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
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
Post ACA - Private Insurance and Group Health Plans

• 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.
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
The 2014 Health Insurance Marketplace (Exchanges)

- The Health Insurance Marketplace provides a new and easier way to find affordable health insurance.
- Many people will get a break on costs at the Marketplace. New tax credits can reduce insurance premiums right away.
- Every health plan will offer comprehensive coverage, from doctors to medications to hospital visits, and free preventive care.
- Through the same streamlined application process, many will find out if they are eligible for Medicaid or CHIP.
Get your options & info

Answer a few quick questions and you'll get:
- A list of coverage options you may qualify for (specific plans and prices available Oct. 1)
- Answers that will help you make good decisions
- A personalized checklist to help you get ready to apply

Which best describes you?
- I'm looking for coverage for myself or my family
- I'm looking for coverage for a small business I own or operate

Why are we asking these questions?
The 2014 Health Insurance Marketplace (Exchanges)

Get your options & info

What's your gender?
- Male
- Female

What state do you live in?
- California

How old are you?
- Under 30
- 30-64
- 65+

Why are we asking these questions?
The 2014 Health Insurance Marketplace (Exchanges)

Your Results

Type
I'm looking for coverage for myself or my family

State
California

Age
30-64

Gender
Male

Insured
I'm eligible for insurance through my employer or a family member's employer

Health Condition
Yes

Additional Info.
Dependent under 18

Options You Might Be Eligible For

Lower Costs on Marketplace Coverage
Based on the information you provided, you may be able to get lower costs for your monthly premiums and out-of-pocket costs when you get insurance through the Marketplace. Whether you qualify will depend on your household size and income. Plans and prices will be available October 1, 2013. You will learn your exact costs and savings when you apply.

Learn more about lower costs on Marketplace insurance

Medicaid
Based on the information you provided, you could be eligible for free or low-cost health coverage through Medicaid, which provides coverage to millions of Americans with limited incomes or disabilities. New rules in many states mean you may qualify in 2014 even if you haven't qualified before. Your eligibility will depend on your household income and family size.

Learn more about Medicaid and how you may be able to enroll right now

The Children's Health Insurance Program (CHIP)
Based on the information you provided, your children may qualify for coverage through the Children's Health Insurance Program (CHIP). Your eligibility will depend on your household size and income. CHIP provides coverage for families with incomes too high to qualify for Medicaid, but who may not be able to afford private insurance.

Learn more about CHIP and how you may be able to enroll right now

Top Information for You

What are my preventive care benefits?
Enrolling in the 2014 Health Insurance Marketplace (Exchanges)

- Open October 1, 2013 to March 31, 2014.
- Coverage starts as early as January 1, 2014.
- Open October 15 to December 7 each year beginning in 2014
- Special Enrollment Periods available in certain circumstances during the year (childbirth, employment changes, etc.)
- Medicaid and CHIP enrollment open year-round
The Exchanges - Stay tuned!

• For more information, go to: HealthCare.gov; CuidadoDeSalud.gov
• Sign up to get updates at healthcare.gov/subscribe, twitter.com/HealthCareGov, and facebook.com/Healthcare.gov
• 24/7 Call Center: 1-800-318-2596 (1-855-889-4325 TTY/TDD)
• Partner resources available at marketplace.cms.gov
• Starting October 1, 2013, visit HealthCare.gov to:
  – Learn about available health coverage choices
  – Find community-based Navigators that will provide unbiased advice about coverage choices
  – Sign up for coverage online or on the phone
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 California on Medicaid Expansion?

• On June 27, 2013, Governor Jerry Brown signed legislation expanding Medi-Cal under the ACA to more than 1.4 million previously uninsured Californians*

• CA legislation includes provision to re evaluate participation should federal payment drop below 70%
  – ACA currently dictates that the federal share will be at 100% through 206, and decline to 90% by the year 2020

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).
    - CA SPA submitted by March 31, 2013 but is the only state plan that CMS has not yet sanctioned for technical reasons.

*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- California*

• Once the CA SPA is sanctioned, CA Medi-Cal will apply the increased payment retroactive to dates of service beginning January 1, 2013, with 2 exceptions
  – If the provider is eligible based on board certification, the attestation is only retroactive to the begin date of the board certification if that is after January 1, 2013.
  – If the provider is newly enrolled in the Medi-Cal program, the attestation would only be retroactive to the date of enrollment.

• Self attestation forms and instructions are at: http://files.medi-cal.ca.gov/pubsdoco/aca/aca_attestation_form_instructions.pdf.

*ACA Increased Medicaid Payment for Primary Care Physicians. Available at: http://files.medi-cal.ca.gov/pubsdoco/aca/aca_form_landing.asp.
Post ACA – Medicaid Primary Care Payment Bump Up - California

• 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 can receive the enhanced payment via enrollment, using same self-attestation form
  – Direct supervision means that the supervising physician shall accept full professional liability for the services rendered

• Managed care plans are required to begin making the enhanced payments to eligible physicians upon receipt of the associated capitation payments
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.
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 California, the maximum has gone from $17.55 to $26.03
  – In reality, this is an increase from $9.00 in 2012 to $26.03*

• However, no minimum payment level was established and states remain free to determine their state’s regional maximum administration fee.

Available at: http://cairweb.org/billing/
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 CA, $27.52

• 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

• 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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<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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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

*See: http://www.hrsa.gov/grants/apply/assistance/sbhcc/. immunize.org
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?

• Travel vaccines are likely to not 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 for all adults?
Visit IAC Resources!

• Read our publications!
  – http://www.immunize.org/publications/

• Visit our websites!
  – www.immunize.org
  – www.vaccineinformation.org
  – www.izcoalitions.org
  – www.preventinfluenza.org

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Thank You!