

# Medicare coverage for vaccines

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# Overview

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- Background
- Medicare's coverage of and spending for vaccines
- Vaccination rates of Medicare beneficiaries
- Review Commission's 2007 recommendation
- Consider three vaccine coverage options

# Why government plays a large role in vaccination

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- Vaccines are among the medical interventions with largest social returns
  - Preserve health and economic activity
  - Avoid medical costs and stress on health care delivery system
- Individuals at risk of contracting contagious disease have a stake in seeing that others are vaccinated
- Encourage manufacturer R&D and production of vaccines
- ➔ Government role through vaccination mandates (e.g., state requirements for routine childhood vaccinations), direct purchases and stockpiles, liability protection, R&D investment

# SARS-CoV-2 vaccine development

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- ~\$10 billion for vaccines and treatments in Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020
- Operation Warp Speed (OWS) goal of delivering up to 300 million doses of a safe and effective vaccine by early 2021
- OWS supporting several vaccine candidates, three of which are now in phase-3 clinical trials
- Federal funding for R&D and vaccine purchases before clinical trials completed to speed up large-scale manufacturing
- Some vaccine candidates may get emergency use authorization

# Medicare's coverage of vaccines spans Part B and Part D

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- Part B covers:
  - Seasonal influenza
  - Pneumococcal disease
  - Hepatitis B for patients at high or intermediate risk
  - CARES Act requires coverage of SARS-CoV-2 vaccines under Part B with no beneficiary cost sharing
- Part D covers all commercially available vaccines not covered by Part B such as for shingles or hepatitis A

# In 2018, Medicare spent about \$2 billion on vaccines across Part B and Part D

	Spending		Number of doses	
	\$ (millions)	Percent	(millions)	Percent
<b>Part B vaccines<sup>1</sup></b>				
Influenza	\$706	51%	17.3	79%
Pneumococcal pneumonia	627	46	4.3	19
Hepatitis B	<u>38</u>	<u>3</u>	<u>0.4</u>	<u>2</u>
<b>Total</b>	<b>1,371</b>	<b>100</b>	<b>20.9</b>	<b>100</b>
<b>Part D vaccines<sup>2</sup></b>				
Herpes zoster	\$450	89%	3.1	76%
Tetanus / Diphtheria	30	6	0.7	17
Hepatitis A / B	17	3	0.2	6
Other	<u>8</u>	<u>2</u>	<u>0.1</u>	<u>2</u>
<b>Total</b>	<b>505</b>	<b>100</b>	<b>4.0</b>	<b>100</b>

# Vaccine coverage and payments under Part B vs. Part D

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## Part B

- Generally no cost sharing
- Payment based on 95% AWP
- Administered in a wide variety of settings
  - Mass immunizers, e.g., pharmacies
  - Physician offices
  - Hospitals
  - Skilled nursing facilities and other settings

## Part D

- Cost-sharing amounts vary by plan and benefit phase
- Payment based on plan bids
  - Plans negotiate payment with pharmacies
  - Plans may negotiate rebates with manufacturers
- Most are administered in pharmacies

# Some goals for vaccination rates among Medicare beneficiaries have not been reached

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- Seasonal influenza
  - Goal: 90% of adults age 65 and older
  - 68% vaccinated in 2018-2019, similar to 67% in 2010-2011<sup>1</sup>
- Pneumococcal
  - Goal: 90% of adults age 65 and older
  - 59% vaccinated by 2017, up from 40% in 2010<sup>2</sup>
- Shingles
  - Goal: 30% of adults age 60 and older
  - About one-third vaccinated by 2018, up from 7% in 2008<sup>3,4</sup>

Note: <sup>1</sup>CDC 2019 (<https://www.cdc.gov/flu/fluview/coverage-1819estimates.htm>), <sup>2</sup>Black et al. 2018 (<https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/pcv13-medicare-beneficiaries.html>), <sup>3</sup>Terlizzi and Black 2020

(<https://www.cdc.gov/nchs/data/databriefs/db370-h.pdf>), <sup>4</sup>MedPAC analysis of Part D prescription drug event data for a cohort of beneficiaries age 60 or older who newly enrolled in Part D in 2010 or existing enrollees who turned 60 in 2010

# Racial and ethnic disparity in vaccine use among Medicare beneficiaries

Vaccination rate by race/ethnicity			
	FFS Part B		Part D
	Influenza <sup>1</sup>  2017-'18 flu season	Pneumo- coccal <sup>2</sup>  (ever vaccinated by 9/2017)	Shingles <sup>3</sup>  (ever vaccinated by 12/2018)
White	53%	61%	34%
Black	34	45	18
Hispanic	35	42	23

- Racial/ethnic disparity in both Part B and Part D
- Lower vaccine use among Blacks and Hispanics even with limited or \$0 cost sharing
  - No cost sharing under Part B
  - Nominal copays for Part D's low-income subsidy enrollees
  - Plans with low or \$0 copay for vaccines

Note: FFS (Fee-for-service) Data are preliminary and subject to change. <sup>1</sup>MedPAC and Acumen, LLC, analysis of Medicare claims data for beneficiaries of all ages. <sup>2</sup>Black et. al 2018 analysis of Medicare claims data for those age 65 or older (<https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/pcv13-medicare-beneficiaries.html>). <sup>3</sup>MedPAC analysis of Part D prescription drug event data for a cohort of beneficiaries age 60 or older who newly enrolled in Part D in 2010 or existing enrollees who turned 60 in 2010.

# In 2007, the Commission recommended coverage of vaccines under Part B instead of Part D

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- At the time:
  - No clear way for physicians to bill Part D plans
  - Patients would pay for vaccine upfront and then seek reimbursement from plans, hurdle to seeking appropriate preventive care
- Today:
  - Some of the original rationales for the recommendation no longer apply
  - Nevertheless there may still be reasons to support moving all vaccine coverage to Part B

# Option 1: Cover all vaccines in Part B only, no cost sharing

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- Advantages:
  - More Part B beneficiaries than enrollees in Part D
  - No cost sharing for vaccines for contagious diseases
  - Wide variety of settings available for administering vaccines
  - Less confusing to beneficiaries and providers
- Disadvantages:
  - AWP-based payment places little or no constraints on pricing
  - Limited tools to encourage use of lower cost vaccines with similar health outcomes when available

## Option 2: Cover new vaccines for highly contagious diseases in Part B with no cost sharing, all others in Part D

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- **Advantages:**
  - Widest coverage for vaccines with largest social benefits
  - Part D plans would cover all others
    - Could negotiate with manufacturers over price for formulary placement
    - Potentially larger rebates if there are competing vaccine products
- **Disadvantages:**
  - Few pricing constraints on new vaccines placed in Part B
  - Continued variation in cost sharing for vaccines in Part D, which may deter some use
  - Unclear how well Part D plans could or would constrain prices

## Option 3: Keep current approach to vaccine coverage but eliminate vaccine cost sharing in Part D

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- Advantages:
  - For Part D enrollees, would broaden access to Part D vaccines
  - Manufacturers of new vaccines would expect that they would have to negotiate with Part D plans
- Disadvantages:
  - Eliminating cost sharing may not increase vaccine use much
  - Some beneficiaries in Part B but not in Part D would not have access to new vaccines
  - Would reduce bargaining leverage of Part D plans in their negotiations with manufacturers

# Next steps

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- Clarifications and questions
- Provide guidance with respect to a potential recommendation in the spring
- Materials will be included as a chapter in June 2021 report to the Congress

# Summary of options

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- Option 1: Reiterate 2007 recommendation to cover all vaccines in Part B only, no cost sharing
- Option 2: Cover new vaccines for highly contagious diseases in Part B with no cost sharing, all others in Part D
- Option 3: Keep the current approach to vaccine coverage but eliminate vaccine cost sharing under Part D