Vaccine 32 (2014) 618–623

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Vaccination benefits and cost-sharing policy for non-institutionalized adult Medicaid enrollees in the United States

Alexandra M. Stewart[a,*], Megan C. Lindley[b,1], Kristen H.M. Chang[c,2], Marisa A. Cox[d,3]

[a] Immunization Law and Policy Program, Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2021 K Street, Suite 800, Washington, DC 20006, USA
[b] National Center for Immunization & Respiratory Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, Georgia 30333, USA
[c] Immunization Law and Policy Program, Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2021 K Street, Suite 800, Washington, D.C. 20006, USA
[d] Immunization Law and Policy Program, Department of Health Policy, School of Public Health and Health Services The George Washington University, 2021 K Street, Suite 800, Washington, DC 20006, USA

ARTICLE INFO

Article history:
Received 9 August 2013
Received in revised form
14 November 2013
Accepted 17 November 2013
Available online 27 November 2013

Keywords:
Medicaid
Adult vaccination
Health reform
Health insurance

ABSTRACT

Medicaid is the largest funding source of health services for the poorest people in the United States. Medicaid enrollees have greater health care, needs, and higher health risks than other individuals in the country and, experience disproportionately low rates of preventive care. Without, Medicaid coverage, poor uninsured adults may not be vaccinated or would, rely on publicly-funded programs that provide vaccinations. We examined each programs' policies related to benefit coverage and, copayments for adult enrollees. Our study was completed between October 2011 and September 2012 using a document review and a survey of Medicaid administrators that assessed coverage and cost-sharing policy for fee-for-service programs. Results were compared to a similar review, conducted in 2003. Over the past 10 years, Medicaid programs have typically maintained or expanded vaccination coverage benefits for adults and nearly half have explicitly prohibited copayments. The 17 programs that cover all recommended vaccines while prohibiting, copayments demonstrate a commitment to providing increased access to vaccinations for adult enrollees. When developing responses to fiscal and political challenges, the programs that do not cover all ACIP recommended adult vaccines or those that permit copayments for vaccinations, should consider all strategies to increase vaccinations and reduce costs to enrollees.

Medicaid is the largest source of funding for medical and health-related services for the poorest people in the United States [1]. Every state, DC, and 5 Territories participate in the program [2,3]. In 2011, over 19 million adults, ages 19 through 64, were enrolled in the 50 states and the District of Columbia, with almost 11 million residing in ten states (CA, NY, FL, PA, MI, OH, IL, TX, MA, and TN) [4]. The distribution of adult enrollees varied by state in 2011, ranging from 4% in NH to 19% in DC and VT [4].

While federal law outlines minimum requirements for all Medicaid programs, including mandatory benefits for a defined beneficiary population, each state retains authority to define several aspects of the program, including optional benefits, provider payment levels, and delivery systems. Vaccination services for adult enrollees are governed at the program level: each state determines which adult vaccines will be covered, enrollee cost-sharing policy, provider reimbursement policy, and the settings where vaccines may be administered.

Medicaid enrollees have greater health care needs and higher health risks than other individuals in the country [5,6]. Nondisabled enrollees report their health status to be fair or poor (33%) at approximately triple the rate of privately insured individuals (12%) [7] and experience disproportionately low rates of preventive care [5,8]. They may not be able to afford preventive services due to their relatively high cost in relation to enrollee incomes [9]. Under the Patient Protection and Affordable Care Act (PPACA), also known as health reform, vaccination coverage benefits remain an optional service for adult enrollees who were enrolled in Medicaid beneficiary categories established before January 1, 2014. However, beginning January 1, 2014, Medicaid programs covering all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration costs while prohibiting cost-sharing will receive an additional 1% Federal Medical Assistance Percentage (FMAP) [10]. The FMAP determines the amount of federal matching funds that states receive for Medicaid

* Corresponding author. Tel.: +1 202 994 4141; fax: +1 202 994 4040.
E-mail addresses: stewarta@gwu.edu (A.M. Stewart), cvx9@cdc.gov (M.C. Lindley), khmchang4@gmail.com (K.H.M. Chang), mcox@gwu.edu (M.A. Cox).
[1] Tel.: +1 404 639 8717.
[2] Tel.: +1 202 994 4146; fax: +1 202 994 4040.
[3] Tel.: +1 202 994 4147; fax: +1 202 994 4040.

0264-410X/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.vaccine.2013.11.050

expenditures. Additionally, the PPACA requires programs to cover vaccines in accordance with ACIP recommendations for newly eligible adults who enroll on or after January 1, 2014.

However, because many states may not participate in program expansion under the PPACA, millions of adults who would otherwise be eligible to enroll in Medicaid will not have ensured access to vaccinations. Without Medicaid coverage, poor uninsured adults may not be vaccinated or would rely on publicly-funded programs that provide vaccinations [11].

Our study assessed benefit coverage and cost-sharing for vaccination services for non-institutionalized adults among fee-for-service programs throughout the country, excluding the 5 U.S. Territories. This review analyzes how states respond to changes in regulatory and fiscal environments and how these changes impact access to recommended vaccinations for millions of poor adults.

1. Methods

Between October 2011 and September 2012, we conducted a document review and developed and administered a survey assessing coverage and cost-sharing policy for Medicaid fee-for-service programs. The results were compared to our 2003 study entitled The Epidemiology of US Immunization Law: Medicaid Coverage of Immunizations for Non-Institutionalized Adults (2003 study) [12].

1.1. Document review

The document review included materials from all 51 programs. From October 2011 through March 2012, we conducted a web-based document search, using search terms: "Medicaid fee schedule," "Medicaid physician visit cost-sharing", and "adult Medicaid immunization or vaccination." The search yielded state-issued provider manuals, physician bulletins and newsletters, consumer handbooks, fee schedules, commercially available state plan summaries, and Current Procedural Terminology (CPT) codes related to coverage of, cost-sharing and payment for adult vaccination services under Medicaid.

1.2. Survey population

Medicaid administrators from 50 states and DC were asked to complete a survey, and verify the results from the document review and the 2003 study. This study was exempted from review in accordance with guidelines of our Institutional Review Board (IRB).

1.3. Survey design and administration

We developed a survey in collaboration with the National Center for Immunization & Respiratory Diseases (NCIRD) Immunization Services Division (ISD) of the Centers for Disease Control and Prevention (CDC).

On March 14, 2012, we emailed a letter signed by a CDC official and the principal investigator to each Medicaid program director. The letter introduced the project, provided links and attachments to study materials, and provided instructions for submitting completed responses. The survey was disseminated using Survey Monkey, an online survey tool.

We queried administrators about the programs' fee-for-service plans' coverage of vaccines recommended for adults in 2012, whether the program prohibits cost-sharing for adult vaccination services, and about their reimbursement policy, anticipated response to health reform, and adult vaccination program management.

Rank order scale questions were used to prioritize the factors that influence coverage decisions [13]. Open-ended questions were used to determine how the 1% FMAP increase would affect program coverage or cost-sharing decisions for adult vaccinations and to identify the reimbursement rates for adult vaccines [13]. We used multiple choice questions to determine coverage levels for beneficiaries enrolled before January 1, 2014 and to determine the factors that influence coverage decisions [13].

Between April 2, 2012 and September 5, 2012, participants who had not submitted completed surveys received follow-up e-mails and phone calls every two weeks or as necessary. Participants submitted completed surveys via e-mail, facsimile, or online between March 18, 2012 and September 28, 2012. No state attempted to submit a survey after September 28, 2012.

1.4. Comparison of 2012 data to 2003 study

The results of the 2003 document review included data from 50 of the 51 programs. In 2003, data from DC was unavailable; but was obtained for the 2012 update. We compared the 2003 and 2012 research results to determine whether coverage, cost-sharing, or provider reimbursement policies changed. In the 2003 study, only 1 CPT code per vaccine was used as a measure of benefit coverage and may have resulted in an underestimation of coverage. The 2012 study incorporates all CPT codes applicable to each vaccine under review to ensure accurate measurement of vaccine benefit coverage.

2. Results

2.1. Survey response and characteristics of respondents

By October 1, 2012, 42/51 programs (82%) responded to the survey. Of the 9 programs that did not complete the survey, 2 programs (WV, WI) declined to participate and 7 (IL, KS, NH, NC, OH, PA, and RI) did not respond.

The 42 responding programs cover approximately 16 million of the more than 19 million Medicaid enrollees ages 19 through 64 [4]. Respondents included 6 of the 10 largest programs and covered 41% of all enrollees ages 19 through 64. The median respondent program has approximately 223, 210 enrollees in this age group.

2.2. Vaccine benefit coverage

Table 1 shows changes in vaccination coverage benefits for adult enrollees between 2003 and 2012, as measured by the document review. Ninety-eight percent of all programs (50/51) cover at least 1 vaccine for non-institutionalized adult enrollees, an increase from 2003 when 94% of programs (47/50) covered at least 1 vaccine. In 2012, the majority of programs (71%, 36/51) cover all ACIP recommended vaccines, representing an 8 percentage point increase from 2003 (63%, 32/50). In 2003, AK, FL, and LA did not cover any vaccines. By 2012, AK and LA added coverage of certain vaccines, while FL continued to exclude coverage of any vaccine for non-institutionalized adults (Table 1).

Most of the states that did not cover all ACIP recommended vaccines in 2003 increased benefit coverage to include hepatitis A and B, influenza, meningococcal, and Td vaccines by 2012. However, four states (GA, ND, SD, and TX) decreased coverage since 2003. Georgia eliminated the highest number of vaccines and no longer covers MMR, varicella, Td or pneumococcal vaccines, but added HPV and zoster. Even though LA and MS cover the fewest vaccines, both states now offer HPV, influenza, and pneumococcal vaccines (Table 1).

In 2012, influenza vaccine was the most frequently covered vaccine (98%, 50/51), with 6 different formulations available for use among adults. While DE, MA, and NH are the only programs that covered all 6 influenza vaccines, 88% of programs (45/51) covered the intramuscular (90656 and 90658), preservative and