

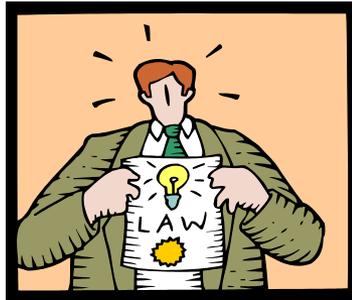
Immunizations in the Affordable Care Act: An Opportunity to Increase Access

Phyllis Arthur

**Sr. Director, Vaccines, Immunotherapeutics and Diagnostics
Policy**

Health Care Reform

- In March of 2010 the U.S Congress passed the consolidated Affordable Care Act (ACA)



- Patient Protection and Affordable Care Act (PL 11-148)
- Health Care and Education Reconciliation Act of 2010 (PL 111-152)

Overall Health System Provisions

- Overall emphasis on prevention, wellness and coordination of care throughout the Act
- Creation of the State health insurance exchanges
- Creation and funding of the Prevention and Public Health Fund (PPHF) which includes funds for immunization infrastructure
- Grant programs for construction and operation of community health centers and school-based health centers
- Encourages continued investment in health information systems such as electronic health and medical records and immunization registries



Overall Health System Potential Impact

- State exchanges could help create attractive insurance pools in some markets and make health insurance available to smaller businesses OR exchanges could drive some businesses and plans out of the health care market in some markets
- State Medicaid plans may develop special exchange plans that serve beneficiaries between Medicaid and private health insurance
- The PPHF has funded a key vaccine initiative within the CDC – The Billing project – which may help state and local health departments learn to bill private insurance for the vaccines they administer to insured patients in the public health clinics
- Community and school-based clinics may offer an increased access opportunity for vaccination of adolescents

Private Sector Health Plans Provisions

- Cover a specific basket of preventive health services at first dollar (no co-pay) including all ACIP-recommended vaccines across all ages
 - All services with either an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF)
 - All immunizations with an ACIP recommendation within a year of CDC adoption
 - Preventive care and screening guidelines for infants, children and adolescents from the Health Resources and Services Administration (HRSA)
 - Additional preventive care and screening guidelines for women from HRSA
- Extend dependent coverage up to age 26
 - First two provisions are impacted by the transition of health plans from grandfathered status
- HHS must submit quality reporting requirements for use by health plans – March 2012
- Development of the Essential Benefits Package (EBP) for exchange plans



Private Sector Health Plans

Potential Impact

- First dollar coverage may expand access for many insured individuals, especially for adolescent and adult vaccines
 - As health plans lose their grandfathered status, the number of “underinsured” children should decrease
 - It is currently unclear how long it will take for plans to “lose” their grandfather status. One survey of health plans reported that over 60% of plans expected to lose their status by the end of 2012*
 - The long-term impact this may have on VFC doses and the need or uses for Section 317 Funds is not yet well understood
- Extending dependent coverage up to age 26 may help with access to certain vaccines for young adults
- New quality reporting requirements for health plans may be an opportunity to standardize adult immunization quality measures similar to those for children and adolescents

Medicaid Provisions

- Program eligibility will be expanded to childless adults at or below 133% of FPL
 - Expect up to 16 million new enrollees by 2014
- States required to benchmark coverage to newly eligible enrollees, including immunization services to children and adults
- CMS and AHRQ must promulgate a set of quality measures related to health care for adults (Medicaid Quality Measurement Program)
 - In January 2011, CMS / AHRQ published a draft set of 35 adult quality measures that included only one vaccine measure – influenza in 5-64 year olds
- Opportunity for a 1% increase in FMAP to Medicaid programs that offer specific basket of preventive services (including vaccines) to enrollees at first dollar
- Reimbursement for Medicaid primary care physicians (specifically Peds, FPs and IMs) will be raised to Medicare rates for two years (2013-2014) using federal funds to the States

Medicaid Provisions

Potential Impact

- Medicaid enrollee expansion could potentially increase access to adult vaccines for up to 16 million adults
- As States begin to report on the CMS and AHRQ adult quality measures, there is the opportunity to expand the number of measures related to adult immunizations
- The 1% FMAP to Medicaid programs that offer specific basket of preventive services (including vaccines) to enrollees at first dollar may be very economically beneficial to States but that is currently unclear
- Medicaid primary care physicians (specifically Peds, FPs and IMs) may immunize more of their patients, however it is vital that HHS demonstrate the impact this increase in payment has on rates in order to secure future funding

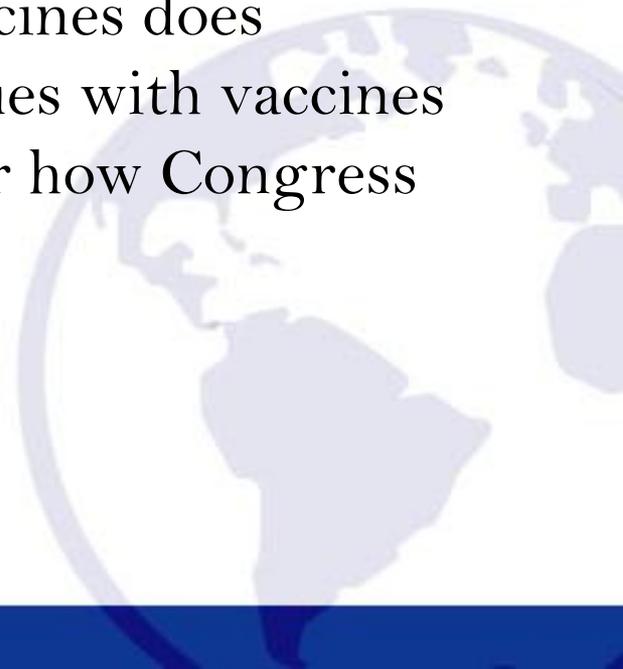
Medicare Provisions

- Implementation of the Personalized Prevention Plan (PPP) for all new and existing beneficiaries
 - Starting in January 2011 Medicare providers must complete a PPP for all beneficiaries that outlines all of the preventive services appropriate for that individual. The provider can then implement the service or refer the patient.
 - All cost-sharing eliminated for services under PPP
- GAO study of the impact of Medicare Part D coverage of immunizations on access and utilization of vaccines by beneficiaries
 - Study was published in December 2011 and discusses multiple reasons why immunization rates for Part D vaccines may be lower than those in Part B

Medicare Provisions

Potential Impact

- The Personalized Prevention Plan for all new and existing beneficiaries offers up a strong potential model for how providers can routinely discuss vaccines as part of an overall discussion of preventive services
- The GAO study on the impact of Medicare Part D coverage on access and utilization of vaccines does highlight some of the administrative issues with vaccines in provider offices. It is currently unclear how Congress will use this information.



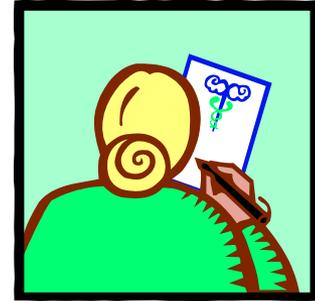
Implementation by the States

- As of March 2012:
 - **13** states and Washington DC are in the implementation process for Exchanges
 - **3** have indicated intent to establish an Exchange
 - **20** are studying options for Exchange programs
 - **12** have done nothing
 - **2** have indicated their intent to not establish



Individual Mandate

- Effective January 2014, most Americans required to have coverage or pay a fee
 - Fee is greater of \$695 per person (\$2085/family) or 2.5% of household income
 - Some exceptions, e.g. 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).
- Employers not mandated to provide coverage but there are penalties for not doing so



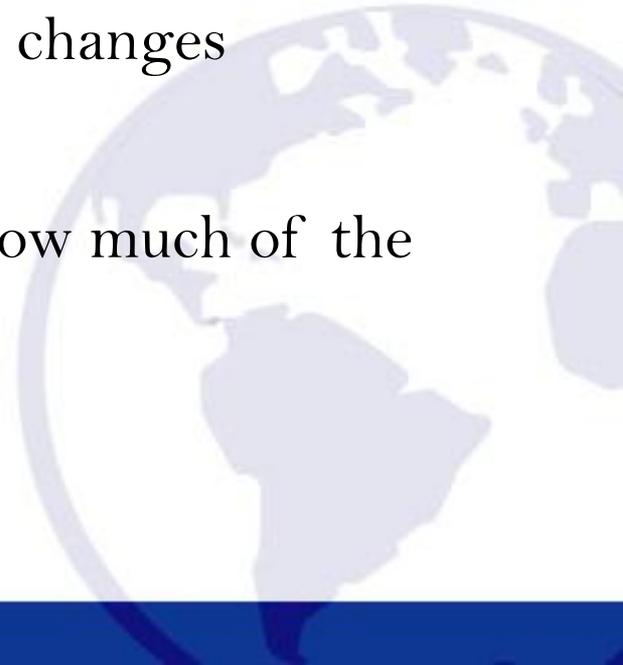
Supreme Court Case

- Challenges to the ACA Law
 - December 13, 2010 – US District Court in Virginia ruled that the individual coverage mandate provision of the ACA was unconstitutional.
 - Over the course of 2011 several Appellate Courts rule on the ACA's constitutionality – results are split.
 - The case was filed by 26 States (led by Florida) and the Tennessee-based National Federation of Independent Businesses.
 - SCOTUS heard arguments the week of March 26th and a decision is expected in June.



Supreme Court Case – Key Issues

- Three important issues comprise the case:
 - Constitutionality of the “individual mandate”
 - *Healthcare* market vs *Health insurance* market
 - Whether or not Medicaid expansion is coercion
 - Federal funds conditional upon state changes
 - Severability
 - If the mandate is unconstitutional how much of the ACA can remain?

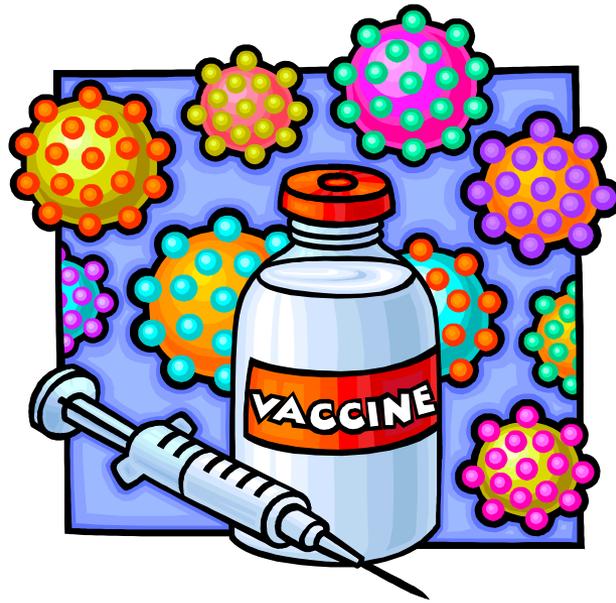


Public health advocates can play a key role in how ACA gets implemented

- Follow the implementation of the law
- Be a strong voice for the importance of prevention in general and vaccines in particular and advocate to include immunizations in all plans at the State and local level
- If possible, work with your health departments to evaluate the potential value of the 1% FMAP for your State
- Help HHS gather data on the impact of the reimbursement “bump” for Medicaid providers on immunization rates
- Encourage your State to report on the influenza quality measure in the Medicaid Quality Measurement Program



Questions?



Background



Grandfathered status

- State-regulated private health insurance sold in individual and group health markets 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
- 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
- In 2011, 50% of plans had grandfathered status
 - Half more expected to lose that status by 2012
 - Small plans likely to lose status quicker than large plans



Medicare D to B and vaccines

- Historically influenza, pneumococcal and hepatitis B vaccines have been covered under Part B
- Medicare Modernization Act (MMA) of 2003 included new vaccines in definition of covered drugs under Part D
- This creates access problems for beneficiaries for:
 - Herpes zoster, Tdap and all new vaccines

Vaccine access issues in Part D

- While almost all beneficiaries have access to Part B, only 27 million have Part D plans; some may have private coverage and others no coverage
- Fragmentation of access makes it difficult for providers to know which patients are covered for vaccines
- Because of the need to pay out of pocket for some vaccines, there is a disproportionate impact on low-income beneficiaries
- Variations in State laws mean that pharmacies and other immunization sites may be considered out-of-network