must consider whether it can shape a more “modest” remedy that would preserve the statute and eliminate its unconstitutional provisions.<sup>6</sup> It set out three principles that should frame a remedies analysis and remanded the case back to the First Circuit to determine the appropriate relief.<sup>7</sup>

Advocates on both sides were watching carefully to see how the First Circuit would apply these principles, as the Supreme Court clearly suggested limited relief would be possible in the case. If the First Circuit had found a way to preserve part of the parental notification statute while nullifying its unconstitutional application, the decision would have seriously impacted how adolescent abortion rights are both legislated and litigated in the future.

Now, with the Act’s repeal, the case will no longer be decided. Thus, advocates will have to wait for another case to see the real ramifications of *Ayotte* on abortion rights advocacy.

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1 Portions of this article derive from Gudeman, *The Ayotte Opinion: Implications for New Hampshire and Other States*, Youth Law News, Jan.–Mar. 2006.

2 H.B. 184, 2007 Gen. Court, 160<sup>th</sup> Sess. (N.H. 2007).

3 *Planned Parenthood of N. New Eng. v. Heed*, 296 F. Supp. 2d 59 (D.N.H., 2003).

4 *Planned Parenthood of N. New Eng. v. Heed*, 390 F.3d 53, 65 (1<sup>st</sup> Cir. 2004), cert. granted sub nom. *Ayotte v. Planned Parenthood of N. New Eng.* (U.S. May 23, 2005)(No. 04-1144).

5 *Stenberg v. Carhart*, 530 U.S. 914, 946 (2000) (invalidating an abortion statute *in toto* for its lack of health exception).

6 *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 331 (2006).

7 *Id.* at 329-330, 332.

Approximately 55 percent of children are covered by private insurance that includes vaccination as a benefit;<sup>21</sup> however, insurance coverage alone is not enough to guarantee vaccine availability. Insurance is a reimbursement program. If a service is covered by insurance, it simply means the insurance company promises to reimburse a health provider for delivering that service to an insured patient. It does not obligate a clinician to provide the service. Ultimately, private insurance coverage only increases service availability if clinicians are willing to provide the service. In this case, many doctors and clinics are choosing not to stock or administer the newest, most expensive vaccines, such as HPV, because the cost to provide them to privately insured patients puts the doctors' practices at financial risk.<sup>22</sup> An examination of the economics highlights the problem.

### The High Cost of the HPV Vaccine Limits Availability for Privately Insured Girls

Because insurance is a reimbursement program, private providers must front all service delivery costs and do not recoup their expenses until they deliver the services and process the billing paperwork. In the case of the HPV vaccine, this means that doctors must initially outlay a large amount of money. For example, a private pediatric practice might have 500 female patients between the ages of 9 and 18 – the target population for the HPV vaccine. The practice predicts that 80 percent of its eligible patients (400 girls) will request the vaccine.<sup>23</sup> The HPV vaccine is a 3-dose series with each shot costing \$120. In order to meet expected demand, the practice

will have to purchase 1,200 doses, for a total cost of \$144,000. The vaccine then must be stored in a carefully controlled refrigerated climate.<sup>24</sup> If the office does not have adequate refrigeration space to store 1,200 doses of the new vaccine, it will have to purchase a new refrigerator -- another up-front cost. Providers must also pay for syringes, alcohol pads, and clinician salaries.<sup>25</sup> There may also be additional administrative costs.<sup>26</sup>

A practice's reluctance to undertake this large initial investment is compounded by the significant risk that it may not be able to recoup the money in full and in a timely manner. One reason for this is the difficulty in predicting demand for a new and controversial vaccine, such as the HPV vaccine. As the difficulty in accurately predicting demand increases, so does the doctor's financial risk. In the hypothetical example cited above, if demand for the vaccine is only 50 percent rather than 80 percent in the first year, the practice will be left with \$54,000 worth of vaccine in stock.<sup>27</sup> The risk of not receiving full or even partial reimbursement is increased by the "lengthy, paperwork-laden process" of private insurance.<sup>28</sup> Further, some insurance programs do not reimburse providers for the full cost of vaccine delivery. For example, some insurers only reimburse \$122 for each HPV vaccination – just two dollars more than the cost of the vaccine itself. This does not cover the expenses health care providers incur in administering the vaccine.<sup>29</sup>

Given the economic realities, some medical practices have chosen not to stock the vaccine until the price goes down or demand can be more reliably predicted. Others deliberately

under-stock the vaccine. Some vaccinate patients selectively, based on the insurance reimbursement rates paid by their health plans. Addressing this dilemma, one doctor said: "I feel very uncomfortable that I can't offer the same care to [all] patients. I feel guilty, almost, that I vaccinated the kid I saw before, but I can't vaccinate this one."<sup>30</sup> The vaccine's high cost results in fewer providers dispensing the vaccine, shortages within many of the clinics that do provide it, and potential ethical problems for providers who have to distribute the vaccine selectively.

### Greater Access to Vaccine for Uninsured Girls

Adolescents without private insurance usually can receive ACIP-recommended vaccines for free or at low cost through the federal Vaccines for Children (VFC) program or a state-based vaccine program. The federal and state governments established these programs to help minors without insurance find affordable vaccines. Ironically, because of the way these programs are set up, minors without insurance may have an easier time getting the HPV vaccine than those who are privately insured.

### The Vaccines for Children Program (VFC)

VFC is a federally funded program that pays for ACIP-recommended vaccines for children 18 and under who are Medicaid eligible, uninsured, underinsured, American Indian,<sup>31</sup> or Alaskan native.<sup>32</sup> Twenty-seven percent of children under 18 are in Medicaid programs. Eleven percent of all children under 18 are uninsured,<sup>33</sup> and almost

21 IOM, *Calling the Shots*, *supra*, fn. 23.

22 Wasserman, *Vaccine costs hurt doctors, patients*, *Sentinel and Enterprise* (Massachusetts) (May 27, 2007), available at [www.sentinelandenterprise.com](http://www.sentinelandenterprise.com).

23 In a 2006 study, 81 percent of California parents said they were likely to vaccinate their daughters against HPV. See *supra*, fn. 5.

24 Centers for Disease Control, *Vaccine Management: Recommendations for Storage and Handling of Selected Biologicals*, (Jan. 2007), available at [http://www.cdc.gov/mil1.sjlibrary.org/nip/publications/vac\\_mgt\\_book.pdf](http://www.cdc.gov/mil1.sjlibrary.org/nip/publications/vac_mgt_book.pdf).

25 *HPV Shot can be Hard to Find*, *ScienceDaily* (May 1, 2007) (quoting Dr. Herschel Lessin of N.Y., "I have to pay for nursing time, supplies, syringes, alcohol pads, dropped doses and time to explain [the vaccine]."), available at [www.sciencedaily.com/upi/index.php?feed=Science..](http://www.sciencedaily.com/upi/index.php?feed=Science..)

26 For example, because vaccination requires 3 visits, the office will have to determine how to build those additional visits into its schedule and how to bill for them.

27 The vaccine has a shelf life of at least two years (three years if refrigerated). *The CDC releases its HPV recommendations*, *JournalWatch* (Aug. 24, 2006), available at <http://womens-health.jwvch.org/cgi/content/full/2006/824/1>. Therefore, it is very likely it will be used at some point, but meanwhile, the practice is short \$54,000 in cash at the end of the fiscal year and must purchase vaccine for the next year.

28 Wasserman, *supra*, fn. 20.

29 *ScienceDaily*, *supra*, fn. 23.

30 *Id.*

31 As defined by the Indian Health Services Act. See *infra*, fn. 20.

32 Centers for Disease Control, DHHS, *VFC: Which Children are Eligible?*, available at <http://www.cdc.gov/vaccines/programs/vfc/parents/eligible-children.htm>.

33 DeNavas-Walt, Proctor, Lee, U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, Current Population Reports, P60-231, U.S. Government Printing Office, Washington, D.C., 2006, at 69.

13 percent of 12- to 17-year-olds are uninsured. Not surprisingly, 40 percent of all childhood vaccinations are paid for by the Vaccines for Children Program.<sup>34</sup>

VFC is administered through the states. VFC purchases vaccine in large quantities and distributes it to private and public health care providers who have enrolled with their state program. Though the program is only 12 years old, approximately 85 percent of pediatricians nationwide are enrolled to provide VFC vaccines.<sup>35</sup>

With such high provider participation, VFC funded vaccines are not hard to find, with one exception – “underinsured” girls can only gain access to VFC funded vaccine in certain locations. For purposes of VFC, “underinsured” children are those enrolled in private health insurance plans but whose plan does not cover vaccinations or a particular VFC vaccine.<sup>36</sup> These children may receive VFC funded vaccines only at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).<sup>37</sup> In some states, there are many FQHCs and RHCs with multiple sites in large urban areas. In other states, the FQHCs and RHCs are few and unevenly distributed. Children facing this barrier, or who may not be VFC eligible, still may be eligible for a state or local vaccine program.

### State Programs

Approximately 15 states have universal vaccine coverage programs.<sup>38</sup> The

specifics differ from state to state, but in general the programs allow resident children of a certain age or within a certain age group to gain access to specified vaccines for free, irrespective of insurance or VFC status. For example, in North Carolina’s Universal Childhood Vaccine Distribution Program (UCVDP), the state’s immunization branch distributes free vaccine to all providers in the state, and all children are eligible to receive them, regardless of insurance status.<sup>39</sup> Some state plans, such as Washington’s, distribute all ACIP-recommended vaccines.<sup>40</sup> Others distribute only those vaccines required for school entry. Several states already have made the necessary appropriations to be able to provide the HPV vaccine universally.<sup>41</sup>

Most states do not have universal vaccine coverage programs. However, these states usually administer programs that supplement the VFC program, at least to some extent, by providing vaccination to underinsured children. Such programs are often partially funded with Section 317 money.<sup>42</sup> Section 317 is a federal award program administered by the CDC and designed to support state and local vaccine services.<sup>43</sup>

The VFC and state programs have been successful because so many health providers participate. Providers are willing to participate in the programs because there is little to no financial risk for them. Under these plans, the federal and state governments purchase vaccine and then sup-

ply it to participating providers free of charge. There is no out-of-pocket cost to the provider and no risk of loss due to low demand. Although VFC does not pay vaccine administration fees, providers can cover these costs in several ways. In many cases, providers can bill their state Medicaid program for administrative costs related to administering the HPV vaccine to eligible girls.<sup>44</sup> Alternatively, federal law allows them to charge a small administrative fee to patients who can afford it.<sup>45</sup> Overall, the clinicians’ financial risk in stocking and distributing the vaccine as part of the VFC or state programs is minimal. As a result, uninsured girls may find it easier than insured ones to find an HPV vaccine provider willing and able to vaccinate them.<sup>46</sup>

### Delaying Delivery of the Vaccine Significantly Increases Risk that Girls Will Contract HPV

The limited availability of privately insured vaccine may impact a large number of girls. Sixty percent of children under 18 years of age have employer-sponsored health insurance. Another 5.5 percent are covered by direct purchase private health insurance.<sup>47</sup>

In most cases, the limited availability of privately insured vaccine will delay but not completely deny vaccination to girls.<sup>48</sup> Unfortunately, delay in administering the HPV vaccine can be just as detrimental as not administering the vaccine altogether. The statistics on infection rates highlight

34 Rodewald, Immunization Services Division, Centers for Disease Control, *Childhood Vaccine Financing: Implications for States*, PowerPoint slide presented to National Vaccine Advisory Committee, Nov. 29, 2005 (stating that in 2004, 40 percent of vaccine doses were funded by VFC; 45 percent funded by private sector; 8 percent by section 317; and 7 percent by state, citing vaccine manufacturers biologics surveillance data 2004), available at [www.hhs.gov/nvpo/nvac/RodewaldVaccineFinancingState-PerspectiveNov05.ppt](http://www.hhs.gov/nvpo/nvac/RodewaldVaccineFinancingState-PerspectiveNov05.ppt).

35 National Association of County and City Health Officials (NACCHO), Proceedings from NACCHO Adolescent Health and Immunization Meeting, March, 2006, available at <https://www.naccho.org/topics/hpdp/documents/MarchMeetingProceedingsDocument.pdf>.

36 VFC: Which Children are Eligible?, *supra*, fn. 20.

37 *Id.*

38 National Conference of State Legislators, *Financing Childhood Immunizations*, available at <http://www.ncsl.org/programs/health/immuni2.htm> (In 2000, States with universal programs included: Alaska, Idaho, Maine, Massachusetts, New Hampshire, New Mexico, North Dakota, Rhode Island, Vermont, Washington, Wyoming, Connecticut, Nevada, North Carolina, and South Dakota. Since then, at least one, Massachusetts, has dropped universal coverage.).

39 Immunize North Carolina, *UCVDP Program*, available at <http://www.immunizenc.com/UCVDP.htm>.

40 Washington State Dept. of Health, VFC program website, at <http://www.doh.wa.gov/cfh/immunize/vaccine4.htm>.

41 Some examples include New Hampshire, South Dakota and Alaska. See Kaiser Daily Reports, *New Hampshire To Offer Gardasil to Girls at No Cost Under State Immunization Program*

(Dec. 1, 2006), available at [http://www.kaisernet.org/daily\\_reports/rep\\_index.cfm?hint=2&DR\\_ID=41366](http://www.kaisernet.org/daily_reports/rep_index.cfm?hint=2&DR_ID=41366); see S. D. Dept. of Health, *South Dakota HPV Vaccination Initiative*, available at <http://www.state.sd.us/doh/HPV/index.htm>; Ak. Dept. Health and Soc Services, *Federal Funding to Boost Alaska’s Vaccine Program*, available at <http://www.hss.state.ak.us/press/2007/pr053107fed-funding-hpv-vax.htm>.

42 Public Health Services Act § 317, 42 U.S.C. § 247b.

43 Assoc. of Immunization Managers, *Principles on Section 317 Vaccine Purchase Funding Allocation*, available at [http://www.immunizationmanagers.org/pdfs/Funding\\_Allocation.pdf](http://www.immunizationmanagers.org/pdfs/Funding_Allocation.pdf).

44 Centers for Disease Control, DHHS, *VFC: For Parents, Do I Have to Pay Anything?*, available at <http://www.cdc.gov/vaccines/programs/vfc/parents/default.htm>

45 *Id.*

46 This is not to suggest that the VFC and state programs function perfectly. They do not; as one example, there have been reports of waiting lists for VFC funded HPV vaccine because the government underestimated demand and did not distribute sufficient amounts of the vaccine. However, these programs have been successful at enrolling providers.

47 DeNavas-Walt, Proctor, Lee, U.S. Census Bureau, *Current Population Reports, P60-231, Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Government Printing Office, Washington, D.C., 2006, at 69.

48 It will delay vaccination because families will have to track down local providers who are both stocking the vaccine and taking their insurance. Waiting lists are not uncommon. However, this problem will only deny vaccination if no local providers are willing to distribute the vaccine.

how important it is to vaccinate girls before they engage in any sexual activity. If a minor has to wait three, six, or 12 months to get vaccinated, the likelihood that she already has been infected by HPV increases. Also, to the extent that this shortage leads to waiting lists for older teens, some girls may miss their opportunity to be vaccinated at all. Girls who are privately insured under a caregiver's insurance plan may lose that coverage at age 18. Girls over 18 are not eligible for VFC or most state funded programs. And, very few state Medicaid programs plan to cover the HPV vaccination for women aged 19 and up. Thus, girls who do not receive the vaccine as a minor will most likely have to pay for the vaccine out-of-pocket as adults. Because of the vaccine's high cost, many young women will be unwilling or unable to do so.

### **State Legislation Mandating Insurance Coverage Should Reduce Doctors' Financial Risk**

Concerns about the HPV vaccine's high cost prompted 18 states to propose legislation this year that addresses vaccine funding. Fifteen of those bills require or would have required private insurance to include the HPV immunization as a health plan benefit.<sup>49</sup> As experience proves, however, mandating private insurance coverage will not facilitate vaccine availability if providers refuse to stock or distribute the vaccine.

States should consider their insurance coverage bills in light of this real world experience. Mandating insurance coverage will not increase the

number of girls receiving the vaccine unless legislators also include measures to reduce clinicians' financial risk when providing the vaccine to privately insured girls. Legislators should consider amending their current bills to do just this. Two options they could consider: amending legislation to clarify that coverage must include adequate compensation for vaccine services, including coverage of administration costs; and including in their bills vaccine buy-back programs to reduce the financial risk when clinicians are left with vaccine overstock. But beyond this year's legislation, real world experience suggests that private insurance mandates will not guarantee vaccine availability for all. Legislators should work with clinicians, health financing experts, and patient advocates to explore other ways to increase access to the vaccine.

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49 National Conference of State Legislators, *HPV Vaccine: Introduced Legislation 2007*, available at <http://www.ncsl.org/programs/health/HPVvaccine.htm>. (States that introduced mandatory insurance coverage legislation in 2007 include: Arizona (S.B. 1502); California (A.B. 1429); Georgia (H.B. 11); Hawaii (H.B. 590); Illinois (S.B. 937); Iowa (S.F. 514; H.F. 661); Nevada (S.B. 409); New Jersey (S. 2284); New Mexico (S.B. 407); New York (S.B. 4172; A.B. 8536; A.B. 6296); Oregon (H.B. 3253); Pennsylvania (H.B. 352); Rhode Island (H.B. 5061); Texas (S.B. 815); Virginia (H.B. 2877)).