The Affordable Care Act (ACA) and Immunizations – Opportunities and Challenges

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Disclosures

I have financial relationships with Baxter, GSK Vaccines, Pfizer, and Sanofi Pasteur, as a expert consultant.

I do NOT intend to discuss an unapproved or investigative use of a commercial product/device in my presentation.
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)
  – BRIEF summary of ACA impact on immunizations
  – Updates for the ACA, FAQs
  – What are the challenges for immunization efforts in the era of the ACA

• Resources from the Immunization Action Coalition (IAC)
The Affordable Care Act

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

• 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?
Private Insurance and Group Health Plans

• ACA mandates provision of ACIP-recommended vaccines at no cost-sharing
  – Must cover adult children up to age 26 years
  – No pre-existing conditions for children <18 years

• 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
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
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.
Loss of grandfathered status

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.
## Change in Number of Grandfathered Plans**

<table>
<thead>
<tr>
<th>Percentage of Covered Workers in a Grandfathered Health Plan</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>All Small Firms (3-199 Workers)</td>
<td>63%</td>
<td>54%*</td>
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<td>All Large Firms (200 or More Workers)</td>
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<td>ALL FIRMS</td>
<td>56%</td>
<td>48%*</td>
<td>36%*</td>
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<tr>
<th>Percentage of Firms with At Least One Grandfathered Plan</th>
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<tr>
<td>All Small Firms (3-199 Workers)</td>
<td>72%</td>
<td>58%*</td>
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<td>All Large Firms (200 or More Workers)</td>
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<tr>
<td>ALL FIRMS</td>
<td>72%</td>
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<td>54%</td>
<td>37%*</td>
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*p<.05; statistically different from previous year

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
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**

• States decide whether existing Medicaid enrollees are to be covered for the alternative benefits package

• Creates disparity between newly eligible and already enrolled persons in expanded states, and between expanded states and states with traditional Medicaid


**CMS Final regulation, July 5 2013. Available at: http://www.ofr.gov/%28X%29%281%29S%281vpecb3pcilomwwyusd4jf2b%29%29/OFRUpload/OFRData/2013-16271_PI.pdf
Where states are on expanded Medicaid – August 28, 2014

Notes: Based on literature review as of 8/28/2014. All policies subject to change without notice.
HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.
### Medicaid & ACA: Standardizing Immunization Coverage*

**States Implementing/Reviewing Expansion (n=32)**

9 states did not respond to GW survey: IL, KS, NH, NC, OH, PA, RI, WV, WI = Standardizing IZ Coverage Unknown

<table>
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<tr>
<th>WILL STANDARDIZE COVERAGE (n=1)</th>
<th>WILL NOT STANDARDIZE COVERAGE (n=20)</th>
<th>NO DECISION TO STANDARDIZE COVERAGE (n=5)</th>
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<td>Arkansas</td>
<td>18 states = ACIP Coverage in 2012</td>
<td>2 states = ACIP Coverage in 2012</td>
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<td>2 STATES= DO NOT COVER TO ACIP in 2012</td>
<td>3 STATES = DO NOT COVER TO ACIP in 2012</td>
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<td>California</td>
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*Arkansas*

In 2012, did not cover:
- Varicella
- HPV
- Zoster

*Source: Milken Institute/SPH Medicaid Benefit Design and Cost-sharing Policy 2013 – Presented by Alexandra Stewart at 2014 NAIIS Meeting, Atlanta, GA*
1% FMAP (Section 4106 of ACA) - Update

• To incentivize states to cover preventive 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.

• CMS has provided guidance on this provision
  - States will have to submit a state plan amendment in order to receive this benefit
  - 11 states have approved 4106 SPAs
  - There is no deadline for states to submit SPAs and no end date for the 1 percent increase
Medicaid Primary Care Payment Increase

• 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
  – Intent was to encourage physician participation as Medicaid expanded.
  – Opportunity to show importance of adequate payment on coverage

*Section 1202 of the Affordable Care Act (ACA)
The “Bump Up” also updated the 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.

• Nationally, this raised the payment to about $25...

• However, no minimum payment level was established and states remain free to determine their state’s regional maximum administration fee after 2014.
Medicaid Primary Care Payment Increase

- Reauthorizing language is in Section 304 of Pallone & Waxman *Children’s Health Insurance Program Extension and Improvement Act of 2014* senate bill:
  - Extends payment increase to 2019.
  - Expands eligible providers to non-physician providers including physician assistants and nurse practitioners as well as obstetricians/gynecologists, neurologists and psychiatrists providing services.
  - However, no appropriations language currently available.
  - In President’s FY 2015 budget but likely a continuing resolution will fund government into 2015 so authorizing language will expire.
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 may use state funds to purchase adult vaccines under CDC contracts

- 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. Continued into 2014 budgets...
  - CDC 2013 professional judgment - $>900 million

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 13 Final Operating Plan Budget Request</th>
<th>FY 14 Final Budget Request</th>
<th>FY 15 President’s Request</th>
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<td>Section 317 Immunization Program, Operations, and Implementation</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

Other considerations

For private insurance

- ACIP recommendations that apply for certain individuals rather than an entire population are covered
  - If the vaccine is prescribed by a health care provider consistent with the ACIP recommendations, a plan or issuer is required to provide coverage.*

Other Considerations

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? Not likely

- Travel vaccines are not covered unless indicated in the footnotes of the ACIP schedules...
Other Considerations

For private insurance

• Network Adequacy/Out of Network Providers
  – If payment becomes less of an issue, access to vaccinations becomes primary barrier to coverage.
  – Increase access points for getting vaccinated
    • All providers of care for adults have a responsibility to assess, counsel, recommend, and if feasible, deliver the vaccine
    • Need to improve the number of in-network providers
  – 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
  – CDC “billables” project – contracting to make public health departments in-network providers.
Other Considerations

Medicaid Expansion

• Expansion and implementation of the Exchanges will be extremely varied given the variability in states’ participation.
  – Differences will exist even in “expanded” states between newly enrolled and those enrolled before 2014

• “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

• Public Education about “cost-free” vaccinations is necessary.

• Provider Outreach remains critical
  – They may not know who is covered
  – Complexities of coverage still remain
  – Need to maintain and enhance the provider immunization incentives…

• Health information technology
  – Integrating existing IIS into EHRs and meaningful use becomes critical with more providers
Where the uninsured populations are – by state, post-ACA

Notes: Based on literature review as of 6/34/13. All results possible to change without notice. Results are estimates based on literature review, census data, and Advisory Board research.

Challenges Remain

• ~30 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 will health plans implement new coverage still fuzzy…
  – 2014 was relatively quiet; bigger changes in 2015 as the employer shared-responsibility provision in the ACA takes effect for large employers
  – While payment may not be an issue, adequacy of provider payment for vaccines and administration remains?

• Continuing Medicare B/D challenge
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 for all adults?
ACA Web Resources

• AAP

• AAPA
ACA Web Resources

• ACP
  http://www.acponline.org/advocacy/where_we_stand/affordable_care_act/.

• ACOG
  http://www.acog.org/About_ACOG/ACOG_Departments/Government_Relations_and_Outreach/HCRIImplementation.

• AAFP
  http://www.aafp.org/advocacy/act/aca.html
ACA Web Resources

• CMS

• Office of Health Care Reform

• Medscape
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