Childhood Immunization Programs in New England States

A cursory review of funding mechanisms for childhood immunization programs in Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, and recent legislative developments.

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DATE:  January 10, 2013

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DISCLAIMER:  Information in this packet was gathered by a Kidsvax.org™ researcher from public documents as of January 10, 2013.  No effort has been made to supplement information beyond this date.  Kidsvax.org™ is not itself a policy maker or a public policy organization and takes no position on the matters discussed in these materials.  We remain passionate, nonetheless, about helping governmental and other programs which seek to afford children access to free childhood vaccines.

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Summary

Historical Context

Vaccines are among the greatest medical breakthroughs of all time, putting an end to diseases that have plagued the human condition throughout our recorded history. If there was a final cause or ideal of biomedicine, it may be to universally accomplish what vaccines accomplish in particular cases—namely to prevent the contagion of diseases. In 1796 Edward Jenner performed the first vaccination by injecting pus from a cowpox lesion into an eight-year old boy to immunize him against smallpox.\(^1\) Since then, vaccines have been developed to prevent other manifold communicable diseases including measles, mumps, rubella, diphtheria, tetanus, and polio.

Disease avoidance lowers future health care costs and adds economic productivity to the underlying population. CDC estimates that investing $1 in childhood vaccines to treat thirteen avoidable diseases saves $10.20 in future medical costs.\(^2\) “All told, CDC estimates that by preventing 20 million cases of disease, the investment saves $13.6 billion in direct costs and a total $68.9 billion when you add in indirect costs to society, such as missed work, long-term disability, and death.”\(^3\)

Since the immunological efficacy of vaccines depends upon “herd immunity” (the administration of these vaccines to a high percentage of the populace), securing these benefits has historically encountered issues relating to funding mechanisms. In pursuance of the requisite high immunization rate, utilitarian governmental measures such as public funding and state mandates have become standard in developed countries during the nineteenth and twentieth centuries to ensure access to and incentives for the routine administration of childhood vaccines.

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\(^3\) Ibid.
Public funding ensures that wealth or insurance coverage does not limit access to vaccines. Although public funding was highly successful in securing these benefits within the twentieth century immunological landscape and achieved enormous progress in immunization practices, current immunization practices have been faced with new market challenges as pressures to reduce government spending have intensified and the price of vaccines have increased. Laws also struggle to keep pace with market changes in health benefits plans and claims management, as a majority of larger firms switch from a fully-underwritten plan to a self-funded plan and many no longer purchase stop loss coverage.4

**Macro-Environment**

As the list of recommended vaccines increases, and the cost of these vaccines escalates, many state budgets have been unable to sustain the cost of providing vaccinations to their residents. In response to these changing market conditions, many states have adapted their laws to establish stable funding mechanisms that preserve children’s access to all recommended childhood vaccines, regardless of wealth or coverage. To accomplish this objective, some states assess private firms (that provide or administer health benefits plans) to supplement strained and limited public funding options. These universal vaccine supply funding models have been successful in preserving unencumbered access to all recommended childhood vaccines and does so in a manner beneficial to both providers, insurers, and the general populace.

Under older models, health providers must front the cost of purchasing the vaccines and later seek reimbursement. This non-universal supply model puts strain on many smaller medical practices, which are not in the best position to bear the burden of these costs for extended periods and oftentimes not entirely reimbursed. Many providers in this situation choose not to purchase all recommended vaccines, particularly the newer, more expensive vaccines because of these financial risks.5 Non-universal models also produces potential


economic obstacles, such as income or coverage, to children being able to receive all recommended vaccines.

**Universal Supply Models**

Universal purchase supply programs allow states to maintain high immunization rates by providing vaccine serums to providers at no cost to the provider, while simultaneously lowering administrative costs, taking advantage of vaccines prices at the federal contract rate, and facilitating high provider participation in all recommended childhood vaccines.

Under a universal supply model, the cost of the upcoming years’ vaccines are estimated and then charged to payers in an assessment or surcharge. Some assessments go to a general fund and are distributed by state appropriation in the annual budget, but recent models establish a separate fund exclusively used for expenses relating to providing children with vaccines, wherein vaccine assessments and surcharges are deposited and used to fund the state vaccine program. A primary concern in constructing a universal model is how to equitably distribute the costs of the program to all pertinent firms providing or administering health benefit plans. Thus, governing statutes should clearly delineate the assessment base (payers) and the manner of determining and billing the cost of the program (assessment calculation), among other pertinent issues.

With more vaccines becoming recommended, and costs multiplying, there is currently a distinction between “universal purchase” supply policies, which provide all recommended vaccines, and “universal select” supply policies, which provides all but a few (usually the more expensive) of the recommended vaccines. Strong universal purchase policies are typically buttressed by a stable, efficient, and mutually beneficial funding mechanism. These funding mechanisms uphold a policy of ensuring universal access to vaccines for all state residents at no charge to the provider or individual.
Maine

Child Covered Lives

Under 22 M.R.S.A. § 1066 “Universal Childhood Immunization Program,” children from birth until the age of 19 who live in Maine are given access to a uniform set of vaccines as determined and adjusted by the Maine Vaccine Board (MVB).

Health Insurers

Health insurance carriers pay a quarterly assessment fee into the Childhood Immunization Fund. 22 M.R.S.A. § 1066(5)(C)(1). “Health insurance carrier” is defined to include: 1) insurance companies; 2) health maintenance organizations; 3) preferred provider arrangement administrators; 4) union or collective bargaining agreement plans; 5) nonprofit hospitals or medical service organizations or health plans; 6) third party administrators, and 7) self-insured employers. 22 M.R.S.A. § 1066 (2)(G).

Assessment

All health insurance carriers and third party administrators responsible for child health care benefits are required to pay an assessment to cover the costs of purchasing and administering the recommended vaccines. A monthly assessment per child covered life is calculated by (1) anticipating the costs of funding for the succeeding year, (2) adding a reserve of up to 10%, (3) subtracting unexpended assessments from previous year, and (4) dividing prongs 1-3 by the number of child covered lives. Payer then self reports the assessment calculation by multiplying this assessment rate by the number of child covered lives for each insurer.

Maine’s statute further provides for an interim assessment which allows for immediate funding to any changes in cost or scheduling mid-cycle.
Vermont

**Covered Lives**

The Vermont Immunization Pilot Program covers the lives of individuals, child and adult, whose care is provided by Vermont licensed health care providers in practices located in Vermont.

**Health Insurers**

Under the “Vermont Immunization Pilot: Vaccine Purchasing Pool Implementation Procedures,” a health insurer is defined as “any health insurance company, nonprofit hospital and medical service corporation, managed care organizations, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.” (Procedures: IZ Pilot, “definitions,” 3)

**Participating Providers**

“All primary care provider practices are expected to participate,” including private practices, federally qualified health centers, rural health centers, and, clinics for the uninsured. (Procedures: IZ Pilot, 4.1). Practice settings which are not currently included in the pilot program are specialty care providers, nursing homes, home health agencies, hospitals (other than hospital newborn services), college health services, retail outlets, or employer worksites that administer vaccines. *Id.* at 4.3. Optional enrollment in the pilot program is provided to obstetrics, gynecology, and hospital newborn services. *Id.* at 4.2.

**Assessment**

Vaccine supply costs for the next year are calculated by Vermont Department of Health (VDH) and billed to insurers for the upcoming year in the form of an assessment, or vaccine purchasing pool fee. The assessment fee is billed quarterly to insurers with 200 or more covered lives, based on qualifying insurer’s share of the market. VDH calculates the assessment fee by: (1) multiplying the projected cost of vaccines by the volume anticipated, (2) adding a surcharge to cover the immunization program’s administration costs, and (3) divvying the costs to insurers with 200 or more covered lives based on the percentage of the market they cover (calculated by VHCURES).

Various adjustments are also in place to correct deviations from anticipated projections.
New Hampshire

Child Covered Lives
The New Hampshire Vaccine Association (hereafter “NHVA”) provides vaccines for in-state children under 19 years of age.

Payers
New Hampshire RSA § 126-Q: NHVA provides that all health insurers licensed pursuant to RSA 402, 420-A, or 420-B are required to pay an assessment to NHVA to cover the costs of all recommended vaccines. This language includes (1) individual health insurers, (2) group health insurers, and (3) stop loss insurers. Currently self-insured entities not purchasing stop loss insurance are not assessed.

Assessment
The NHVA estimates an assessment fee by determining the remaining costs for childhood vaccines after all other sources, including (1) state and federal funds, (2) any carry forward assessment funds held by the NHVA, as well as (3) any unexpended state vaccine funds from prior years. Each insurer is assessed in proportion to its number of all covered lives, adult and children. NHVA calculates its assessments on an annual basis.
Massachusetts

Current Status

Massachusetts’ current immunization program is universal select, meaning that all but a few vaccines are funded by a state appropriation in the state budget. Although Massachusetts provided all recommended vaccines free of charge to providers for over 100 years, there is no current state funding for the HPV vaccine or the booster dose of Mmcv. For these vaccines, providers must buy the vaccines up front and later seek reimbursement from insurers.

Proposed Legislation (see Addendum)

http://www.malegislature.gov/Bills/187/Senate/S02362/History

Current Senate Bill No. 2362 (substituted for the following older drafts: SB 2120, SB 529) proposes that a separate Vaccine Purchase Trust Fund be established to ensure access to all recommended childhood vaccines and enable Massachusetts to purchase vaccines at a reduced purchase price under the federal contract, similar to Maine, New Hampshire, and Washington. The bill would also establish a vaccine purchase advisory council and an immunization registry to keep all childhood vaccine information in a central location.

The proposed legislation covers children under 19 years of age that are residents of Massachusetts. It requires Massachusetts health insurers (defined as “surcharge payors”) to pay an annual assessment into the Vaccine Trust Fund. The vaccine purchase advisory council is responsible for deciding what vaccines will be provided and what quantity will be needed. The council also determines the amount of funding needed for each fiscal year by calculating the total non-federal program cost. The commissioner of public health bears ultimate responsibility for deciding the final vaccines to be purchased.

The legislation requires that “Every surcharge payor, to the extent not preempted by federal law, shall provide benefits for . . . routine childhood immunizations for residents [children].” The proposed legislation utilizes the
current definition of “surcharge payor” as defined under section 34 of chapter 118G. Said statute defines surcharge payor as follows:

“Surcharge payor”, an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers, as defined in this section; provided, however, that the term “surcharge payor” shall include a managed care organization; and provided further, that “surcharge payor” shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers’ compensation program established under chapter 152. Mass. Gen. Laws Ann. ch. 118G, § 34.

In summary, the proposed bill provides a savings clause for preemption and annually assesses “surcharge payors” for the program cost. It seeks to establish a permanent universal purchase supply model. The bill was referred to the “House committee on Ways and Means” on 7/23/12.
Connecticut

*(see addendum for source text)*

**Act Establishing Vaccine Program**

In June of 2012, Connecticut amended its Connecticut General Statutes § 19a-7f “Childhood immunization schedules. Establishment of Vaccine Program in Bridgeport, New Haven, and Hartford” via Bill No. 6001, “An Act Implementing Provisions of the State Budget for the Fiscal Year . . . ” (June 12 Special Session 2012). Commencing January 1, 2013, the statute requires that all health care providers utilize any vaccine that is on the Recommended Childhood Immunization Schedule, with a few exceptions, such as in the event of a supply shortage. The statute provides funding by state appropriation out of the General Fund for all recommended vaccines.

**Payers**

All Connecticut health insurers, health care centers, third-party administrator, and “exempt insurers” are required to annually self-report its number of covered lives. An “exempt insurer” is “a *domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure.*”

Any failure to so report results in a $100 penalty fee for each day from the date such report was due. Each payor must remit an annual assessment equal to its percentage of covered lives of the vaccine program cost. The statute provides an appeal process by which any payer can challenge the assessment amount billed to it.
Rhode Island

**Act Establishing a Childhood Immunization Program**

On June 20, 2012, the governor of Rhode Island signed into law H7410, an act establishing a childhood immunization program and funding mechanism.

**Payers**

This law imposes a “surcharge” on insurers, HMOs, and medical corporations to cover the non-federal vaccine program costs. In pertinent part, “insurer” is defined as:

“. . . all persons (as defined below) offering, administering, and/or insuring healthcare services, including, but not limited to, policies of accident and sickness insurance . . .; nonprofit hospital or medical service plans . . .; any other person whose primary function is to provide diagnostic, therapeutic, or preventative services to a defined population on the basis of a periodic premium; all domestic, foreign, or alien insurance companies, mutual associations and organizations; health maintenance organizations . . .; all persons providing health benefits coverage on a self-insurance basis; and all third party administrators.”

“Surcharge” is defined as “the assessment imposed on net claims charges pursuant to this chapter.

This law effectually imposes an assessment, as a tax, on all health benefits payers to cover the non-federal vaccine program costs. The funds are deposited into a separate “childhood immunization account” to be used solely for the “childhood immunization program.”
Some Main Differences Between States

- **Funds Management**: State Appropriation v. Separate Vaccine Account.
- **Assessment Base**: How are the payers defined in the statute?
- **Assessment Calculation**: based on all covered lives v. pediatric lives.
- **Payment Schedule**: Annual v. Quarterly.
- **Immunization Registry**: a few states (i.e. NH and MA) do not use one.
- **Penalties for untimely remittance of assessment or failure to timely report**: differs by state.
### SECTION TEN:
**Plan Funding**

#### Exhibit 10.1

<table>
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<td>17%</td>
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<td>1,000-4,999 Workers</td>
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<td>5,000 or More Workers</td>
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<td>72%</td>
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<td><strong>ALL FIRMS</strong></td>
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<td>49%</td>
<td>49%</td>
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<td>59%</td>
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* Estimate is statistically different from estimate for the previous year shown (p<.05).

**Note:** Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in the averages in this exhibit for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

**Source:** Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012.
<table>
<thead>
<tr>
<th>IZ PROGRAMS</th>
<th>Maine</th>
<th>Vermont</th>
<th>Massachusetts</th>
<th>New Hampshire</th>
<th>Rhode Island</th>
<th>Connecticut</th>
</tr>
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<tbody>
<tr>
<td><strong>Health Department</strong></td>
<td>Dep’t of Health and Human Services (DHHS) Mary Mayhew T: 207-287-3707</td>
<td>Vermont Dep’t of Health (VDH) Harry Chen, M.D., Commissioner</td>
<td>Massachusetts Dep’t of Public Health (MDPH) John Auerbach, Commissioner T: 617-624-6000</td>
<td>NH Dep’t of Health &amp; Human Services (DHHS) Nicholas Tournas, Commissioner T: 603-271-4331</td>
<td>R.I. Dep’t of Health (RIDH) Christopher F. Koller, Commissioner T: 401-462-9517</td>
<td>Connecticut Dep’t of Health Jewel Mullen, Commissioner T: 860-509-7101</td>
</tr>
<tr>
<td><strong>IZ Division</strong></td>
<td>Division of Infectious Disease</td>
<td>Immunization Program T: 802-863-7638 Amanda J. LaScala, (Data Assistant) T: 802-652-2072</td>
<td>Immunization Program T: 617-983-6880</td>
<td>Immunization Program T: 617-983-6880</td>
<td>Immunization Program T: 617-983-6880</td>
<td>Immunization Program T: 617-983-6880</td>
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<tr>
<td><strong>Insurance Department</strong></td>
<td>Bureau of Insurance Eric Cioppa Superintendent of Insurance</td>
<td>Dep’t of Banking, Insurance, Securities and Health Care Administration (BISHCA) Steven Binball, Commissioner T: 802-828-3301</td>
<td>Massachusetts Division of Insurance Joseph Murphy, Commissioner T: 617-521-7794</td>
<td>NH Insurance Department Roger A. Sevigny, Commissioner T: 603-271-2261</td>
<td>Rhode Island Department of Business Regulation Christopher F. Koller, Office of Health Insurance Commissioner T: 401-462-9517</td>
<td>Connecticut Insurance Department Thomas B. Leonard, Commissioner T: 860-297-3801</td>
</tr>
<tr>
<td><strong>Supply Policy</strong></td>
<td>Universal Purchase</td>
<td>Universal Purchase (Vaccine Purchasing Pool Pilot Program)</td>
<td>Universal Select</td>
<td>Universal Purchase</td>
<td>Universal Select</td>
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<td><strong>Assessment Rate</strong></td>
<td>2011/12 Annual Assessment = $83.76 per child covered life Monthly = $6.98</td>
<td>N/A</td>
<td>2010-11 Annual Assessment = $22.00 per covered life Monthly = $1.83</td>
<td>Information managed confidentially by KIDSNET--available to insurers upon request.</td>
<td></td>
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<tr>
<td><strong>Covered Lives</strong></td>
<td>Child: 142,389</td>
<td>Child</td>
<td>Child: 1,566,381*</td>
<td>Child</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Total: 341,219*</td>
<td>Total</td>
<td>Total: 501,563</td>
<td>Total</td>
<td></td>
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<tr>
<td><strong>Total Billed Assessments</strong></td>
<td>$11,389,135</td>
<td>Children: $9,645,007* Adults: $1,861,744*</td>
<td>State Appropriated Pediatric Budget = $114,617,965* given by Tejman Talebian (Deputy Program Manager)</td>
<td>$8,992,444</td>
<td>Annually reported to the general assembly on or before February 1.</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment Determination</strong></td>
<td>1) costs of fund for the succeeding program year 2) Add reserve of up to 10% 3) Subtract unexpended assessments from previous year 4) Calculate assessment on a monthly basis per child by dividing prongs 1-3 by number of covered lives divided by 12 (mos.) 5) Calculate assessment on a monthly basis per child by dividing prongs 1-3 by number of covered lives divided by 12 (mos.)</td>
<td>1) (projected) cost of vaccine multiplied by the amount 2) proportion of privately insured adults, by age, with private insurance 3) add administrative surcharge 4) adjust amount to account for federal funds available for insured population and any over- or under- charges in previous year 5) calculate amount due from each participating health insurance company Procedures: IZ Pilot</td>
<td>Currently, the cost of the vaccines which the state funds (all but the HPV and the second dose of mumps) are calculated as part of state appropriations for health care. Under the Moore’s 529 bill to establish a universal childhood immunization program, the assessment would be deposited in a separate account and subject to a universal purchase supply policy.</td>
<td>1) Multiply the ratio of covered lives to the total number of non-elderly NH residents by the total non-federal program cost 2) Each insurer assessed in proportion to the number of covered lives 3) amount association raises will include credit for any surpluses remaining from prior years, as well as reasonable costs for the association’s administration N.H. REV. STAT. § 126-Q-4.</td>
<td>Assessment determined by director of health in concurrence with primary payors according to the projected costs of ACIP recommended and state mandated vaccines after the federal share has been determined by the CDC. Primary payors will receive six months advance notice of any recommended change in rate. Assessments deposited separately into either the “childhood” or “adult immunization account.” R.I. GEN. LAWS § 23-1-46.</td>
<td>&quot;health and welfare fee&quot; shall be determined by Insurance Commissioner and assessed against each domestic insurer or health care center for the next fiscal year. Fee shall be a percentage of the total amount appropriated for the purchase, storage, and distribution of routine immunizations. Calculation will be based on premiums and subscriber charges in same manner as calculations under section 38A-48 of CT general stat. CONN. GEN. STAT. § 19a-7j.</td>
</tr>
</tbody>
</table>
IZ PROGRAMS | Maine | Vermont | Massachusetts | New Hampshire | Rhode Island | Connecticut
---|---|---|---|---|---|---
**Insurers Who Pay**
Health Insurance Carrier or a TPA, §1066(2)(B) & (5)(C)(1).
“Health Insurance Carrier” includes:
(1) Insurance Companies,
(2) HMOs,
(3) Preferred Provider
Arrangement Administrators,
(4) Union Plans,
(5) Nonprofit hospitals or medical service organizations or health plans,
(6) TPAs, or
(7) Self-insured Employer. ME. REV. STAT. 22 §1066(2)
(G).
Private Health Insurers with 200 or more covered lives pay a Vaccine Purchasing Pool Fee. Currently, most vaccines are funded through a state appropriation. The MDPH charges an assessment to health insurers. The proposed senate bill 529 would require all health insurers to pay an assessment into a separate vaccine trust fund. “Health Insurer” would include: (1) Surcharge payors, (2) Plans for state employees, (3) Medicaid, (4) Any other medical assistance program operated by government unit for qualified persons. All Health Insurers (licensed pursuant to RSA 402, 420-A, or 420-B), including (1) individual health insurers, (2) group health insurers, and (3) stop loss insurers.

**Insurer Payments**
Quarterly Payments equal to monthly assessment rate multiplied by number of (child) covered lives. Quarterly payments based on anticipated costs for the upcoming fiscal year. Under the proposed senate bill 529, insurers would be required to pay 100% of all “reasonable and customary” charges for services, including cost of vaccines (excluding vaccines provided by the state) and the administration costs. 1) Annual Payments equal to that quarter’s number of covered lives divided by 3 and multiplied by the assessment rate set by NHVA, OR
2) According to a Prototype Installment Plan (1/3 initially, the rest payable within 2 months). [not used to date]
Insurers are assessed: 1) a child immunization assessment; and 2) an adult immunization assessment. Insurers assessed greater than $10,000/year shall be assessed in four quarterly payments. R.I. GEN. LAWS § 23-1-46.

**Lives Covered**
Children under the age of 19 who reside in the state. Individuals whose care is provided by Vermont licensed health care providers in practices located in Vermont. NOTE: VDH will work w/border states to ensure consistent policies. Procedures § 2.0
Currently, under MGLA 111 § 181, all lives are covered for most vaccines. The proposed legislation would adopt a universal purchase supply policy for children until they turn 19. Children of the state of NH under the age of 19 years of age.
- Children in Rhode Island from birth through age 18 are provided with all recommended vaccines.
- Adults in Rhode Island are provided with seasonal influenza and pneumococcal vaccine.

**Immunization Registry**
Yes | Yes | Currently: No Proposed: Yes | No | Yes | Yes

**Which Vaccines When?**
Determined by MVB according to information published by:
- federal Department of Health and Human Services (DHHS)
- Centers for Disease Control and Prevention (CDC)
- Advisory Committee on Immunization Practices (ACIP)
Immunize patients according to Vermont Recommended Immunization Schedule (based on ACIP recommendations). Procedures § 9.0
Recommended by (1) federal Vaccines for Children Program and (2) the US DHHS Advisory Committee on Immunization Practices. Childhood Immunization Schedule developed by Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP).
Routine Childhood Immunization Schedule as recommended by Advisory Committee for Immunization Practices (ACIP) and the Academy of Pediatrics (AAP). R.I. GEN. LAWS § 23-1-44.
Routine Childhood Immunization Schedule as recommended by Advisory Committee for Immunization Practices (ACIP) and the Academy of Pediatrics (AAP). R.I. GEN. LAWS § 23-1-44.

"NOTE: NOT CURRENT TO DATE
Current as of Feb. 25, 2012."
§ 1066. Universal Childhood Immunization Program

1. Program established. The Universal Childhood Immunization Program is established to provide all children from birth until 19 years of age in the State with access to a uniform set of vaccines as determined and periodically updated by the Maine Vaccine Board. The program is administered by the department for the purposes of expanding access to immunizations against all diseases as recommended by the federal Department of Health and Human Services, Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, optimizing public and private resources and lowering the cost of providing immunizations to children. The program is overseen by the Maine Vaccine Board.

[2009, c. 595, § 2 (NEW).]

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Advisory committee" means the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, Centers for Disease Control and Prevention or its successor organization. [2009, c. 595, § 2 (NEW).]

B. "Assessed entity" means a health insurance carrier or a 3rd-party administrator registered under Title 24-A. [2009, c. 652, Pt. E, §1 (AMD); 2009, c. 652, Pt. E, §3 (AFF).]

C. "Board" means the Maine Vaccine Board established in subsection 3. [2009, c. 595, § 2 (NEW).]

D. "Child" means a person who has not attained 19 years of age and who resides in the State. [2009, c. 595, § 2 (NEW).]

E. "Covered life months" means the number of months during a calendar year that a person is covered under a health insurance plan provided or administered by an assessed entity. [2009, c. 652, Pt. E, §2 (AMD); 2009, c. 652, Pt. E, §3 (AFF).]

F. "Fund" means the Childhood Immunization Fund established in subsection 7. [2009, c. 595, § 2 (NEW).]

G. "Health insurance carrier" means:

(1) An insurance company licensed in accordance with Title 24-A to provide health insurance;

(2) A health maintenance organization licensed pursuant to Title 24-A, chapter 56;

(3) A preferred provider arrangement administrator registered pursuant to Title 24-A, chapter 32;

(4) A fraternal benefit society as defined in Title 24-A, section 4101;

(5) A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;

(6) A multiple-employer welfare arrangement approved by the superintendent under Title 24-A, section 6603; or

(7) A self-insured employer subject to state regulation as described in Title 24-A, section 2848-A. [2009, c. 595, § 2 (NEW).]

H. "New vaccine" means a vaccine recommended by the advisory committee for which an initial federal contract price is established by the United States Department of Health and Human Services, Centers for Disease Control and Prevention between October 1st and July 1st. [2009, c. 595, § 2 (NEW).]

I. "Program" means the Universal Childhood Immunization Program established in subsection 1. [2009, c. 595, § 2 (NEW).]

J. "Provider" means a person licensed by this State to provide health care services to individuals or a partnership or corporation made up of those persons. [2009, c. 595, § 2 (NEW).]
K. "Service agent" means a person or entity qualified by good business reputation, training, education and experience to administer the fund and perform responsibilities assigned by the board. A service agent must hold all licenses, registrations and permits required to engage in activities or undertake responsibilities assigned by the board. [ 2009, c. 595, § 2 (NEW) ]

L. "Superintendent" means the Superintendent of Insurance. [ 2009, c. 595, § 2 (NEW) ]

M. "Total costs of the fund" means the costs of vaccines provided under the program to children projected to be covered by assessed entities during the succeeding program year and the annual operating expenses of the board, including costs the board may incur for staff, a service agent, legal representation, administrative support services and other expenses approved by the board. [ 2009, c. 595, § 2 (NEW) ]

[ 2009, c. 652, Pt. E, §§1, 2 (AMD) ; 2009, c. 652, Pt. E, §3 (AFF) ]

3. Maine Vaccine Board. The Maine Vaccine Board is established pursuant to this subsection to oversee the program.

A. The board consists of 10 members.

(1) The commissioner shall serve as an ex officio, nonvoting member.

(2) The Treasurer of State shall serve as an ex officio, nonvoting member.

(3) The Governor shall appoint 8 members, as follows:

(a) Three representatives of health insurance carriers, appointed from a list of nominees submitted by a statewide association of health insurance carriers;

(b) Three representatives of providers in the State, appointed from lists of nominees submitted by statewide associations of providers, including associations of primary care providers, allopathic and osteopathic physicians, nurse practitioners and persons with expertise in public health;

(c) A representative of employers that self-insure for health coverage, appointed from lists of nominees submitted by statewide associations of employers; and

(d) A representative of the pharmaceutical manufacturing industry, appointed from a list of nominees submitted by a statewide association of pharmaceutical manufacturers. [ 2009, c. 595, § 2 (NEW) ]

B. With the exception of the representative of the pharmaceutical manufacturing industry, who serves a one-year term, the term of an appointed member to the board is 3 years. All members, with the exception of the representative of the pharmaceutical manufacturing industry, may serve successive terms. A member whose term has expired may serve until the appointment of the member's successor. [ 2009, c. 595, § 2 (NEW) ]

C. The board shall elect a chair from among its members to serve a 2-year term or for the duration of that person's term. The chair may serve successive terms. Five voting members constitute a quorum. Decisions of the board require the affirmative vote of 5 members. [ 2009, c. 595, § 2 (NEW) ]

D. The board shall meet 4 times per year and when a meeting is called by the chair and shall oversee the fund and program and adopt policies and procedures to administer the program and the fund. [ 2009, c. 595, § 2 (NEW) ]

E. By January 1, 2011 and annually thereafter, the board shall determine the list of vaccines to be made available by the program during the succeeding program year beginning July 1st. In making its determination, the board shall consider:

(1) Vaccines recommended by the advisory committee that are available under contract with the United States Department of Health and Human Services, Centers for Disease Control and Prevention;

(2) Recommendations of the department, based on the department's review of the advisory committee recommendations; and

(3) Clinical and cost-benefit analyses.

The board shall review new vaccines and update the list of vaccines to be made available through the program on a timely basis in accordance with the considerations described in this paragraph. [ 2009, c. 595, § 2 (NEW) ]

F. The board shall contract for staff, administrative support services and, if necessary, legal representation; review financial, cost and other
4. Program requirements. The program shall make available to providers vaccines as determined by the board pursuant to subsection 3, paragraph E. [ 2009, c. 595, § 2 (NEW) ]

5. Assessments. By January 1, 2011 and annually thereafter, the board shall determine an assessment for each assessed entity in accordance with this subsection. The board shall provide a mechanism to protect against duplicate counting of children. The board may conduct an audit of the number of covered life months for children as reported by an assessed entity. An assessment determination made pursuant to this subsection is an adjudicatory proceeding within the meaning of Title 5, chapter 375, subchapter 4.

A. In determining the amount of the assessment, the board shall:

(1) Determine the total costs of the fund for the succeeding program year;

(2) Add a reserve of up to 10% of the total costs of the fund under subparagraph (1) for unanticipated costs associated with providing vaccines to children covered by the assessed entity;

(3) Subtract the amount of any unexpended assessments collected in the preceding year and any unexpended interest accrued to the fund during the preceding year; and

(4) Calculate the assessment on a monthly basis per child to be paid by an assessed entity by dividing the amount determined in accordance with subparagraphs (1), (2) and (3) by the number of children projected to be covered by the assessed entity during the succeeding program year divided by 12. [ 2009, c. 595, § 2 (NEW) ]

B. The board shall provide the assessed entity with notice of the assessment amount for the succeeding program year no later than January 1, 2011 and annually thereafter. [ 2009, c. 595, § 2 (NEW) ]

C. Beginning July 1, 2011, the assessment must be paid on a quarterly basis as follows:

(1) An assessed entity shall pay a quarterly assessment equal to the monthly assessment rate per child as described under paragraph A, subparagraph (4) multiplied by the number of child member months covered by the assessed entity in the preceding calendar quarter; and

(2) The assessment must be paid within 45 days following the close of the calendar quarter. [ 2009, c. 595, § 2 (NEW) ]

D. After the close of a program year, the board shall reconcile the total assessments paid by assessed entities, including interim assessments determined under paragraph E, with the actual costs of vaccines provided under the program to children covered by assessed entities during that program year and the annual operating expenses of the program during that program year. Any unexpended assessments must be used to reduce the assessment in the succeeding program year as required under paragraph A, subparagraph (3). [ 2009, c. 595, § 2 (NEW) ]

E. The board may determine an interim assessment for new vaccines that the board has made available through the program pursuant to subsection 3, paragraph E. The board shall calculate the interim assessment in accordance with paragraph A, and the interim assessment is payable the calendar quarter that begins no less than 30 days following the establishment of the federal contract price. The board may not impose more than one interim assessment per year, except in the case of a public health emergency declared in accordance with state or federal law. [ 2009, c. 595, § 2 (NEW) ]

F. If the combination of funding available from the United States Department of Health and Human Services, Centers for Disease Control and Prevention, Vaccines for Children Program and the immunization grant program under the federal Public Health Service Act, Section 1928 of the Social Security Act, 42 United States Code, Section 1396s is insufficient to provide coverage for vaccines for the children who qualify for vaccines under the Vaccines for Children Program, money from the fund may not be used to cover the cost of vaccines for children who would otherwise be provided vaccines under the Vaccines for Children Program. [ 2009, c. 595, § 2 (NEW) ]

G. If the assessments under this subsection are insufficient to cover the cost of vaccines to be
provided to children covered by assessed entities, the State is not required to cover the cost of vaccines for those children. [2009, c. 595, § 2 (NEW).]

[2009, c. 595, § 2 (NEW).]

6. Failure to pay assessment. If an assessment under subsection 5 is not paid on the due date established by the board, the provisions of this subsection apply.

A. The board shall submit a report to the superintendent listing each assessed entity that has failed to pay an assessment under subsection 5. [2009, c. 595, § 2 (NEW).]

B. If an assessed entity has not paid an assessment under subsection 5 within 45 days following the close of the calendar quarter, interest accrues at 12% per annum on or after the due date. Interest paid under this paragraph must be deposited into the fund. Upon application, the board may waive such interest payments for good cause shown. [2009, c. 595, § 2 (NEW).]

The superintendent may take any action authorized under Title 24-A to enforce collection of any unpaid assessment or fine and may impose any penalty authorized under Title 24-A for noncompliance with this section if the assessed entity has engaged in a pattern of conduct that demonstrates a lack of good faith in complying with the requirements of this subsection.

[2009, c. 595, § 2 (NEW).]

7. Fund. The Childhood Immunization Fund is established for the sole purpose of funding the program, including any costs of vaccines provided under the program to children and any costs the board may incur for staff, a service agent, administrative support services, legal representation and contracted services. The fund is administered by the board or the service agent, which shall act as a fiduciary and manage and invest the fund in conformance with prudent investor standards and maintain complete records of all assets, investments, deposits, disbursements and other transactions of the fund. All money and securities in the fund must be held in trust by the Treasurer of State for the purpose of making payments under this section and are not money or property for the general use of the State. The Treasurer of State is the custodian of the fund and may make disbursements only upon written direction from the board or the service agent. All assessments collected pursuant to this section, all interest on the balance in the fund and all income from any other source must be deposited into the fund. The fund does not lapse. No portion of the fund may be used to subsidize other programs or budgets.

[2009, c. 595, § 2 (NEW).]

8. Reporting. By January 15th of each year the board shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding the operation of the program, the progress of the program in expanding access to immunizations for children and the assets, investments and expenditures of the fund.

[2009, c. 595, § 2 (NEW).]

9. Service agent. The board, by written contract, may delegate administration of the fund to a service agent. The service agent:

A. May contract with attorneys acceptable to the board for legal representation for the board; [2009, c. 595, § 2 (NEW).]

B. May levy assessments, institute collection procedures, including legal action if necessary, and deposit money in the fund with the Treasurer of State if those funds are not needed to meet immediate cash flow demands; and [2009, c. 595, § 2 (NEW).]

C. Shall make recommendations to the board regarding policies, rules and standards necessary for the proper administration of the fund. [2009, c. 595, § 2 (NEW).]

[2009, c. 595, § 2 (NEW).]

10. Freedom from liability. There is no liability on the part of, and a cause of action may not arise against, a member of the board for any acts or omissions in the performance of the member's duties under this section. This immunity does not extend to willful neglect or malfeasance that would otherwise be actionable.

[2009, c. 595, § 2 (NEW).]

11. Rules. The department and the board shall jointly adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.
[2009, c. 595, § 2 (NEW).]  

§ 1130. Immunization pilot program

(a) As used in this section:

(1) "Health care facility" shall have the same meaning as in section 9402 of this title.

(2) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(3) "Health insurer" shall have the same meaning as in section 9402 of this title, but does not apply to insurers providing coverage only for a specified disease or other limited benefit coverage.

(4) "Immunizations" means vaccines and the application of the vaccines as recommended by the practice guidelines for children and adults established by the Advisory Committee on Immunization Practices (ACIP) to the Centers for Disease Control and Prevention (CDC).

(5) "State health care programs" shall include Medicaid, the Vermont health access plan, Dr. Dynasaur, and any other health care program providing immunizations with funds through the Global Commitment for Health waiver approved by the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act.

(b)(1) The department of health shall establish an immunization pilot program with the ultimate goal of ensuring universal access to vaccines for all Vermonters at no charge to the individual and to reduce the cost at which the state may purchase vaccines. The pilot program shall be in effect from January 1, 2010, through December 31, 2012. During the term of the pilot program, the department shall purchase, provide for the distribution of, and monitor the use of vaccines as provided for in this subsection and subsection (c) of this section. The cost of the vaccines and an administrative surcharge shall be reimbursed by health insurers as provided for in subsections (e) and (f) of this section.

(2) The department shall solicit, facilitate, and supervise the participation of health care professionals, health care facilities, and insurers in the immunization pilot program in order to accomplish the state's goal of universal access to immunizations at the lowest practicable cost to individuals, insurers, and state health care programs.

(3) The department shall gather and analyze data regarding the immunization pilot program for the purpose of ensuring its quality and maximizing protection of Vermonters against diseases preventable by vaccination.

(c) The immunization pilot program shall include a bulk purchasing pool to maximize the discounts, rebates, or negotiated price of all vaccines for children and certain recommended vaccines for adults. The department shall determine which vaccines for adults shall be purchased under the program. The department may join a multi-state purchasing pool or contract with a wholesale distributor to negotiate prices for the vaccines provided through the program.

(d) The immunization pilot program shall provide for distribution of the vaccines to health care professionals and health care facilities for administration to patients.

(e) Health insurers shall reimburse the department for the actual cost of vaccines provided to their subscribers and for the administration surcharge established in subsection (f) of this section.

(f) The department shall charge each health insurer a surcharge for the costs and administration of the immunization pilot program. The surcharge shall be deposited into an existing special fund and used solely for the purpose of administering the pilot program.

(g)(1) No later than July 1, 2009, the commissioner shall convene an advisory committee to provide recommendations regarding the immunization pilot program, including:

(A) the vaccines to be included in the pilot program;

(B) the pilot program's target patient utilization goal.
for each vaccine selected for inclusion in the pilot;

(C) the purchase price of vaccines;

(D) the administrative surcharge established pursuant to subsection (f) of this section; and

(E) the design of the evaluation for the immunization pilot program.

(2) The advisory committee shall include representatives from the three largest health insurers licensed to do business in Vermont and the department of Vermont health access and shall be chaired by the chief of the immunization program for the department of health.

(3) The advisory committee shall meet throughout the term of the pilot program.

(h) The department of health shall develop, with input from the advisory committee established pursuant to subsection (g) of this section, an evaluation methodology to determine the costs and effectiveness of the pilot program, including whether the total cost to health insurers of participation in the pilot program is less than or equal to their estimated costs had they not participated in the program.

(i) The department may adopt rules under chapter 25 of Title 3 if necessary to implement this section.

NEW HAMPSHIRE STATUTES

Title 10. Public Health

Chapter 126-Q. New Hampshire Vaccine Association

Current through Chapter 268 of the 2011 Legislative Session

§ 126-Q:1. Definitions

In this chapter:

I. "Association" means the New Hampshire vaccine association.

II. "Commissioner" means the commissioner of the department of health and human services.

III. "Covered lives" shall have the same meaning as defined in RSA404-G:2, V.

IV. "Estimated vaccine cost" means the estimated cost to the state over the course of a state fiscal year of the purchase, distribution, and administration of vaccines purchased at the federal discount rate by the department of health and human services.

V. "Health insurance" shall have the same meaning as defined in RSA404-G:2, VII.

VI. [Repealed.]

VII. "Total non-federal program cost" means the estimated vaccine cost less the amount of federal revenue available to the state for the purchase, distribution, and administration of vaccines.

VIII. "Vaccine" means any preparations of killed microorganisms, living attenuated organisms, or living fully virulent organisms that are approved by the federal Food and Drug Administration and recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and have been authorized by the commissioner of the department of health and human services for administration to children of the state of New Hampshire under the age of 19 years for the purposes of producing or artificially increasing immunity to particular life-threatening and disabling diseases.


§ 126-Q:2. Creation of Association

There is hereby created a nonprofit corporation to be known as the New Hampshire vaccine association. The association is formed to assess insurers for the cost of vaccines provided to certain children in New Hampshire.


§ 126-Q:3. Membership, Powers, and Duties of the New Hampshire Vaccine Association

I. The New Hampshire vaccine association shall be comprised of all insurers currently writing or maintaining health insurance in New Hampshire.

II. The New Hampshire vaccine association shall be a not-for-profit, voluntary corporation under RSA 292 and shall possess all general powers of a not-for-profit corporation.

III. The board of directors shall include:

(a) Three representatives selected from the insurers currently writing or maintaining health insurance in New Hampshire and having the most covered lives in New Hampshire.

(b) Two health care provider representatives appointed by the commissioner.

(c) The commissioner of the department of health and human services, who shall serve as an ex-officio member.

(d) The commissioner of the department of insurance who shall serve as an ex-officio member.

IV. The directors' terms and appointments shall be specified in the plan of operation adopted by the New Hampshire vaccine association.

V. The board of directors of the association shall:

(a) Prepare and adopt articles of association and
(b) Prepare and adopt a plan of operation.

(c) Submit the plan of operation to the commissioner of insurance for approval after the consultation with the commissioner.

(d) Conduct all activities in accordance with the approved plan of operation.

(e) On an annual basis, no later than November 1 of each year, establish the amount of the assessment.

(f) Enter into contracts as necessary or proper to collect and disburse the assessment.

(g) Enter into contracts as necessary or proper to administer the plan of operation.

(h) Sue or be sued, including taking any legal action necessary or proper for the recovery of any assessment for, on behalf of, or against members of the association or other participating person.

(i) Appoint from among its directors, committees as necessary to provide technical assistance in the operation of the association, including the hiring of independent consultants as necessary.

(j) Notify, in writing, each insurer of the insurer's assessment by November 15 of each year.

(k) Submit an annual report to the commissioner of insurance, in a manner and form determined by the commissioner, listing the association membership base, providing a count of covered lives by member, identifying changes in association membership and covered lives, describing the collection of assessments, listing payment delinquencies, and containing such other related information as the commissioner may require.

(l) Allow each insurer up to 90 days after the notification required by subparagraph (j) to remit its assessment or submit an assessment payment plan, subject to approval by the association and initial payment under an approved assessment payment plan.

(m) Deposit annual assessments collected by the association less the association’s administrative costs with the state treasurer to the credit of the vaccine purchase fund established pursuant to RSA141-C:17-a.

(n) Perform any other functions as may be necessary or proper to carry out the plan of operation.


§ 126-Q:4. Assessment Determination

I. The commissioner shall calculate the total non-federal program cost no later than October 1 of each year.

II. The board shall determine the amount to be raised by the association by multiplying the ratio of the number of covered lives to the total number of non-elderly New Hampshire residents by the total non-federal program cost.

III. For any year in which the total calculated cost to be received is less than the anticipated cost for vaccines, the association shall pay the amount of the increase to the state.

IV. Each insurer writing or maintaining health insurance in New Hampshire shall be assessed in proportion to the number of its covered lives.

V. The aggregate amount to be raised by the association shall include credit for any surpluses remaining from prior years, as well as reasonable costs for the association's administration.


§ 126-Q:5. Powers and Duties

In addition to the duties and powers enumerated elsewhere in this chapter:

I. The commissioner of insurance shall fine any insurer that fails to pay an assessment within 6 months of notification under RSA126-Q:3, V(j). The fine shall be at least $5,000 and no more than 125 percent of the amount of the delinquent assessment. Fines so levied shall be deposited with the state treasurer to the credit of the vaccine purchase fund established pursuant to RSA141-C:17-a.

I-a. The insurance commissioner shall annually review the report required under RSA126-Q:3, V(k) on association membership, covered lives, and the payment of assessments to ensure that all insurers that should be members of the association are
participating in the association and that all association members have accurately reported covered lives and paid the proper assessment. The association shall remedy any problem identified by the commissioner with respect to membership in the association, reporting of covered lives, or payment of the assessment.

II. The commissioner and the commissioner of insurance may adopt rules, pursuant to RSA 541-A, as necessary to carry out the purposes of this chapter.


§ 126-Q:6. Examinations and Annual Reports

The board of directors shall submit to the commissioner, no later than 120 days after the close of the association's fiscal year, a financial report in a form approved by the commissioner.


§ 126-Q:7. Exemption From Taxes

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.


§ 126-Q:8. Immunity From Liability

There shall be no liability on the part of and no cause of action of any nature shall arise against any association member or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter.


§ 126-Q:9. Severability of Chapter

If any provisions of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

SENATE . . . . . . No. 2362

The Commonwealth of Massachusetts

SENATE, July 19, 2012

The committee on Ways and Means, to whom was referred the Senate bill establishing the Massachusetts Childhood Vaccine Program (Senate, No. 2120); report recommending that the same ought to pass with an amendment substituting a new draft with the same title (Senate, No. 2362).

For the committee,

STEPHEN M. BREWER.
An Act establishing the Massachusetts Childhood Vaccine Program.

    Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1  SECTION 1. The General Laws are hereby amended by inserting after chapter 118H the following chapter:-

3  Chapter 118I

4  Childhood Vaccine Program

5  Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:

7  “Children”, individuals less than 19 years of age.

8  “Estimated vaccine cost”, the estimated cost over the course of a fiscal year for the purchase, storage and distribution of vaccines for all children in the commonwealth.

10 “Routine childhood immunizations”, immunizations for children until their nineteenth birthday including, but not limited to: (1) the immunizations recommended by the federal

12 Vaccines for Children Program; and (2) any immunizations recommended by the Advisory
Committee on Immunization Practices of the United States Department of Health and Human Services.

“Surcharge payors”, those entities defined as surcharge payors under section 34 of chapter 118G, whose assessment may be collected in a manner consistent with said chapter 118G.

“Total non-federal program cost”, the estimated annual cost of vaccines needed for routine childhood immunizations for children covered by surcharge payors in the commonwealth less the amount of federal revenue available to the commonwealth for purchase, storage, distribution and administration of such vaccines.

Section 2. There shall be established in the commonwealth a separate trust fund to be known as the Vaccine Purchase Trust Fund to support a universal purchase system for childhood vaccines in the commonwealth. The fund shall be expended to cover the costs to purchase, store and distribute vaccines for routine childhood immunizations and to administer the fund and the immunization registry, established under section 24M of chapter 111. The fund shall consist of all monies paid to the commonwealth under section 4 and any interest earnings on such monies. The fund shall be maintained by the commissioner of health care finance and policy or a designee. The monies shall be expended under the direction of the department of public health, without prior appropriation, solely to cover total non-federal program costs; provided, however, that the amount to be expended for storing and distributing vaccines for routine childhood immunizations, if such costs are not covered by federal contribution, and for the costs of administering the immunization registry, shall not exceed 10 per cent of the total amount of the fund expended for the purchase of vaccines needed for routine childhood immunizations for all
children in the commonwealth. Any balance in the fund at the close of a fiscal year shall be
available for expenditure in subsequent fiscal years and shall not be transferred to any other fund
or revert to the General Fund. The commissioner of health care finance and policy or a designee
shall report annually to the house and senate committees on ways and means the amount of funds
collected and any expenditures made from the fund.

Section 3. There shall be a vaccine purchase advisory council consisting of the
commissioner of public health or a designee, who shall serve as chair; the medical director of the
universal immunization program of the department of public health established under section 24I
of chapter 111; the commissioner of health care finance and policy or a designee; the executive
director of the commonwealth health insurance connector authority or a designee; 3 persons to be
appointed by the commissioner of insurance, each of whom shall be a representative of 1 of the 3
health insurance companies having the most insured lives in the commonwealth; and 8 persons to
be appointed by the commissioner of public health, 1 of whom shall be a representative of an
employer that self-insures for health coverage who shall be appointed from lists of nominees
submitted by statewide associations of employers, 1 of whom shall be a representative of the
pharmaceutical manufacturing industry with expertise in researching, developing and
manufacturing vaccines, 1 of whom shall be a member of the Massachusetts Medical Society, 1
of whom shall be a member of the Massachusetts chapter of the American Academy of
Pediatrics, 1 of whom shall be a member of the Massachusetts Academy of Family Physicians,
and 3 of whom shall be physicians licensed to practice in the commonwealth and who shall have
expertise in the area of childhood vaccines. The council shall recommend the types of vaccines
to be purchased based on a list of routine childhood immunizations and shall take into account
provider preference, cost, availability and other factors as determined by the council. The
council shall recommend the amount of funding needed each fiscal year by calculating the total non-federal program cost. The commissioner of public health shall determine the final vaccines to be purchased.

Section 4. The commissioner of health care finance and policy shall determine the final amount required to be included in the Vaccine Purchase Trust Fund for the next fiscal year to cover the estimated vaccine cost under this chapter and shall annually provide surcharge payors notice of the assessment amount for the trust fund year not later than January 1.

Under regulations adopted by the commissioner of health care finance and policy, each surcharge payor in the commonwealth shall pay to the commissioner of health care finance and policy, for deposit in the Vaccine Purchase Trust Fund, a routine childhood immunizations surcharge assessed by the commissioner; provided, however, that the amount of the routine childhood immunizations surcharge assessed to cover the costs for storing and distributing such vaccines, if such costs are not covered by federal contribution, and for the costs of administering the immunization registry, shall not exceed 10 per cent of the amount of the routine childhood immunizations surcharge assessed to cover the purchase of vaccines needed for routine childhood immunizations for all children in the commonwealth. The regulations shall establish dates for assessing and payment of such surcharge and shall permit and enable expenditure of funds by the department of public health. The annual contribution into the trust fund shall be deposited annually by July 1. The surcharge shall be a percentage of the final amount determined by the commissioner of health care finance and policy under this section; provided, however that the commissioner of health care finance and policy shall not increase the total amount of the surcharge more than 4 per cent over the previous fiscal year unless the commissioner of health care finance and policy, in consultation with the commissioner of public
health, submits a detailed report to the legislature explaining the need for such increase. If the
reason for such increase is due to the purchase of new vaccines, as recommended by the vaccine
purchase advisory council, such report shall include an analysis of cost savings generated by use
of the state vaccine purchasing discount.

Section 5. The department of public health may adopt rules and regulations as necessary
to implement the universal purchase and distribution system under this chapter and other
applicable state and federal laws. The rules and regulations shall establish the system by which
vaccines are distributed for children in the commonwealth.

Section 6. Every surcharge payor, to the extent not preempted by federal law, shall
provide benefits for: (i) routine childhood immunizations for residents of the commonwealth;
and (ii) immunizations for residents of the commonwealth who are 19 years of age and older
according to the most recent schedules recommended by the Advisory Committee on
Immunization Practices of the United States Department of Health and Human Services. These
benefits shall be exempt from any copayment, coinsurance, deductible or dollar limit provisions
in the health insurance policy or contract.

SECTION 2. Notwithstanding any general or special law to the contrary, in fiscal year
2014, the commissioner of health care finance and policy shall not increase the total amount of
the routine childhood immunizations surcharge more than 7 per cent over item 4580-1000 in the
fiscal year 2013 general appropriations act, plus any supplemental fiscal year 2013 funding to
said item 4580-1000, unless the commissioner of health care finance and policy, in consultation
with the commissioner of public health, submits a detailed report to the legislature explaining the
need for such increase; and provided further, that in state fiscal year 2015, the commissioner of
103 health care finance and policy shall not increase the total amount of the surcharge more than 7
104 per cent over the fiscal year 2014 surcharge amount unless the commissioner of health care
105 finance and policy, in consultation with the commissioner of public health, submits a detailed
106 report to the legislature explaining the need for such increase.

107 SECTION 3. The routine childhood immunizations surcharge assessment required under
108 section 4 of chapter 118I of the General Laws shall take effect on July 1, 2013.
Act Establishing the Massachusetts Childhood Vaccine Program (H. 348 / S. 529)

Lead Sponsors: Representative Alice K. Wolf and Senator Richard Moore

Overview:

An Act Establishing the Massachusetts Childhood Vaccine Program would establish a stable financing framework to guarantee that all children 0-18 years of age receive all of the vaccines recommended by the federal Advisory Committee on Immunization Practices (ACIP), which sets national standards for immunizations. This proposal represents a novel public-private collaboration that will greatly improve child health while saving the Commonwealth money in both the short and long terms.

Currently, an assessment is charged to Massachusetts insurers for the cost of state-supplied childhood vaccines at the reduced purchase price the state receives under the federal contract. This financing system has been successfully implemented via state budget language from FY10 through FY12, saving the Commonwealth approximately $50 million per year. This bill would make permanent this financing mechanism and establish a Vaccine Purchase Trust Fund ensuring access to all recommended childhood vaccines.

The bill would also provide funding for the Massachusetts immunization registry authorized by M.G.L. c. 111, Section 24M. The immunization registry will create a statewide interactive data repository of all immunizations that providers can access to ensure complete and timely immunization of their patients. It also permits families to obtain quick summaries of their immunization histories for school and camp use and to inform a health care provider new to them. The registry will help ensure high immunization rates for children and adults and will allow for the tracking of the approximately 3.5 million doses of vaccine distributed by the Massachusetts Department of Public Health (DPH) annually. The registry will generate cost savings by reducing waste associated with over-immunization and by ensuring timely administration of disease-preventing vaccines.

Current Status of Massachusetts Childhood Vaccines Program and Immunization Registry:

- Massachusetts is no longer a universal childhood vaccine distribution state. While for over 100 years the Commonwealth supplied routinely recommended childhood vaccines free of charge to providers, there is currently no state funding for human papillomavirus (HPV) vaccine or the recommended booster dose of meningococcal vaccine, and funding for other adolescent vaccines has been reduced.
- Massachusetts is one of only three states without a fully operational immunization registry. Legislation establishing the framework for the registry was passed as outside language in the budget in June 2010, but there was no funding designated for this critical system. Lack of identified funding will limit DPH’s ability to roll-out the system statewide from its current pilot phase to protect the Commonwealth’s investment in vaccines.

Benefits of this Legislation:

For Providers:

- Would reestablish a universal vaccine distribution program covering all ACIP-recommended childhood vaccines.
- Would roll out the pilot Massachusetts immunization registry, which will assist providers to anticipate vaccines schedules, automatically generate vaccine reminders, identify those overdue, and print school and camp forms for their patients.
• Would support providers with clinical decision-making by interpreting increasingly complex immunization schedules, improving patient safety.
• Would facilitate Massachusetts’ providers and hospitals using the immunization registry to become eligible for thousands to million of dollars of federal stimulus funding from the Health Information Technology for Economic and Clinical Health Incentive (HITECH) Act of 2009.*

For Families:
• Would guarantee access to all recommended vaccines for their children.
• Would keep family vaccine records in a secure, centralized, accessible location.
• Would ensure timely administration of vaccines, including catch-up of missed vaccines.
• Would help families receive automated reminders to help stay current on vaccines.
• Would simplify the generation of school and camp vaccine documentation.

For the Commonwealth:
• Would save money:
  o All childhood vaccines would be purchased at the federal discount rate (on average 40% less than if purchased by the private sector) and would be fully funded via assessment of insurers.
  o Stable funding for the immunization registry, also via insurer assessment, would reduce vaccine wastage, duplicate immunization, and provider administrative costs, saving over $5.5M per year.
  o State funds supporting the roll-out and maintenance of the immunization registry would be eligible for significant federal matching funds (90% FFP).
• Would provide an essential infrastructure for responding to natural disasters, bioterrorism events, influenza pandemics and other emergencies.
• Would restore a seamless, equitable universal vaccine programs for children; expanding for the first time to include HPV and the booster dose of meningococcal vaccines.
• Would guarantee that Massachusetts maintains one of the highest childhood vaccination rates in the country.
• Would bring Massachusetts into line with CDC expectations to maintain a vaccine registry.

For more information, contact Kathleen Hornby at 617-722-2810 or Kathleen.Hornby@MAHouse.gov

* Incentive payments are available for Medicare- and Medicaid-eligible providers who purchase and “meaningfully use” electronic health record systems. Data exchange with the immunization registry will satisfy the criteria for “meaningful use”. Through the HITECH act, providers are eligible for as much as $44,000 per clinician from Medicare, and $63,750 per clinician from Medicaid. Hospitals can receive a $2 million base incentive, plus additional funding based on their Medicaid/Medicare share. This “meaningful use” must meet specified objectives that will help improve safety, quality, and efficiency of patient care.
General Assembly  

**Bill No. 6001**  

*05779__________*

Referred to Committee on No Committee

Introduced by:

REP. DONOVAN, 84th Dist.

SEN. WILLIAMS, 29th Dist.

**AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR BEGINNING JULY 1, 2012.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 1 of public act 12-104 is repealed and the following is substituted in lieu thereof (Effective July 1, 2012):

Sec. 212. Section 19a-7f of the 2012 supplement to the general statutes is amended by adding subsection (c) as follows (Effective from passage):

(NEW) (c) Not later than October 1, 2012, the Department of Public Health shall (1) post on its Internet web site its most current policy regarding vaccine wastage. Such policy shall include a statement of the factors said department used to determine such policy and shall be updated as necessary to reflect the most current policy in effect, and (2) make a form available to health care providers for the purpose of reporting to said department instances when a health care provider does not receive a full order of a requested vaccine. Not later than January 1, 2013, and biannually thereafter, said department shall, within available resources, track, record and investigate all such reported instances and shall post aggregate findings of such instances and the reasons for such findings on said department’s Internet web site.
Sec. 213. Subsections (a) and (b) of section 19a-7f of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (Effective October 1, 2012):

(a) The Commissioner of Public Health shall determine the standard of care for immunization for the children of this state. The standard of care for immunization shall be based on the recommended schedules for active immunization for normal infants and children published by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. The commissioner shall establish, within available appropriations, an immunization program which shall: (1) Provide vaccine at no cost to health care providers in Connecticut to administer to children so that cost of vaccine will not be a barrier to age-appropriate vaccination in this state; (2) with the assistance of hospital maternity programs, provide all parents in this state with the recommended immunization schedule for normal infants and children, a booklet to record immunizations at the time of the infant's discharge from the hospital nursery and a list of sites where immunization may be provided; (3) inform in a timely manner all health care providers of changes in the recommended immunization schedule; (4) assist hospitals, local health providers and local health departments to develop and implement record-keeping and outreach programs to identify and immunize those children who have fallen behind the recommended immunization schedule or who lack access to regular preventative health care and have the authority to gather such data as may be needed to evaluate such efforts; (5) assist in the development of a program to assess the vaccination status of children who are clients of state and federal programs serving the health and welfare of children and make provision for vaccination of those who are behind the recommended immunization schedule; (6) access available state and federal funds including, but not limited to, any funds available through the federal Childhood Immunization Reauthorization or any funds available through the Medicaid program; (7) solicit, receive and expend funds from any public or private source; and (8) develop and make available to parents and health care providers public health educational materials about the benefits of timely immunization.

(b) (1) Commencing October 1, 2011, one group health care provider located in Bridgeport and one group health care provider located in New Haven, as identified by the Commissioner of Public Health, and any health care provider located in Hartford who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s may select under said federal program, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (A) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (B) made available to the department by the National Centers for Disease Control and Prevention.
(2) Not later than June 1, 2012, the Commissioner of Public Health shall provide an evaluation of the vaccine program established in subdivision (1) of this subsection to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such evaluation shall include, but not be limited to, an assessment of the program's impact on child immunization rates, an assessment of any health or safety risks posed by the program, and recommendations regarding future expansion of the program.

(3) (A) Provided the evaluation submitted pursuant to subdivision (2) of this subsection does not indicate a significant reduction in child immunization rates or an increased risk to the health and safety of children, commencing October 1, 2012, (i) any health care provider who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s may select, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (II) made available to the department by the National Centers for Disease Control and Prevention, and (ii) any health care provider who administers vaccines to children may select, and the department shall provide, subject to inclusion in such program due to available appropriations, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, (II) made available to the department by the National Centers for Disease Control and Prevention, and (III) equivalent, as determined by the commissioner, to the cost for vaccine series completion of comparable available licensed vaccines.

(B) Commencing January 1, 2013, (i) any health care provider who administers vaccines to children under the federal Vaccines For Children immunization program that is operated by the Department of Public Health under authority of 42 USC 1396s shall utilize, and the department shall provide, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (II) made available to the department by the National Centers for Disease Control and Prevention, and (ii) any health care provider who administers vaccines to children shall utilize, and the department shall provide, subject to inclusion in such program due to available appropriations, any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (I) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, (II) made available to the department by the National Centers for Disease Control and
Prevention, and (III) equivalent, as determined by the commissioner, to the cost for vaccine series completion of comparable available licensed vaccines.

(C) For purposes of subparagraphs (A)(ii) and (B)(ii) of this subdivision, "comparable" means a vaccine (i) protects a recipient against the same infection or infections, (ii) has similar safety and efficacy profiles, (iii) requires the same number of doses, and (iv) is recommended for similar populations by the National Centers for Disease Control and Prevention.

(4) (A) The provisions of this subsection shall not apply in the event of a public health emergency, as defined in section 19a-131, or an attack, major disaster, emergency or disaster emergency, as those terms are defined in section 28-1.

(B) Nothing in this subsection shall require a health care provider to procure a vaccine from the Department of Public Health when such provider is directed by said department to procure such vaccine from another source, including, but not limited to, during a declared national or state vaccine shortage.

(C) Nothing in this subsection shall require a health care provider to utilize or administer a vaccine provided by said department if, based upon such provider's medical judgment, (i) administration of such vaccine is not medically appropriate, or (ii) the administration of another vaccine that said department is not authorized to supply under subdivision (3) of this subsection is more medically appropriate.

(5) No health care provider shall seek or receive remuneration for or sell any vaccine serum provided by said department under this section. Nothing in this section shall prohibit a health care provider from charging or billing for administering a vaccine.

(6) Not later than January 1, 2014, said department shall submit a report to the General Assembly, in accordance with section 11-4a, evaluating the effectiveness of implementing expanded vaccine choice and universal health care provider participation.

Sec. 214. Section 19a-7j of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2012):

(a) Not later than September [1, 2003, and] first, annually, thereafter, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amount appropriated for the following purposes: (A) To purchase, store and distribute vaccines for routine immunizations included in the schedule for active immunization required by section 19a-7f, as amended by this act; (B) to purchase, store and distribute (i) vaccines to prevent hepatitis A and B in persons of all ages, as recommended by the schedule for immunizations published by the National
Advisory Committee for Immunization Practices, (ii) antibiotics necessary for the treatment of tuberculosis and biologics and antibiotics necessary for the detection and treatment of tuberculosis infections, and (iii) antibiotics to support treatment of patients in communicable disease control clinics, as defined in section 19a-216a; and (C) to provide services needed to collect up-to-date information on childhood immunizations for all children enrolled in Medicaid who reach two years of age during the year preceding the current fiscal year, to incorporate such information into the childhood immunization registry, as defined in section 19a-7h, and (2) inform the Insurance Commissioner of such amount.

(b) (1) As used in this subsection, (A) "health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and (B) "exempt insurer" means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under [paragraph (C) of subdivision (11) of section 38a-720 and section 38a-720a].

[(b) (2) (A) Each domestic insurer or health care center doing [life insurance or] health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the General Fund, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section. Not later than October 1, 2003, and annually thereafter, the Insurance Commissioner shall determine the fee to be assessed against each such domestic insurer or health care center for the next fiscal year. Such fee shall be a percentage of the total amount appropriated, as identified in subsection (a) of this section, and shall be calculated on the basis of life insurance premiums and health insurance premiums and subscriber charges in the same manner as calculations under section 38a-48. Not later than November 1, 2003, and annually thereafter, the Insurance Commissioner shall submit a statement to each such insurer and health care center that includes the proposed fee for the insurer or health care center calculated in accordance with this section. As used in this section, "health insurance" means health insurance, as defined in subdivisions (1) to (13), inclusive, of section 38a-469.]

(B) Each third-party administrator licensed pursuant to section 38a-720a that provides administrative services for self-insured health benefit plans and each exempt insurer shall, on behalf of the self-insured health benefit plans for which such third-party administrator or exempt insurer provides administrative services, annually pay to the Insurance Commissioner, for deposit in the General Fund, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(3) Not later than September first, annually, each such insurer, health care center, third-party administrator and exempt insurer shall report to the Insurance Commissioner, on a form designated by said commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding for which such insurer, health care center, third-party administrator or exempt insurer is providing health insurance or

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Comment [RM1]: § 38a-469. Definitions
Currentness
As used in this title, unless the context otherwise requires or a different meaning is specifically prescribed, "health insurance" policy means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage: (1) Basic hospital expense coverage; (2) basic medical-surgical expense coverage; (3) hospital confinement indemnity coverage; (4) major medical expense coverage; (5) disability income protection coverage; (6) accident only coverage; (7) long term care coverage; (8) specified accident coverage; (9) Medicare supplement coverage; (10) limited benefit health coverage; (11) hospital or medical service plan contract; (12) hospital and medical coverage provided to subscribers of a health care center; (13) specified disease coverage; (14) TriCare supplement coverage; (15) travel health coverage; and (16) single service ancillary health coverage, including, but not limited to, dental, vision or prescription drug coverage.

Comment [RM2]: C.G.S.A. § 38a-720a License. Exemptions. Written agreement required
Currentness
(a) No person shall offer to act as or hold himself out to be a third-party administrator in this state unless such person is licensed pursuant to section 38a-720j, or is exempt from licensure pursuant to subsection (b) of this section. This requirement shall not apply to a person employed by a third-party administrator to the extent that such person's activities are under the supervision and control of the third-party administrator. The authority granted to a third-party administrator pursuant to sections 38a-720 to 38a-726, inclusive, shall not exempt such third-party administrator's employees from the licensing requirements of chapters 701b and 702.2
(b) (1) Any insurer licensed in this state that directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims on, residents of this state in connection with life, annuity or health coverage offered or provided by an insurer. “Third-party administrator” does not include: (i) any insurance holding company, group insurance holding company, or insurance holding company group licensed pursuant to section 38a-720j of which the insurer is a member; or (ii) any person employed by a third-party administrator pursuant to sections 38a-720 to 38a-726, inclusive.

Comment [RM3]: § 38a-720a. License. Exemptions. Written agreement required
Currentness
(b) (1) Any insurer licensed in this state that directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims on, residents of this state in connection with life, annuity or health coverage offered or provided by an insurer. “Third-party administrator” does not include: (i) any insurance holding company, group insurance holding company, or insurance holding company group licensed pursuant to section 38a-720j of which the insurer is a member; or (ii) any person employed by a third-party administrator pursuant to sections 38a-720 to 38a-726, inclusive.

Comment [RM4]: Payers
Comment [RM5]: TPA
administering a self-insured health benefit plan that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(4) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer, health care center, third-party administrator and exempt insurer. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subdivision (3) of this subsection by a factor, determined annually by said commissioner as set forth in this subdivision, to fully fund the amount determined under subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing such amount by the total number of lives reported to said commissioner pursuant to subdivision (3) of this subsection.

(5) (A) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer, health care center, third-party administrator and exempt insurer that includes the proposed fee for the insurer, health care center, third-party administrator or exempt insurer calculated in accordance with this subsection. Each such insurer, health care center, third-party administrator and exempt insurer shall pay such fee to the Insurance Commissioner not later than February first, annually.

[(c)] (B) Any [domestic] such insurer, [or] health care center, third-party administrator or exempt insurer aggrieved by an assessment levied under this [section] subsection may appeal therefrom in the same manner as provided for appeals under section 38a-52, as amended by this act.

(6) Any insurer, health care center, third-party administrator or exempt insurer that fails to file the report required under subdivision (3) of this subsection shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due. The Insurance Commissioner may require an insurer, health care center, third-party administrator or exempt insurer subject to this subsection to produce the records in its possession, and may require any other person to produce the records in such person’s possession, that were used to prepare such report, for said commissioner’s or said commissioner’s designee’s examination. If said commissioner determines there is other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported under subdivision (3) of this subsection and the number actually reported, such insurer, health care center, third-party administrator or exempt insurer shall pay a civil penalty of not more than fifteen thousand dollars for each report filed for which said commissioner determines there is such a discrepancy.
A N A C T

RELATING TO HEALTH AND SAFETY -- TAXATION OF HEALTHCARE SERVICES

Introduced By: Representatives Jackson, O’Neill, Keable, Petrarca, and Gallison.

Date Introduced: February 08, 2012.

Referred To: House Corporations.

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-1-46 of the General Laws in Chapter 23-1 entitled "Department of Health" is hereby amended to read as follows:

23-1-46. Insurers Surcharge. -- (a) Beginning in the fiscal year 2007, each licensed or regulated pursuant to the provisions of chapters 18, 19, 20, and 41 of title-
shall be assessed a child immunization assessment and an adult immunization assessment for the purposes set forth in this section. The department of health shall make available to each insurer, upon its request, information regarding the department of health's immunization programs and the costs related to the program. Further, the department of health shall submit to the general assembly an annual report on the immunization programs and cost related to the programs, on or before February 1 of each year. Annual assessments shall be based on direct premiums written in the year prior to the assessment and for the child immunization program shall not include any Medicare Supplement Policy (as defined in section 27-18.2-1(g)), Medicaid or Medicare premiums. Adult influenza immunization program annual assessments shall include contributions related to the program costs from Medicare, Medicaid and Medicare Managed Care. As to accident and sickness insurance, the direct premium written shall include, but is not limited to, group, blanket, and individual policies. Those insurers assessed greater than ten thousand dollars ($10,000) for the year shall be assessed four (4) quarterly payments of twenty-five percent (25%) of their total assessment. Beginning July 1, 2001, the annual rate of assessment shall be determined by the director of health in concurrence with the primary payors, those being insurers assessed at greater than ten thousand dollars ($10,000) for the previous year. This rate shall be calculated by the projected costs for the Advisory Committee on Immunization Practices (ACIP) recommended and state mandated vaccines after the federal share has been determined by the
Centers for Disease Control and Prevention. The primary payors shall be informed of any recommended change in rates at least six (6) months in advance, and rates shall be adjusted no more frequently than one time annually. For the childhood vaccine program the director of the department of health shall deposit these amounts in Beginning in fiscal year 2012, a portion of the amount collected from the surcharge described in section 44-65.1-1 et seq., up to the actual amount expended by the state for vaccines for children that are recommended by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and/or mandated by state law, less the federal share determined by the Centers for Disease Control and Prevention, shall be deposited into the "childhood immunization account" described in subsection 23-1-45(a). These assessments funds shall be used solely for the purposes of the "childhood immunization programs" described in section 23-1-44 and no other. For the adult immunization program the director of the department of health shall deposit these amounts in the "adult immunization account"; Beginning in fiscal year 2012, a portion of the amount collected from the surcharge described in section 44-65.1-1 et seq., up to the actual amount expended by the state for adult immunizations recommended by ACIP and/or mandated by state law, less the federal share determined by the centers for disease control and prevention, shall be deposited into the "adult immunization account” described in subsection 23-1-45(c). These funds shall be used solely for the purposes of the “adult immunization programs” described in section 23-1-44 and no other.
(b) The department of health shall submit to the general assembly an annual report on the
immunization programs and cost related to the programs, on or before February 1 of each year.

The department of health shall make available to each payer of the surcharge, upon its request,
detailed information regarding the department of health’s immunization programs and the costs
related to those programs. Any funds collected in excess of funds needed to carry-out ACIP
recommendations shall be deducted from the subsequent year’s assessments.

SECTION 2. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of Human Services" is hereby amended to read as follows:

42-12-29. Children's health account. -- (a) There is created within the general fund a
restricted receipt account to be known as the "children's health account". All money in the
account shall be utilized by the department of human services to effectuate coverage for the
following service categories: (1) home health services, which include pediatric private duty
nursing and certified nursing assistant services; (2) comprehensive, evaluation, diagnosis,
assessment, referral and evaluation (CEDARR) services, which include CEDARR family center
services, home based therapeutic services, personal assistance services and supports (PASS) and
kids connect services and (3) child and adolescent treatment services (CAITS). All money
received pursuant to this section shall be deposited in the children's health account. The general
treasurer is authorized and directed to draw his or her orders on the account upon receipt of
properly authenticated vouchers from the department of human services.

(b) Beginning in the fiscal year 2007, each insurer licensed or regulated pursuant-
provisions of chapters 18, 19, 20, and 41 of title 27 shall be assessed for the purposes set forth in this section. The department of human services shall make available to each insurer, upon its request, information regarding the department of human services child health program and the costs related to the program. Further, the department of human services shall submit to the general assembly an annual report on the program and cost related to the program, on or before February 1 of each year. Annual assessments shall be based on direct premiums written in the year prior to the assessment and shall not include any Medicare Supplement Policy (as defined in section 27-18-2.1(g)), Medicare managed care, Medicare, Federal Employees Health Plan, Medicaid/Rite Care or dental premiums. As to accident and sickness insurance, the direct premium written shall include, but is not limited to, group, blanket, and individual policies. Those insurers assessed greater than five hundred thousand dollars ($500,000) for the year shall be assessed four (4) quarterly payments of twenty-five percent (25%) of their total assessment. Beginning July 1, 2006, the annual rate of assessment shall be determined by the director of human services in concurrence with the primary payors, those being insurers likely to be assessed at greater than five hundred thousand dollars ($500,000). The director of the department of human services shall deposit that amount. Beginning in fiscal year 2012, a portion of the amount collected from the surcharge described in section 44-65.1-1 et seq., up to the actual amount expended by the state for the services described in subsection 42-12-29(a), but not more than the
limit set forth in subsection 42-12-29(d), shall be deposited in the "children's health account". The

assessmnt funds shall be used solely for the purposes of the "children's health account" and no

other.

(c) The department of human services shall submit to the general assembly an annual report on the program and cost related to the program, on or before February 1 of each year. The department of health shall make available to each payer of the surcharge, upon its request, detailed information regarding the department of health’s children's health programs described in subsection (a) and the costs related to those programs. Any funds collected in excess of funds needed to carry out the programs shall be deducted from the subsequent year's assessment.

(d) The total annual assessment on all insurers share of the surcharge shall be equivalent to the amount paid by the department of human services for all services, as listed in subsection (a), but not to exceed seven thousand five hundred dollars ($7,500) six thousand dollars ($6,000) per child per service per year.

(e) The children's health account shall be exempt from the indirect cost recovery provisions of section 35-4-27 of the general laws.

SECTION 3. Section 44-17-1 of the General Laws in Chapter 44-17 entitled "Taxation of Insurance Companies" is hereby amended to read as follows:

44-17-1. Companies required to file -- Payment of tax -- Retaliatory rates. --

Every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer, including any health maintenance organization, as defined in section 27-41-1, any
malpractice insurance joint underwriters association as defined in section 42-14.1-1, any

nonprofit dental service corporation as defined in section 27-20.1-2 and any nonprofit hospital or medical service corporation, as defined in chapters 27-19 and 27-20, except companies mentioned in section 44-17-6, health maintenance organizations as defined in section 27-41-1, nonprofit hospital or medical service corporations as defined in chapters 27-19 and 27-20, insurers as defined in subdivision 42-62-4(7) and organizations defined in section 27-25-1, transacting business in this state, shall, on or before March 1 in each year, file with the tax administrator, in the form that he or she may prescribe, a return under oath or affirmation signed by a duly authorized officer or agent of the company, containing information that may be deemed necessary for the determination of the tax imposed by this chapter, and shall at the same time pay an annual tax to the tax administrator of two percent (2%) of the gross premiums on contracts of insurance, except for ocean marine insurance, as referred to in section 44-17-6, covering property and risks, within the state, written during the calendar year ending December 31st next preceding, but in the case of foreign or alien companies, except as provided in section 27-2-17(d) the tax is not less in amount than is imposed by the laws of the state or country under which the companies are organized upon like companies incorporated in this state or upon its agents, if doing business to the same extent in the state or country.

SECTION 4. Title 44 of the General Laws entitled "TAXATION" is hereby amended by adding thereto the following chapter:
4-32 CHAPTER 65.1

4-33 HEALTHCARE SERVICES SURCHARGE

5-34 44-65.1-1. Short title. – This chapter shall be known and may be cited as “The
5-35 Healthcare Services Surcharge Act.”
5-36 44-65.1-2. Definitions. – The following words and phrases as used in this chapter
5-37 have the following meaning:
5-38 (1) “Administrator” means the tax administrator within the department of
5-39 administration.
5-40 (2) “Healthcare services” means and includes all the professional and technical
5-41 components of an admission, diagnostic procedure, therapeutic procedure,
5-42 assessment, treatment,
5-43 ordering and/or filling of medications, and such other services, activities, or supplies
5-44 provided by
5-45 or through a provider (as defined below) on an inpatient or outpatient basis for the
diagnosis,
5-46 treatment, or management of an injury, disease, or medical, mental health, substance
abuse, or
5-47 other condition.
5-48 (3) “Insurer” means all persons (as defined below) offering, administering, and/or
5-49 insuring healthcare services, including, but not limited to, policies of accident and
5-50 sickness, insurance, as defined by chapter 18 of title 27; nonprofit hospital or medical service
5-51 plans, as
5-52 defined by chapters 19 and 20 of title 27; any other person whose primary function is
5-53 to provide
5-54 diagnostic, therapeutic, or preventive services to a defined population on the basis of
5-55 a periodic
5-56 premium; all domestic, foreign, or alien insurance companies, mutual associations
5-57 and
5-58 organizations; health maintenance organizations, as defined by chapter 41 of title 27;
5-59 all persons
5-60 providing health benefits coverage on a self-insurance basis; and all third party
5-54 (4) “Net claims charge” means either: (i) The amount paid on a cash basis by an insurer to a provider for healthcare services for a patient or, in the case of global payment arrangements, paid by an insurer to a provider for health care services rendered to the insurer’s members; or (ii) The gross amount received on a cash basis by a provider from all income derived from the provision of health care services to patients whose health care services are not paid or reimbursed by an insurer, less: (A) Charges attributable to charity care; (B) Bad debt expenses; and (C) Contractual allowances.

5-61 (5) “Patient” means any individual receiving health care services from a provider, other than a patient whose healthcare services are paid or reimbursed by Part A or Part B of the Medicare program, a Medicare Supplemental policy (as defined in subsection 27-18-2.1(g)) or Medicare Managed Care policy, Medicaid and RIte Care programs, the Federal Employees Health Benefit program, Tricare, CHAMPUS, the Veterans Healthcare program, the Indian Health Service program, or the Rhode Island state employee benefits program under chapter 36-12; provided, however, that an individual who is not enrolled in any such benefit plan or program, but who is eligible for Medicaid or RIte Care, or whose household income does not exceed four hundred percent (400%) of the federal poverty level for a family of the size involved, shall not be considered a “patient” for purposes of this chapter.

5-63 (6) “Person” means any individual, corporation, company, association, partnership.
44-65.1-3. Imposition of surcharge. – (a) A surcharge shall be imposed upon the net claims charge in each month at the rate provided in this subsection. Beginning July 1, 2011, the surcharge shall be imposed at a rate of four and eight tenths percent (4.8%); from and after July 1, 2012, the surcharge shall be imposed at a rate of two and eight tenths percent (2.8%) plus a rate determined in accordance with subsection (c). This surcharge shall be in addition to any other fees or assessments upon the insurer or provider allowable by law.

(b) The surcharge shall be paid by or on behalf of the provider of healthcare services as follows: (1) For all net claims charges paid or reimbursed by an insurer, the surcharge shall be paid by the insurer; and (2) For all net claims charges for patients (as defined herein) that are not paid or reimbursed by an insurer, attributable to charity care or bad debt expense, or subject to contractual allowances, the surcharge shall be paid by the provider.

(c) The administrator, with the advice of the directors of the department of health and the
department of human services, will calculate the surcharge percentage for each fiscal
year based on the projected funding needs for the childhood and adult immunization vaccine
programs described in section 23-1-46, the children’s health services programs described in
section 42-12-29, and the projected net claims charge of all persons subject to the surcharge. The
administrator will establish and publish the surcharge percentage for the year beginning July 1,
2012 before May 1, 2012, and annually by May 1 thereafter.

44-65.1-4. Returns and payment. – (a) Subject to subsection (b), every person
required to pay a surcharge shall on or before the twenty-fifty (25th) day of the month
following the month of receipt of net claims charge make a return to the administrator together with
payment of the monthly surcharge.

(b) Any person required to pay the surcharge that can substantiate that the person’s surcharge liability has averaged less than twenty-five thousand dollars ($25,000) per month may file returns and remit payment on or before the last day of July, October, January and April of each year for the preceding three (3) months’ period; provided, however, that the person will be required to make monthly payments if the administrator determines that: (1) The person has become delinquent in either the filing of the return or the payment of the surcharge due thereon; or (2) The liability of the person exceeds seventy-five thousand dollars ($75,000) in surcharge per quarter for any two (2) subsequent quarters.

(c) The administrator is authorized to adopt rules, pursuant to this chapter, relative to the form of the return and the data that it must contain for the correct computation of net claims.
7-44 charge or the surcharge. All returns shall be signed by the person required to pay the surcharge, or

7-45 by its authorized representative, subject to the pains and penalties of perjury. If a return shows an

7-46 overpayment of the surcharge due, the administrator shall refund or credit the overpayment to the

7-47 person required to pay the surcharge.

7-48 (d) The administrator, for good cause shown, may extend the time within which a person

7-49 is required to file a return, and if the return is filed during the period of extension no penalty or

7-50 late filing charge may be imposed for failure to file the return at the time required by this chapter.

7-51 but the person shall be liable for interest as prescribed in this chapter. Failure to file the return

7-52 during the period for the extension shall void the extension.

7-53 44-65.1-5. Set-off for delinquent payment of surcharge. – If a person required to pay a

7-54 surcharge shall fail to pay a surcharge within thirty (30) days of its due date, the administrator

7-55 may request any agency of state government making payments to the person to set-off the amount

7-56 of the delinquency against any payment due the person from the agency of state government and

7-57 remit the sum to the administrator. Upon receipt of the set-off request from the administrator, any

7-58 agency of state government is authorized and empowered to set-off the amount of the

7-59 delinquency against any payment or amounts due the person. The amount of set-off shall be

7-60 credited against the surcharge due from the person.

7-61 44-65.1-6. Surcharge on available information – Interest on delinquencies – Penalties

7-62 – Collection powers. – If any person shall fail to file a return within the time required by this

7-63 chapter, or shall file an insufficient or incorrect return, or shall not pay the surcharge imposed by
this chapter when it is due, the administrator shall assess upon the information as may be.

available, which shall be payable upon demand and shall bear interest at the annual rate provided.

by section 44-1-7 of the Rhode Island general laws, as amended, from the date when the

surcharge should have been paid. If any part of the surcharge made is due to negligence or

intentional disregard of the provisions of this chapter, a penalty of ten percent (10%) of the

amount of the determination shall be added to the tax. The administrator shall collect the

surcharge with interest in the same manner and with the same powers as are prescribed for

collection of taxes in this title.

44-65.1-7. Claims for refund –Hearing upon denial. – (a) Any person required to pay

the surcharge may file a claim for refund with the administrator at any time within two (2) years.

after the surcharge has been paid. If the administrator shall determine that the surcharge has been.

overpaid, he or she shall make a refund with interest from the date of overpayment.

(b) Any person whose claim for refund has been denied may, within thirty (30) days from

the date of the mailing by the administrator of the notice of the decision, request a hearing and the

administrator shall, as soon as practicable, set a time and place for the hearing and shall notify the

insurer or provider.

44-65.1-8. Hearing by administrator on application. – Any person aggrieved by the

action of the administrator in determining the amount of any surcharge or penalty imposed under

the provisions of this chapter may apply to the administrator, within thirty (30) days after the

notice of the action is mailed to it, for a hearing relative to the surcharge or penalty.
The 8-16 administrator shall fix a time and place for the hearing and shall so notify the person.

Upon the 8-17 hearing the administrator shall correct manifest errors, if any, disclosed at the hearing and

thereupon assess and collect the amount lawfully due together with any penalty or interest.

thereon.

8-20 44-65.1-9. Appeals. – Appeals from administrative orders or decisions made pursuant to

any provisions of this chapter shall be to the sixth (6th) division district court pursuant to chapter 8

of title 8 of the Rhode Island general laws, as amended. The right to appeal under this section

shall be expressly made conditional upon prepayment of all surcharges, interest, and penalties.

unless the person moves for and is granted an exemption from the prepayment requirement.

pursuant to section 8-8-26 of the Rhode Island general laws, as amended. If the court, after

appeal, holds that the person is entitled to a refund, the insurer or provider shall also be paid.

interest on the amount at the rate provided in section 44-1-7.1 of the Rhode Island general laws.

as amended.

8-29 44-65.1-10. Records. – Every person required to pay the surcharge shall: (1) Keep

records as may be necessary to determine the amount of its liability under this chapter.

(2) Preserve those records for the period of three (3) years following the date of filing of

any return required by this chapter, or until any litigation or prosecution under this chapter is

finally determined.

(3) Make those records available for inspection by the administrator or his/her authorized

agents, upon demand, at reasonable times during regular business hours.
44-65.1-11. Method of payment and deposit of surcharge. – (a) The payments required by this chapter may be made by electronic transfer of monies to the general treasurer.

(b) The general treasurer is authorized to establish an account or accounts and to take all steps necessary to facilitate the electronic transfer of monies to the “childhood immunization account” described in subsection 23-1-45(a) in the amount described in subsection 23-1-46(a); To the “adult immunization account” described in subsection 23-1-45(c) in the amount described in subsection 23-1-46(a); To the “children’s health account” described in subsection 42-12-29(a) in the amount described in subsection 42-12-29(b); With any excess deposited to the general fund.

The general treasurer shall provide the administrator a record of any monies transferred and deposited.

44-65.1-12. Rules and regulations. – The administrator is authorized to make and promulgate rules, regulations, and procedures not inconsistent with state law and fiscal procedures as he or she deems necessary for the proper administration of this chapter and to carry out the provisions, policies, and purposes of this chapter.

44-65.1-13. Surcharge allocation. – A person required to pay a surcharge may pass on the cost of that surcharge in the cost of its services, such as the charges for healthcare services to patients (for providers) or its premium rates (for insurers), without being required to specifically allocate those costs to individuals or populations that actually incurred the surcharge.

44-65.1-14. Severability. – If any provision of this chapter or the application of this chapter to any person or circumstances is held invalid, that invalidity shall not affect
provisions or applications of the chapter that can be given effect without the invalid provision or
application, and to this end the provisions of this chapter are declared to be severable.

SECTION 5. This act shall take effect on July 1, 2012.

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- TAXATION OF HEALTHCARE SERVICES

***

This act would replace the current immunization/children health services assessments and

premium taxes imposed on health insurance companies with a health care services surcharge

calculated to generate the same amount of revenue as the assessments and taxes.

This act would take effect on July 1, 2012.