

Vaccine Coverage Under Medicare Part B May Improve Preventive Care

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Recently, 23 medical organizations sent a letter to the Secretary of the United States Department of Health and Human Services (HHS), Kathleen Sebelius, requesting she “take steps to help ensure that Medicare beneficiaries have meaningful access to all recommended adult vaccines.”¹ The request is based on the authority granted by Section 101 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to include all recommended preventive vaccines within the “additional preventive services” eligible for coverage under Medicare Part B.² The organizations also noted that “Medicare beneficiaries have ready access to the influenza, pneumococcal and hepatitis B vaccines under Medicare Part B,... but unfortunately, the record is significantly less successful for vaccines covered under the Part D Prescription Drug Benefit.”³ Among the vaccines prescribed for preventive purposes and covered under Medicare Part D are hepatitis A vaccine, herpes-zoster vaccine, human papilloma virus vaccine, meningococcal vaccine, anthrax vaccine, rabies vaccine, and tetanus-diphtheria toxoids-acellular pertussis vaccine. Medicare does cover other vaccines under Part B on a therapeutic basis (e.g., tetanus toxoid if a beneficiary steps on a rusty nail). Vaccines are among the most effective public health measures for prevention of disease and disability, and therefore should be available to Medicare beneficiaries.

Vaccine Safety and Availability

The principal concerns for advocates of vaccinations for Medicare beneficiaries is not only ensuring that they readily have access to them but also that they are safe and effective. In a letter sent to Congressman Henry A. Waxman in support for H.R. 4992, the Medicare Improvement Act of 2007, these concerns were expressed as follows:

[W]hile this was an important advance, vaccines are primarily administered in the physician office setting rather than taken orally or otherwise self-administered by the beneficiary like most prescription drugs covered under Part D. Often times, this makes it necessary for the Part D pharmacies or the beneficiaries to transport the vaccines, many of which must be temperature controlled, to the appropriate health professional for administration. Such practices raise important integrity and quality concerns for physicians that administer Part D-covered vaccines.⁴

¹ Infectious Diseases Society of America, *IDSAs Reaffirms Its Support of a Part D to B Shift for all Medicare-Covered Vaccines*, June 25, 2009, available at <http://www.idsociety.org/Content.aspx?id=4176>.

² Pub. L. No. 110-275, 110th Cong. (2008).

³ Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries. Part D plans are offered through private companies that have agreements with Medicare.

⁴ Infectious Diseases Society of America, *IDSAs Joins Other Medical Societies in Support of H.R. 4992*, Feb. 8, 2008, available at <http://www.idsociety.org/list.aspx?tid=160>.

Vaccine safety is measured by the number of adverse events reported.⁵ An adverse event is a medical incident that takes place after an individual receives a vaccine and is believed to be caused by the immunization. Adverse events include true reactions to the vaccine, events that would have occurred even if the person had not been vaccinated (unrelated coincidences), reactions related to mistakes in vaccine preparation, handling, or administration, and events that cannot be related directly to the vaccine (i.e., their cause is unknown).⁶ Adequate vaccine safety and administration helps to maintain the public's confidence needed to keep enough people vaccinated to prevent disease outbreaks. But, how are decisions about vaccination recommendations made?

The Advisory Committee on Immunization Practices

The Advisory Committee on Immunization Practices (ACIP) consists of 15 experts in fields associated with immunization who have been selected by the Secretary of HHS to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control (CDC) on the control of vaccine-preventable diseases.

The Committee develops written recommendations for the routine administration of vaccines to children and adults in the civilian population. Recommendations include age for vaccine administration, number of doses, dosing intervals, and precautions and contraindications. To formulate policy recommendations, the ACIP reviews many factors, including morbidity and mortality associated with a specific preventable disease in the U.S. population and in specific risk groups.

The ACIP is the only entity in the federal government that makes such recommendations, although some recommendations may be developed and issued jointly with nongovernmental professional organizations or other public health service advisory committees. The ACIP annually reviews the recommended Adult Immunization Schedule to ensure that the schedule reflects current recommendations for the licensed vaccines. In October 2008, ACIP approved the Adult Immunization Schedule for 2009.⁷

Medicare Background

Prior to 2003, Medicare only covered hospital care (Medicare Part A) and doctor and out-patient care (Medicare Part B). However, the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003⁸ resulted in providing coverage for prescription drug costs as well (Medicare Part D). A beneficiary may purchase Part D coverage if he or she is entitled to Part A or enrolled under Part B. Today, Medicare

⁵ CDC established the Vaccine Adverse Event System (VAERS) in 1990. It is a national passive reporting system that accepts reports from the public on adverse events associated with vaccines licensed in the U.S.

⁶ See generally Centers for Disease Control and Prevention, Vaccine Adverse Event Reporting System (VAERS), <http://vaers.hhs.gov/index>.

⁷ Centers for Disease Control and Prevention, *Recommended Adult Immunization Schedule: United States, 2009*, 57:33 MMWR 2009, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5753a6.htm>.

⁸ Pub. L. No. 108-173, 108th Cong. (2003).

provides coverage to 45 million Americans, of which 41 million are enrolled in Part B and 28 million enrolled in Part D.⁹

Prescription drug coverage under Part D is voluntary and plans are not required to pay for all covered Part D drugs. They may establish their own formularies, or list of covered drugs for which they will make payment. This, in addition to an initial coverage limit, different costs and benefits from year to year, deductibles, penalty for late enrollment, and a fixed enrollment period, (from November 15 to December 31), may discourage enrollment by certain Medicare beneficiaries.

Conversely, Part B's benefits structure is far less complex. Coverage is limited only by the medical necessity of the patient. Medicare Part B pays 80 percent of reasonable charges regardless of the actual amount billed by the provider. The patient pays the remaining 20 percent.

Health Care Cost and Prevention

Most current health care systems are based on responding to acute medical problems, urgent needs of patients, and other pressing concerns. Many diseases can be prevented, yet health care systems do not make the best use of their available resources to support this process. Given that many medical conditions are preventable, every health care interaction should include prevention support.

Good quality preventive medical care holds the promise of greatly reducing the nation's health care costs and overall burden of disease. The extent of this relationship is evidenced by the words of former Secretary of HHS, Tommy Thompson, in April 2003, at the launch of the *Steps to a Healthier U.S.* national initiative when he said:

[A]pproximately 95% of the \$1.4 trillion that we spend as a nation on health goes to direct medical services, while approximately 5% is allocated to preventing disease and promoting health. This approach is equivalent to waiting for your car to break down before you take it in for maintenance. By changing the way we view our health, the *Steps* initiative helps move us from a disease care system to a true health care system."¹⁰

Conclusion

The close relationship that exists between disease prevention and the state of the health care system has been well documented and is available to those with the responsibility to formulate the public policy.¹¹ The impact of this proposed change for Medicare

⁹ See generally Center for Medicare and Medicaid Services, *Research, Statistics, Data & Systems*, available at www.cms.hhs.gov/home/rsds.asp. For a brief explanation of Medicaid and Medicare, see the CDC's report at <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2008.pdf>.

¹⁰ U.S. Dep't of Health and Human Services, *Steps to a Healthier U.S.*, (2001), available at http://www.healthierus.gov/steps/steps_brochure.pdf.

¹¹ Ed Kelley, et al., *Prevention Healthcare Quality in America: Findings From The First National*

beneficiaries would be very beneficial because an important consequence of the vaccine shortage to primary care quality is disruption of the continuity of care. There are thousands of reimbursement codes under the Medicare system, but only a few are for preventive care. The current health care system is designed around treating patients once they become sick. An increased availability for physician reimbursement can lead to a significant improvement in health maintenance through higher immunization rates and may be used as a measure of quality of care.

If our health care system could shift a small percentage of total spending into programs that help prevent people from getting sick, it would help also to reduce the overall cost of medical care. In view of this we consider that the request made to the Secretary of HHS is a valid one for which it establishment should be supported by others medical, public and private organizations.

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