Impact of the Affordable Care Act (ACA) on Immunizations – Opportunities and Challenges

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Disclaimer

The opinions expressed in this presentation are solely those of the presenter and do not necessarily represent the official positions of the Immunization Action Coalition, or the National Adult and Influenza Immunization Summit
Objectives

• The Affordable Care Act (ACA)
  – What is its impact on immunizations
  – What are the most recent updates for the ACA
  – What are the challenges for immunization efforts in the era of the ACA

• Resources from the Immunization Action Coalition (IAC)
Access to Affordable Coverage, Pre-ACA

- Voluntary employer-sponsored
  - Large gaps for lower wage employees and families, young adults just entering the workforce, and small firms
  - Employer subsidies voluntary
  - No assistance for low wage employees with affordability of employee share

- Medicaid and CHIP for certain low income populations
  - No federal coverage mandates or options for low income adults, whether childless or with or without minor children
    - Exceedingly low eligibility standards for parents of minor children (e.g., <50% FPL in many states)
Access to Affordable Coverage, Pre-ACA

- Medicare for elderly and certain disabled populations
- A weak to non-existent individual market
  - Unaffordable, no federal subsidies
  - Near-total lack of access for persons with pre-existing conditions
- Consequences:
  - ~ 50 million without coverage; 1/3 annual turnover
  - Unstable insurance markets with discrimination against persons needing health care, both prior to and following enrollment
LANDMARK DECISION UPHOLDS HEALTH LAW
ROBERTS CASTS SURPRISE SWING VOTE
Foes vow to fight on despite Supreme Court’s ruling

Across Illinois, cheers, jeers and many questions on implementation

By Peter Frost, Monica Garcia and Deborah L. Shelton, Tribune reporters

Obama declares it ‘victory’ for people; Romney, GOP push anew for repeal

By David G. Savage
Tribune Washington Bureau
WASHINGTON —
The Affordable Care Act

Goals of the ACA

• assure near-universal, stable, and affordable coverage by building on the existing system of public and private health insurance

• contain costs through strategic use of spending reductions, tax increases, and long-term changes in the organization and delivery of health care

• increase the role of prevention and its integration into health care and community-wide efforts

• promote cross-payer efficiency and quality
The Affordable Care Act

Note that intent was to improve access, not necessarily to improve payment to providers

• While not the primary motivation in ACA, there are numerous instances where payment is improved

HHS enforces that intent through regulation
So What Does the ACA Mean for Immunizations?
Post ACA - Private Insurance and Group Health Plans

Immediately, ACA mandated provision of ACIP-recommended vaccines at no cost-sharing

- >190 million privately-insured people will have access to ACIP-recommended vaccinations
- Must cover adult children up to age 26 years who have no health insurance (from 2014, it is regardless of the adult child’s existing coverage)
- No pre-existing conditions for children <18 years
Insurers must implement new ACIP recommendations within a year of CDC adoption.

No plan is required to cover vaccinations delivered by an out-of-network provider.

- Plans that do cover out-of-network provider can do so at out-of-network cost-sharing standards.
- Has created some challenges as many immunization providers are considered out-of-network (pharmacists, public health departments).
Post ACA - Self-Insured Group Health Benefit Plans (ERISA plans)

The ACA extended many of its standards to the self-insured ERISA group health plans

• In particular, all ERISA plans are subject to the ACA’s standards on preventive services coverage

• Thus, must cover all ACIP-recommended vaccines at no cost-sharing
Note...

ACA improves access but does not necessarily guarantee adequacy of payment

- Unfunded mandate? Who picks up the co-pay?

Some plans are grandfathered in the ACA...
What are Grandfathered Plans?

- State-regulated private health insurance sold in individual and group health markets, prior to March 23, 2010, are grandfathered into the ACA.
- Routine changes can be implemented:
  - Cost adjustments consistent with medical inflation
  - Addition of new benefits
  - Modest adjustments to existing benefits
  - Voluntarily adopting new patient protections established under ACA
  - Changes to comply with state or federal requirements
What are Grandfathered Plans?

Grandfathered status is lost if:*

- Plans reduce or eliminate existing coverage
- Plans increase deductibles or co-payments by more than rate of medical inflation plus 15%
- Plans require patients to switch to another grandfathered plan with fewer benefits or higher cost-sharing to avoid new patient protections implemented by ACA
- Plans are acquired by or merge with another plan to avoid complying with ACA

* From: [http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html](http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html)
How Many Plans Remain Grandfathered?

• In 2012,
  – 48% of those who get coverage through their jobs are enrolled in a grandfathered health plan*
    • This is down from 56% in 2011
  – 58% of businesses offering health insurance had at least one grandfathered plan
    • This is down from 76% in 2011
• Small plans likely to lose status quicker than large plans
• By 2014, any remaining grandfathered plans will be considered as providing “minimum essential coverage.”

Post ACA - State regulated health insurance

ACA established market standards for state-regulated health insurance (eg, coops, FEHBP) regardless whether through an exchange or in open market

- Essential health benefits, including preventive services, must be covered
- State health insurance exchanges must be established by 2014 for small businesses

All state-regulated, non-grandfathered insurance plans must include ACIP-recommended vaccines at no cost-sharing
Post ACA - Medicaid Expansion

Effective 2014, all non-elderly persons with incomes up to 133% FPL, based on “modified adjusted gross income,” are Medicaid eligible, in states that opt in*

• States offer new eligible enrollees an “alternative benefits package,” which includes immunization services to children and adults at no cost sharing**

• Makes a considerable number of Americans eligible for Medicaid benefits but creates disparity between newly eligible and traditional Medicaid

• Increased coverage for immunizations for newly eligible enrollees


And where is New York State on Medicaid Expansion?

• Although there is no formal announcement yet from the Governor’s office, New York is expected to participate in Medicaid expansion

• Danielle Holahan, project director for New York's health insurance exchange planning, quoted as saying “New York doesn’t have much work to do to meet the Medicaid expansion requirements outlined in the Affordable Care Act.”*

Post ACA – Medicaid Primary Care Payment Bump Up (applicable to all states)

- Medicaid “Bump Up” - payment increase for primary care services to 100% of Medicare payment rates; 100% FMAP for first 2 years*
  - Increases immunization administration fee to Medicare levels for two years: 2013 and 2014
  - Opportunity to show importance of adequate payment on coverage
  - States must submit a State Plan Amendment (SPA).
    - NY SPA approved May 30th, 2013.

*Section 1202 of the Affordable Care Act (ACA)
Medicaid Payment Increase - Update


• Physicians must self-attest to a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a related sub-specialty.
  – The attestation must be supported by either Board Certification or by a claims history that shows that 60% of codes billed in a prior period were for the eligible E&M codes
  – States need not verify each provider, but will have to review a statistically valid sample of physicians who claim the eligibility every year.
Medicaid Payment Increase - Update

• Services provided by non-physician providers under the personal supervision of an eligible physician are eligible for the payment increase.

• Independently practicing non-physicians who are not associated with a physician are NOT eligible.

• Increased payment assumes that a relationship exists in which the physician has professional oversight or responsibility for the services provided under his or her supervision.
Medicaid Payment Increase – Eligible Codes

- Payment increase is for the entire range of E&M codes including those associated with emergency department services and hospital and critical care services, as well as for the vaccine administration codes.

- Local codes are eligible for the payment increase if the state submits a crosswalk of those codes to the specified E&M codes.

- Increase applies to CHIP Medicaid expansions but not to separate (stand alone) CHIP programs.
Post ACA – Medicaid Primary Care Payment Bump Up- New York*

- N.Y. Medicaid apply the increased payment on a claim by claim basis through the normal eMedNY claims processing for dates of service beginning January 1, 2013 or after.
  - Retroactive pay only applies to providers who attested by August 1, 2013; after August 1, 2013, effective date is when attestation is received.

- Self attestation forms are at:

*NY PCRI FAQ. Available at: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/PrimaryCareRateIncrease_FAQs.pdf.
Post ACA – Medicaid Primary Care Payment Bump Up- New York

- Primary care physicians will self attest that they are board certified in one of the specialties, OR that 60% of their paid CPT codes are the eligible codes

- Nurse midwives and NPs who are under the direct supervision of an eligible physician who has self-attested can receive the enhanced payment
  - Direct supervision means that the supervising physician shall accept full professional liability for the services rendered

- Direct questions to: pcri@health.state.ny.us.

- Nice FAQ at:
  https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/PrimaryCareRateIncrease_FAQs.pdf
Increased Vaccine Administration Payments - VFC

• The amount of the increased payment for vaccine administration differs between children and adults.
  – For children under age 19, payment will be the lesser of the Vaccines for Children (VFC) regional maximum administration fee or the Medicare physician fee schedule rate.

• Per VFC policy, there is no payment for code 90461, which is for additional components in a combination vaccine.
Increased Vaccine Administration Payments - VFC

• With the vaccine administration coding change in 2011, states need to determine the 2009 rate as if it is higher, then it should be used.

• If a state can identify what it paid for vaccine administration codes on July 1, 2009, that rate can be used. The formula from the Final Rule need not apply.
Updated Fee Schedule for the VFC Program

• The final rule also updated the maximum administration fees for the VFC program.
  – This updated fee schedule is what states should use when determining the lesser of amount for the increased primary care payment for vaccine administration for children.

• In New York, it has gone from $17.85 to $25.10

• However, no minimum payment level was established and states remain free to determine their state’s regional maximum administration fee.
Increased Vaccine Administration Payments – Adults on Medicaid

• The increased payments for adult vaccine administration will be at the Medicare rate. (The “lesser of” policy only applies to VFC.)
  – Currently in NY, $25.10

• This includes vaccine administration payments for children aged 19 and 20 who receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program benefit but have aged out of the VFC program
1% FMAP (Section 4106 of ACA) - Update

• In the Medicaid program, preventive services for adults are optional services

• ACA provides for a 1 percent increase in state’s FMAP for preventive services if they cover all USPSTF Grade A/B recommended preventive services and all ACIP-recommended vaccines without cost sharing.

• States will also have to submit a state plan amendment in order to receive this benefit
  – NY was approved June 18, 2013

• Overlap between the services that will qualify for this FMAP increase for states and the primary care increase for providers will be allowed.
Post ACA – Medicare, Effective From 2011

• Any preventive service received in outpatient setting in hospital paid for at 100%
  – Improves access to immunizations provided under Part B of Medicare

• GAO study on impact of Medicare Part D payment on access to immunizations
  – Highlighted access problems with adult vaccine covered under Part D
  – Vaccines provided under Part D still have cost sharing.
  – Urges appropriate steps to address administrative challenges (eg, verifying beneficiaries’ coverage)
Post ACA - Federal Funding for Immunization Programs

- States are permitted to purchase adult vaccines with state funds at CDC-negotiated rates
  - Impact unclear on whether exchange plans will benefit; may be considered private/public partnership?
    - Some states have implemented pilots where the state purchases adult vaccines and distributes to the providers

- Demonstration programs to improve immunization coverage through the use of evidence-based and population-based interventions
  - Provides opportunity to implement broad range of innovative initiatives
Post ACA - Federal Funding for Immunization Programs

Section 317 program was reauthorized, but...

- A $100 million increase for the Section 317 program was provided for out of the Prevention and Public Health Fund for 2011
- 2012 had a $29 million cut...
- CDC 2010 professional judgment - $1.7 billion

<table>
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<tr>
<th>Program</th>
<th>FY 13 President’s Budget Request</th>
<th>FY 13 Enacted Pre-Sequester</th>
<th>FY 13 Final Operating Plan</th>
<th>FY 14 President’s Budget Request</th>
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<td>Section 317 Immunization Program, Operations, and Implementation</td>
<td>$562,200,000</td>
<td>$520,340,000</td>
<td>$528,423,000</td>
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Community Health Centers (CHC)

Community Health Center Fund established, $11 billion over 5 years to expand CHC operations

- Number of patients served expected to double to 35 million by 2019
  - Increases access to immunizations for millions of children and adults in medically underserved communities
  - Underinsurance still an issue until full implementation of the ACA
School-based Health Centers

>1,100 centers serving >2 million children

- HRSA has issued RFP: $75 million for an estimated 150 grants in FY 2013*
- Must provide comprehensive primary health services to be eligible
- While immunizations are not specifically included, increased funding provides opportunities to administer vaccines during school hours
- School-based health centers can also become VFC-registered providers

Challenges Remain

For private insurance

• Confusion remains about what is a routine recommendation? What is a permissive recommendation? Must it be covered under the ACA?

• HHS/DOL has addressed this issue.
  – “Routine” is defined broadly to reflect age and risk-based recommendations as well as catch-up
  – For “permissive” recommendations, if the vaccine is prescribed by a health care provider consistent with the ACIP recommendations, a plan or issuer is required to provide coverage.*

Challenges Remain

For private insurance

• Concern remains about coverage for differences between an FDA indication and an ACIP recommendation

• Example – Shingles Vaccine
  – Shingles has FDA indication for ages 50 and above. ACIP recommendation is for ages 60 and above.
  – Provider provides vaccination to 55 year old based on professional opinion
  – Will it be covered?
Challenges Remain

For private insurance: Out-of-Network Providers

• If payment becomes less of an issue, access to vaccinations becomes primary barrier to coverage.

• Providers need to be offering ALL ACIP-recommended vaccines

• Complementary immunizers such as pharmacists, school-based clinics or public health clinics are considered out-of-network providers and thus ACA provisions do not apply
  – Need to improve the number of in-network providers
  – CDC “biilables” project – making public health departments in-network providers.
Challenges Remain

Medicaid Expansion

• Expansion and implementation of the Exchanges will be extremely varied given the variability in states’ participation.

• “Traditional” Medicaid adult enrollees (in states that opt out of expansion) will not be protected by the ACA provisions
  – About 20 million non-elderly persons comprising pregnant women, parents/caretakers of dependent children, low income parents, working age adults with disabilities.
  – Immunization is optional preventive service for adults
  – Need to advocate for immunization inclusion in Medicaid and Exchanges
Challenges Remain

Medicaid Expansion

• Implementation of the Medicaid bump is slow in some states with differing standards for retroactive payment.
• Certain immunizers are left out of the bump up including Ob-Gyns and pharmacists.
• Results need to be measured so that we can advocate for permanent installation of the payment increase.
Challenges Remain

• Public Education about their cost-free vaccinations is necessary.

• Provider Outreach remains critical
  – Who is covered?
  – Complexities of coverage still remain.
  – Educate on the provider immunization incentives as part of ACA

• Health information technology
  – Integrating existing IIS into EHRs and meaningful use.
Challenges Remain

• ~25 million will remain uninsured so public health safety nets are still necessary
• Improved access for the newly insured but…
  – Disproportionately lower income and residents of medically underserved communities
• How do health plans implement new coverage once added?
  – While payment may not be an issue, adequacy of provider payment for vaccines and administration remains?
• Continuing Medicare B/D challenge
Moving Forward…

• Changing nature of community efforts in light of near-universal coverage
  – Community health teams
  – Collaborative Care projects

• Building immunization into pilots and demonstrations
  – No community transformation grants awarded for IZ

• Health plan quality performance measures
Moving Forward…

• Community prevention and public health organization, financing, and operations with near-universal coverage will evolve
  – Third-party billing – CDC “billables” project
• Opportunity!! Adult immunizations!
  – Primarily private sector enterprise
  – Integrating adult IZ into prevention efforts
  – Making adult IZ standard of care requires development of preventive care infrastructure to deliver the vaccines
  – An Adult Annual Wellness Visit?
Adult Vaccination Opportunities

• Affordable Care Act should increase the number of insured adults eligible for vaccines at not cost sharing

• If private insurance pays for vaccine for insured children, then freed up 317 funds might be used to purchase vaccine for uninsured adults

• 317 Program
  – Requirement to address lagging coverage among children AND adults
  – AIM more involved in adult vaccination issues
Adult Vaccination Opportunities

• Increasing coverage data on adults through BRFSS to raise awareness
  – Influenza, pneumococcal, Tdap and zoster coverage by state

• Medicare and Medicaid include coverage of vaccines for adults
  – But copayments can be a significant cost for vaccines covered by Medicare Part D covered vaccines such as Tdap and Zoster vaccines

• 80% of adults with insurance coverage
Adult Vaccination Opportunities

- Increased access to vaccines at workplaces and retail locations like pharmacies and grocery stores
- Increasing interest in adult immunizations from private and public sectors
  - NVAC 2011 recommendations on adult immunizations
  - Revised 2013 NVAC Standards for Adult IZ Practice to be voted on at September 2013 meeting
  - Increased development of quality measures for adult immunizations
  - Increased attention by professional medical associations (ACP, ACOG, etc)
Thank You!
• Extra Slides
Individual Coverage Required, or Pay a Fee – Eff. Jan 2014

- Fee is greater of $695 per person ($2085/family) or 2.5% of household income
  - Some exceptions, eg for financial hardships, religious objections, persons for whom the lowest cost health plan exceeds 8% of income
- Advance refundable tax credits and cost sharing assistance available up to 400% of federal poverty level (FPL).
- Medicaid eligibility for childless adults up to 138% FPL
Employers not mandated to provide coverage but...

- **$2000/per employee assessment**
  - Employers with 50 or more employees that do not offer coverage; and
  - Have at least one employee who receives a premium credit through a state exchange

- Similar assessment on employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through a state exchange
Employers not mandated to provide coverage but…

- Employers offering coverage must offer choice of Exchange enrollment with subsidy to employees with incomes below 400% FPL, whose share of premium is > 8% of income
- Large employers (>200 FT employees) offering coverage must automatically enroll employees into the employer’s lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.
Refresher: How vaccines are paid in the United States
Vaccine Financing in the United States

Vaccines For Children (VFC, ~43% of children)

- Entitlement for children up to age 19 served by:
  - Medicaid
  - Without health insurance
  - American Indians and Alaska Natives

- Underinsured children can receive VFC vaccines at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs)
Vaccine Financing in the United States

Section 317 (~7% of children)

- Used by states to cover non-VFC eligible children and adolescents (some states also use state funds)
- Also has objective to improve adult IZ
  - Stagnant funding – 317 Coalition working to improve funding levels
  - CDC’s professional judgment - $1.72 billion.
    - Presidential 2013 budget request - $562,200,000
    - 2012 appropriation - $620,200,000
Vaccine Financing in the United States

• Medicare
  – Covers vaccines for those 65 years and older
  – Influenza, Pneumococcal and Hepatitis B – Part B (by legislation)
  – All other vaccines – Part D (eg, shingles)

• Medicaid
  – Only public sector payer that provides for administration fee
  – Admin fee set by states with huge state-to-state variance; states have to contribute enough funds to draw the maximum federal matching contribution allowable
  – No state is close to the caps are set by CMS in 1994 for admin fees
Vaccine Financing in the United States

Private Sector (~47% of children)

- Price of vaccine negotiated with distributors/manufacturers
- Payment negotiated with payers
- Providers responsible for administering vaccine then seeking payment (compare with pharmaceuticals where patient fills prescription)