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Primary care physicians' perspective on financial issues and adult immunization in the Era of the Affordable Care Act

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ABSTRACT

Background: Financial barriers to adult vaccination are poorly understood. Our objectives were to assess among general internists (GIM) and family physicians (FP) shortly after Affordable Care Act (ACA) implementation: (1) proportion of adult patients deferring or refusing vaccines because of cost and frequency of physicians not recommending vaccines for financial reasons; (2) satisfaction with reimbursement for vaccine purchase and administration by payer type; (3) knowledge of Medicare coverage of vaccines; and (4) awareness of vaccine-specific provisions of the ACA.

Methods: We administered an Internet and mail survey from June to October 2013 to national networks of 438 GIMs and 401 FPs.

Results: Response rates were 72% (317/438) for GIM and 59% (236/401) for FP. Among physicians who routinely recommended vaccines, up to 24% of GIM and 30% of FP reported adult patients defer or refuse certain vaccines for financial reasons most of the time. Physicians reported not recommending vaccines because they thought the patient's insurance would not cover it (35%) or the patient could be vaccinated more affordably elsewhere (38%). Among physicians who saw patients with this insurance, dissatisfaction ('very dissatisfied') was highest for payments received from Medicaid (16% vaccine purchase, 14% vaccine administration) and Medicare Part B (11% vaccine purchase, 11% vaccine administration). Depending on the vaccine, 36–71% reported not knowing how Medicare covered the vaccine. Thirty-seven percent were 'not at all aware' and 19% were 'a little aware' of vaccine-specific provisions of the ACA.

Conclusions: Patients are refusing and physicians are not recommending adult vaccinations for financial reasons. Increased knowledge of private and public insurance coverage for adult vaccinations might position physicians to be more likely to recommend vaccines and better enable them to refer patients to other vaccine providers when a particular vaccine or vaccines are not offered in the practice.

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1. Introduction

Most deaths from vaccine preventable disease in the U.S are among adults, yet adult vaccination rates for most recommended vaccines remain low [1]. National stakeholders in adult immunization have voiced concerns about gaps in financing for adult

vaccines [2] being one source of the problem and prior research [3,4] suggests physicians view financial barriers as key contributors to low adult immunization rates. Comparatively, the U.S. pediatric vaccination program has been much more successful [5] and benefits from the financial infrastructure of the Vaccines for Children program (VFC) [6]. Financial barriers to pediatric vaccination [7–11] have been well explored, but there has been little in-depth research of these barriers in the adult immunization program.

The current U.S. system for financing adult vaccine delivery is a mixture of public and private sector efforts, similar to the pediatric

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program, although there is not a comparable program to VFC for adults. Some of the provisions of the Affordable Care Act (ACA) aimed to address financial barriers to vaccination, but holes remain in the financial framework for adult vaccine delivery. The ACA mandates that non-grandfathered private health insurance plans cover Advisory Committee on Immunization Practices (ACIP) recommended vaccines without a copay when administered by an in-network provider, thus decreasing a financial barrier for patients. However, the law does not address payment to providers for vaccine purchase and administration [2]. The ACA temporarily increased Medicaid reimbursement for vaccine administration to Medicare level (\$21) [11] which may have decreased physicians' financial barriers to providing vaccines to Medicaid patients. However, the ACA did not mandate State Medicaid agencies do so and several State Medicaid agencies do not cover all ACIP recommended adult vaccines [12]. The ACA did not affect vaccination coverage benefits in Medicare, the primary payer for adult vaccines for seniors.

Medicare Part B covers seasonal influenza vaccines, pneumococcal vaccines, and hepatitis B vaccine for patients with certain conditions, and vaccines directly related to the treatment of an injury or direct exposure to a disease. Over 90% of Medicare beneficiaries have Medicare Part B coverage [13]. Vaccines not covered by Medicare Part B, must be covered by Medicare Part D plans and are subject to deductibles and copays for each individual vaccine. Not all Medicare beneficiaries have a Part D plan to cover these other vaccines; in 2015, 71% of seniors had Medicare Part D coverage [14].

Little is known about physician awareness of Medicare coverage of vaccines or of the vaccine-specific provisions of the ACA. While physicians have reported concerns about reimbursement for adult vaccine delivery, this has not been assessed by payer type. Given the important role financial barriers may play in patient and provider behaviors related to adult vaccine delivery, we conducted a survey to determine among general internists and family physicians nationally soon after ACA implementation: (1) the proportion of adult patients who defer or refuse vaccines because of cost and the frequency of physicians not recommending vaccines for financial reasons; (2) satisfaction with payment for vaccine administration and purchase by payer type; (3) knowledge of Medicare coverage of vaccines; and (4) awareness of vaccine-specific provisions of the ACA.

2. Methods

2.1. Study setting

From June – October 2013, we administered a survey to a national network of physicians who spent at least half their time practicing primary care. The human subjects review board at the University of Colorado Denver approved this study as exempt research not requiring written informed consent.

2.2. Study population

The Vaccine Policy Collaborative Initiative [15], a survey mechanism to assess physician attitudes about vaccine issues in collaboration with the Centers for Disease Control and Prevention (CDC), conducted the survey. We developed a network of primary care physicians for this program by recruiting general internists (GIM) and family physicians (FP) from the memberships of the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP). We conducted quota sampling [16] to ensure that networks of physicians were similar to the ACP and AAFP memberships with respect to region, urban versus rural location,

and for GIM only, practice setting. We previously demonstrated that survey responses from network physicians compared to those of physicians randomly sampled from American Medical Association physician databases were similar with respect to reported demographic characteristics, practice attributes, and attitudes about vaccination issues [16].

2.3. Survey design

We developed the survey collaboratively with the CDC. We used 4-point Likert scales for assessing frequency of not recommending vaccines for financial reasons ('Never' to 'Frequently'), for satisfaction ('Very satisfied' to 'Very dissatisfied') with insurance payment for vaccine and administration fees for each payer type, and for whether physicians had considered stopping providing vaccines to patients with specific insurance types ('never considered,' 'considered, but not seriously,' 'seriously considered or discussed,' 'already stopped providing all vaccines.'). Private payer types included fee for service (FFS), preferred provider organizations (PPO), and managed care (MCO) or health maintenance organizations (HMO). Public payer types included Medicaid and Medicare Parts B and D. We provided respondents with information about vaccine-specific provisions of the ACA and asked questions regarding their prior awareness of these provisions and whether these provisions would result in their practices changing stocking patterns of adult ACIP routinely recommended vaccines. A national advisory panel of GIM ($n = 3$) and FP ($n = 4$) pre-tested the survey, which we modified based on their feedback. We pilot-tested the survey among 50 GIM and 15 FP nationally and further modified based on their feedback.

2.4. Survey administration

Based on physician preference, we sent the survey over the Internet [17] or through the U.S. Postal Service. We sent the Internet group an initial e-mail with up to 8 e-mail reminders, and we sent the mail group an initial mailing and up to 2 additional reminders. Non-respondents in the Internet group were also sent a mail survey in case of problems with e-mail correspondence. We patterned the mail protocol on Dillman's tailored design method [18].

2.5. Statistical analysis

We pooled Internet and mail surveys for analyses because other studies have found that physician attitudes are similar when obtained by either method [18–20]. We compared respondents with non-respondents on all available characteristics using Wilcoxon and chi-square analyses; characteristics of non-respondents were obtained from the recruitment survey for the sentinel networks. We compared GIM and FP responses using Mantel-Haenszel chi-square and Fisher's exact tests. With the exception of reported proportion of patients who defer or refuse vaccines for financial reasons and reported satisfaction with reimbursement by payer type, responses between specialties were similar and are, therefore, presented together. For comparisons between public (Medicaid, Medicare Parts B & D) and private insurance (HMO/MCO, PPO, FFS) we compared the proportion who responded 'very dissatisfied' to any payer in that group using chi-square analyses. Analyses were performed using SAS software, version 9.4 (SAS Institute, Cary, North Carolina).

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